<u>Health Financ</u> This report	is required by law (42 USC 1395g; 42 CF	SCHNECK MEDIC FR 413.20(b)). F	ailure to repo	ort can result	in all interim)
HOSPITAL AND AND SETTLEMEN				CCN: 150065 P	JSC 1395g). eriod: rom 01/01/2015 o 12/31/2015	OMB NO. 0938- Worksheet S Parts I-III Date/Time Pre 5/18/2016 3:5	epared:
PART I - COS Provider use only	T REPORT STATUS 1. [X]Electronically filed cost rep 2. [] Manually submitted cost repo 3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter	rt enter the numbe	r of times the "L" for low.	e provider res	Date: 5/18/20 ubmitted this c		3:59 pm
Contractor use only	(1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report Final Report fo	for this Prov ⁻ r this Provide	11.Cor ider ССN 12.[С		or Code: olumn 1 is 4: n nes reopened =	
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	CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROV	EDER(S)				
elect Exper endir compl excep healt laws <u>Encry</u> ECR:	REBY CERTIFY that I have read the above tronically filed or manually submitted asses prepared by SCHNECK MEDICAL CENTER ing 12/31/2015 and to the best of my kno lete and prepared from the books and re tot as noted. I further certify that I th care services, and that the services and regulations. <u>yption Information</u> Date: 5/18/2016 Time: 3:59 pm V:v.TVVhnv:Wf3fpQevqzxLKi0	cost report and (150065) for wledge and beli ecords of the pr am familiar wit	the Balance S the cost report ovider in acco h the laws and this cost report adOffice	sheet and State orting period b trand statemen ordance with and regulations of ort were provide Nort Reference or or Administ	ement of Revenu beginning 01/01 nt are true, co opplicable instr regarding the p ded in complian frator of Provid	e and /2015 and rrect, uctions, rovision of ce with such ler(s)	
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PI: EJGOj XOZMO	LIV6QP0Z9iI: Date: 5/18/2016 Time: 3:59 pm jqr.PBV0cyktviEfik:1YR9vp0 08LkEI:phC6dvpUWL1cwbrXuw JdFZIE0TLcfy		Title 5-2 Date	74.16			
		Title V	Title Part A 2.00	XVIII Part B 3.00	HIT 4,00	Title XIX 5.00	
PART II 1.00 Hospita	II - SETTLEMENT SUMMARY		119,292	152,215	38,178	0	1.00
2.00 Subprov 3.00 Subprov 5.00 Swing I 6.00 Swing I 9.00 HOME HI 200.00 Total	vider - IPF vider - IRF bed - SNF bed - NF EALTH AGENCY I	0 0 0 0 0 0	0 0 19,926 0 139,218	0 0 31,957 1 184,173	38,178	0 0 0 0 0 0 0 0 0	2.00 3.00 5.00 6.00
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displays a va required to c instructions, have any comm 7500 Security Please do not Reports Clear under the ass	lid OMB control number. The valid OMB omplete and review the information col search existing resources, gather the ents concerning the accuracy of the ti Boulevard, Attn: PRA Report Clearance send applications, claims, payments, ance Office. Please note that any cor ociated OMB control number listed on t egarding where to submit your document	control number lection is estin data needed, au me estimate(s) of Officer, Mail 3 medical records respondence not his form will no	for this info mated 673 hour nd complete an or suggestions Stop C4-26-05, or any docume pertaining to ot be reviewed	rmation collec s per response d review the i for improving Baltimore, Ma nts containing the informati , forwarded, co	tion is 0938-00 e, including the nformation col the form, ple tryland 21244-1 sensitive info on collection b	050. The time e time to revi lection. If y ase write to: 850. ormation to th burden approve	ew ou CMS, e PRA d

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Prov	ider CCN	I: 150065	Period: From 01/01 To 12/31	/2015	Part I Date/T	neet S-: Time Pro 2016 3:0	epare
	1.00	2.00		3.00			4.00			
20	Hospital and Hospital Health Care Co				1					
00 00	Street: 411 WEST TIPTON STREET City: SEYMOUR	PO Box: State: IN	Zin Cod	e: 47274-	Cour	ity: JACKSON				1.
50	CITY. SETWOOR	Component Name	CCN	CBSA	Provi de			ent Svs	tem (P,	_
			Number	Number		Certified		, 0, or		
							V	XVIII		
	1	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		1500/5	00045		07/1//10/				-
00	Hospi tal	SCHNECK MEDICAL CENTER	150065	99915	1	07/16/196	6 N	P	0	3.
00 00	Subprovider - IPF Subprovider - IRF									4.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF	SCHNECK MEDICAL CENTER	150065	99915		03/04/199	9 N	P	N	7.
00	Swing Beds - NF	SCHNECK MEDICAL CENTER	150065	99915		03/04/199	9 N		0	8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00	Hospital-Based HHA	JACKSON COUNTY HOME	157155	99915		07/01/198	5 N	P	0	12.
00	Soparatoly Cortified ASC	HEALTH								13.
00	Separately Certified ASC Hospital-Based Hospice	HOSPICE OF MEMORIAL	151529	99915		12/09/1994	4			13.
50		HOSPI TAL	131327	77713		12/07/179	1			'4.
00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
00	Other						<u> </u>			19.
						From 1.0			<u>o:</u> 00	-
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	-		1/2015	20.
00	Type of Control (see instructions)					01/01/	8	12/01	172015	21.
	Inpatient PPS Information					1				
00	Does this facility qualify and is it	currently receiving p	ayments for	di spro	portionate	e Y			N	22.
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil			2.06(c)	(2) (Pi ckl (Ð				
01	amendment hospital?) In column 2, er			t		Y			Y	22.
01	Did this hospital receive interim un period? Enter in column 1, "Y" for y					Y			Ŷ	22.
	reporting period occurring prior to									
	for no for the portion of the cost r									
	(see instructions)	1 31	5							
02	Is this a newly merged hospital that							I	N	22.
	determined at cost report settlement					es				
	or "N" for no, for the portion of th	e cost reporting perio	d prior to	October	1. Enter					
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the portion of	the cost r	eporting	g period d	n				
03	Did this hospital receive a geograph	ic reclassification fr	om urban te	rural :	as a resul	t N			N	0.0
05	of the OMB standards for delineating			, iuiui a	15 u i c5u					1 11
			oted by CMS	in FY20	015? Enter	~				22
	in column 1, "Y" for yes or "N" for	no for the portion of								22
	prior to October 1. Enter in column		the cost re	eporting	peri od					22.
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00	prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col medicaid paid days in column 1, the Medicaid eligible unpaid days in col	2, "Y" for yes or "N" r after October 1. (se t more than 499 beds ("Y" for yes or "N" for dicaid days on lines 2 f census days, or 3 if is cost reporting peri- iod? In column 2, ent In-S Medi- paid 1.1 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,	the cost refor no for e instructi as counted no. 4 and/or 25 date of di od differer er "Y" for tate In-S caid Medi days elig unp da 00 2. 630	porting the portons) Doe in accord below? scharge. tfrom yes or tate caid ible M aid pa ys 00 312	period tion of the sthis rdance with In column . Is the the methoo "N" for ne Out-of State edicaid aid days 3.00 0	ne th n d d d d d d d d d d d d d d d d d d	Medi cai HMO day 5. 00	id (ys Me	Other edicaid days 6.00	23.
00	prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per linestate Medicaid paid days in colum Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in colum 4, Medicaid HMO paid and eligible unpaid 4, Medicaid days in colum 5, and other Medicaid days in column 5, and other Medicaid days in colum 1f this provider is an IRF, enter th Medicaid paid days in column 1, the	2, "Y" for yes or "N" r after October 1. (se t more than 499 beds ("Y" for yes or "N" for dicaid days on lines 2 f census days, or 3 if is cost reporting peri- iod? In column 2, ent In-S Medi- paid 1.1 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	the cost refor no for e instructi as counted no. 4 and/or 25 date of di od differer er "Y" for tate In-S caid Medi days elig unp da 00 2. 630	porting the portons) Doe in accord below? scharge. tfrom yes or tate caid ible M aid pa ys 00 312	period tion of the sthis rdance with In column . Is the the methoo "N" for ne Out-of State edicaid aid days 3.00 0	ne th n d d d d d d d d d d d d d d d d d d	Medi cai HMO day 5. 00	id (ys Me	Other edicaid days 6.00	23

			CAL CENTER		1	n Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der		eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/18/20	me Pre	pared:
					Urban/Rur 1.00			Geogr	
26.00	Enter your standard geographic classification (not			jinning of the	1.00	2	2.0	0	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not v reporting period. Enter in column 1, "1" for urban of	wage) st or "2" f	atus at the enc or rural. If ap			2			27.00
35. 00	enter the effective date of the geographic reclassi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		o			35.00
					Begi nni 1. 00		Endi 2. (
36.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent da		Subscript line	36 for number	1.00		2. 0		36.00
37.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perioc	s MDH status		0			37.00
38.00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (
39.00	Does this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage ro CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Énte equireme	er in column 1 nts in accordar	"Y" for yes nce with 42	Y		Y		39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October	on adjus ober 1.	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40. 00
						V 1.00	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)–Capital Does this facility qualify and receive Capital payme	ent for	di sproporti onat	e share in acc	ordance	N	N	N	45.00
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exo pursuant to 42 CFR §412.348(f)? If yes, complete Wks	cepti on	for extraordina	ary circumstanc	es	N	N	N	46.00
47.00 48.00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital payment Teaching Hospitals				10.	N N	N N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in	n approv	ed GME programs	s? Enter "Y" f	or yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is '	or yes o hth of t	r "N" for no ir his cost report	n column 1. If ing period? E	column 1 Inter "Y"				57.00
58.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost rein	l, if a nburseme	pplicable. nt for physicia			N			58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	es, comp	lete Wkst. D-2,			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y'				tions)	N	Direct	GME	60.00
		1.00	2.00	3.00	4.00)	5.0	00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00			61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	9	O. OC	0.00					61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.00					61.03
61. 04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line	2	O. OC	0.00					61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0. 00					61.06

ealth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi de		eriod:	Worksheet S-2	
			T,		5/18/2016 3:0	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count. 1.20 Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted count 	r of FTE residents ructions) Enter in r in column 2, the the IME FTE Jumn 4, direct GME fy each expanded he number of FTE gram. (see the program name, ode, enter in column and enter in column			0.00		61. 1
ACA Drovi of one Affection de la	th Decourses and C	aviana Administration ti			1.00	
ACA Provisions Affecting the Hea 2.00 Enter the number of FTE resident				od for which	0.00	62.0
your hospital received HRSA PCRE	funding (see instruc	ctions)			0.00	02.0
2.01 Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (see instructi		your hospital	0.00	62.(
8.00 Has your facility trained reside "Y" for yes or "N" for no in col	ents in nonprovider se	ettings during this	e instructions)		N	63.
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	+
Section 5504 of the ACA Base Yea	nr FTE Residents in No	onprovider Settings-				
period that begins on or after J			0.00	0.00	0. 000000	
4.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted nor tations occurring in number of unweighted nur hospital. Enter in 1 + column 2)). (see	n-primary care all nonprovider non-primary care column 3 the ratio instructions)				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of			0. 00) 0.00	0. 000000	, 65. C

	Financial Systems		CK MEDICAL C	ENTER		I	n Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der		Period: From 01/01, To 12/31,		Worksheet S- Part I Date/Time Pr 5/18/2016 3:	epared:
					Unweighted FTEs Nonprovider Site		n al	Ratio (col. 1 (col. 1 + col 2))	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovide	r Settina	1.00 IsEffecti ve	2.00 for cost re		3.00 na periods	
	beginning on or after July 1, 20	10	•				·		
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 8 the ratio	ings. dent	0.0	JO	0.00	0. 00000	0 66.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n	Ratio (col. 3 (col. 3 + col 4))	
		1.00	2.0	0	3.00	4.00)	5.00	-
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. 0		0. 00		0 67.00
							1.0	0 2 00 2 00	_
	Inpatient Psychiatric Facility P	PS					1.0	0 2.00 3.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or doe	s it cont	ain an IPF sub	oprovi der?	N		70.00
71.00	If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter lity train (D)? Enter	"Y" for y residents "Y" for y	es or "N" for in a new teac es or "N" for	no. (see chi ng no.		0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	(IRF), or	does it c	ontain an IRF		N		75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 20 new teaching for no. Col	04? Enter g program umn 3: If	"Y" for yes o in accordance column 2 is Y	or "N" for e with 42 (,		0	76.00
								1.00	-
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.					g period? E	nter	N N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (excl uded un				no.	N	85. 00 86. 00
87.00	Is this hospital a "subclause (I			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N	87.00
	for yes or "N" for no.					V		XI X	
	Title V and XIX Services					1.00		2.00	
90.00	Does this facility have title V		hospital se	rvi ces? E	nter "Y" for	N		Y	90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for		nrough the c	ost repor	t either in	N		N	91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicab	le column				N	92.00
	instructions) Enter "Y" for yes	or"N" for no in the	appl i cabl e	column.					
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		imposes of t	itie V an	a XIX? Enter	N		N	93.00
94.00	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and	"N" for n	o in the	N		N	94.00

Health Financial Systems SCHNECK MEDICAL CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 150065 F	lr eriod:	n Lieu	<u>ı of For</u> Workshe		
	F	rom 01/01/ o 12/31/		Part I Date/Ti 5/18/20	me Pre	pared:
		V 1.00		XI 2.0	Х	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no		N	0.00	2. c	0.00	95.00 96.00
applicable column. 97.00 <u>If line 96 is "Y", enter the reduction percentage in the applicable column</u>	n.		0.00		0.00	97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth	nod of payment	N				105. 00 106. 00
<pre>for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instr yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the pr reimbursed. If yes complete Wkst. D-2, Pt. II.</pre>	ructions) If	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sched CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00
Physical 1.00	Occupational 2.00	Speec 3. 00		Respir 4.(
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. N	N	N		N		109.00
				1. 0		_
110.00 Did this hospital participate in the Rural Community Hospital Demonstration the current cost reporting period? Enter "Y" for yes or "N" for no.	on project (41	OA Demo)for	-	N		110.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th	is "E", enter rm care (inclu	in column des	N		0	115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 s this facility legally-required to carry malpractice insurance? Enter "N		"N" for	N N			116. 00 117. 00
no. 118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	0			118. 00
	Premi ums	Losses	5	Insur	ance	
	1.00	2.00		3. 0	00	-
118.01 List amounts of malpractice premiums and paid losses:	987, 64		0			118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other 1	than the	1.00 N		2.0	00	118.02
Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 119.00D0 NOT USE THIS LINE						119.00
120.00 is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	' for yes or ne Outpatient	N		Y		120.00
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. Transplant Center Information	s charged to	Y				121.00
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.	for no. If	N				125.00
126.00 If this is a Medicare certified kidney transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					127.00
128.00 If this is a Medicare certified liver transplant center, enter the certifi	cation date					128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	cation date in					129. 00
130.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.	ti fi cati on					130. 00
131.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.	erti fi cati on					131.00
132.00 If this is a Medicare certified islet transplant center, enter the certifi	cation date					132. 00
 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 	cation date					133. 00
134.00 If this is an organ procurement organization (OPO), enter the OPO number i and termination date, if applicable, in column 2.	n column 1					134.00

IGSPI IAL AND HOSPI IAL HADLIN CARE CORPLEX IDENTIFICATION DATA Provider COE 1500es Period Derivations Derivations INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Derivations Derivations INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Derivations Derivations INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Derivations INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Derivations INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es INIT Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es INIT Provider 1500 Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es Initial Provider COE 1500es INIT Provider 1500 Provid	Health Financial Systems	SCHNECK ME	EDICAL CENTER				In Lie	u of Form CMS-:	2552-10	
To 12/31/2015 Outer/Time Program 140.004er: there any related organization or home office costs as defined in CMS Pub. 15-1. N 140.00 100.014er: there any related organization or home office costs as defined in CMS Pub. 15-1. N 140.00 100.014er: there any related organization or home office costs as defined in CMS Pub. 15-1. N 140.00 100.014er: there any related organization organization. 2.00 3.00 1 110.014er: the home office costs contractor name and contractor name and uddress of the data of the public office costs is as defined in Norsheit As the name and uddress of the data office and enter. the home office costs is none. 10.00 12.00 120.00511y: State: Zip Code: 14.00 143.000 144.00 140.004ere provider based physicians' costs included in Norksheit A? N 146.00 165.00 164.00 165.00 164.00 165.00 164.00 165.00 164.00 165.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00 164.00	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	(IDENTIFICATION DATA	Provi dei	r CCN: 150						
Image: Second									narod	
11 Providers 140.00 00 Other three any related organization or home office costs as defined in QMS Pub. 15-1. N 140.00 10 Oper three any related organization or home office costs as defined in QMS Pub. 15-1. N 140.00 11 Obset three any related organization, enter on lines 141 through 143 the nume and address of the none office costnatcor number. 3.00 141.00 11 Obset. Exercise Address of the costnatcor number. 1.01 141.00 12.00 Development of the costnation of the costnation on and costnation of the cos						5 12	2/31/2013			
11 Providers 140.00 00 Other three any related organization or home office costs as defined in QMS Pub. 15-1. N 140.00 10 Oper three any related organization or home office costs as defined in QMS Pub. 15-1. N 140.00 11 Obset three any related organization, enter on lines 141 through 143 the nume and address of the none office costnatcor number. 3.00 141.00 11 Obset. Exercise Address of the costnatcor number. 1.01 141.00 12.00 Development of the costnation of the costnation on and costnation of the cos										
140.00Arc There any related organization or home office casts as defined in CUS Pub. 15-1. N 140.00 after claimed, entre 1n column 2 the home office casts as defined in CUS Pub. 15-1. S.00 3.00 If this facility is part of a chain organization and theme office costs S.00 3.00 If this facility is part of a chain organization and contractor number. 141.000 S.00 141.000Are: Contractor's Number. 141.000 142.00Errect: Ioo Contractor's Number. 142.00 143.000Lity State Zip Code 142.00 144.00Are provider based physiciam' costs included in Worksheet A? Y 140.00 145.000 For oreal enviroes any claimed rom West. A. Hine 74, are the costs for no. N 145.00 146.00Are provider based physiciam' costs included in Worksheet A? N 145.00 146.00Are provider based physiciam' costs included in Worksheet A? N 146.00 145.00Errect the approvider based physiciam' costs included in Worksheet A? N 146.00 146.00Errect the approvider based physiciam' for no in colum 1. Column 2. N 146.00 146.00Errect the approvider the approvider of allocation' form provider Tron of no no. N N 147.00							1.00	2.00		
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	170 00 Enter in columns 1 and 2 the EHR h	eginning date and endin	ng date for the	reporting					170 00	
			J	· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCN: 1500	65 Period: From 01/01/2015	Worksheet S-	2
				Date/Time Pr 5/18/2016 3:	
				5/16/2010 3.	
				1.00	-
171.00 If line 167 is "Y", does this provider				N	171.00
Medicare cost plans reported on Wkst. S (see instructions)	S-3, Pt. I, line 2, col. 6	5? Enter "Y" for ye	s and "N" for no.		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIUNNAIRE Provider		Period: From 01/01/2015 To 12/31/2015	Date/Time Pr	repared
				Y/N	5/18/2016 3: Date	:07 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	bonses. Enter N for all NO re	esponses. Enter			
	Provider Organization and Operation					
00	Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.
	reporting period? If yes, enter the date of t	the change in column 2. (see	Y/N	Date	V/I	_
			1.00	2.00	3.00	
0	Has the provider terminated participation in	the Medicare Program? If	N N	2.00	5.00	2.
	yes, enter in column 2 the date of termination				ĺ	
ľ	voluntary or "I" for involuntary.					
00	Is the provider involved in business transact	tions, including management	N		ĺ	3.
ľ	contracts, with individuals or entities (e.g. or medical supply companies) that are related				ĺ	
ľ	officers, medical staff, management personnel				ĺ	
ľ	of directors through ownership, control, or f				ĺ	
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports Column 1: Were the financial statements prep	aarad by a Contified Dublic	Y	A		4.
	Accountant? Column 2: If yes, enter "A" for		ř	A	ĺ	4.
ľ	or "R" for Reviewed. Submit complete copy or				ĺ	
ľ	column 3. (see instructions) If no, see instr				ĺ	
0	Are the cost report total expenses and total		N		ĺ	5.
	those on the filed financial statements? If y	yes, submit reconciliation.				
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
	Column 1: Are costs claimed for nursing scho	ool?Column 2: If ves. is th	ne provider is	Ν		6.
	the legal operator of the program?	5			ĺ	
	Are costs claimed for Allied Health Programs?			Ν	ĺ	7.
0	Were nursing school and/or allied health prog		during the	N	ĺ	8.
0	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i		al advation	Ν		9.
0	program in the current cost report? If yes, s			IN	ĺ	7.
00	Was an approved Intern and Resident GME progr		he current	Ν	İ	10.
ſ	cost reporting period? If yes, see instruction	ons.			1	
00	Are GME cost directly assigned to cost center		proved	N	ĺ	11.
	Teaching Program on Worksheet A? If yes, see	Instructions.			Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bac				Y	12.
00	If line 12 is yes, did the provider's bad deb	ot collection policy change d	luring this cos	st reporting	N	13.
00	period? If yes, submit copy.	and/an an naumanta waiwad2 lf		tructions	N	14
	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? IT	yes, see ins	tructions.	N	14.
	Did total beds available change from the pric	or cost reporting period? If	ves, see inst	ructions.	N	15.
				rt A	Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data Was the cost report prepared using the PS&R		N		N	16.
00	Report only? If either column 1 or 3 is yes,		IN IN			10.
ſ	enter the paid-through date of the PS&R				1	
ľ	Report used in columns 2 and 4 . (see				1	
	instructions)					
00	Was the cost report prepared using the PS&R		Y	03/14/2016	Y	17.
ſ	Report for totals and the provider's records for allocation? If either column 1 or 3 is				ĺ	
ľ	yes, enter the paid-through date in columns					
	2 and 4. (see instructions)				1	
	· ·		N		N	18.
	lfline 16 or 17 is yes, were adjustments	1			1	
	made to PS&R Report data for additional			1	1	
	made to PS&R Report data for additional claims that have been billed but are not				l	
	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file					
00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	10
00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments		N		N	19.
00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		Ν	19.
00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		Ν			
00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		N	19.

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE				Period:	Worksheet S-2	
					From 01/01/2015 To 12/31/2015		parad
					12/31/2015	5/18/2016 3:0	
				Pai	rt A	Part B	
		Descr	iption	Y/N	Date	Y/N	
		(0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21.00
					_	1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS ONLY (EXCE	PI CHILDRENS F	IOSPITALS)			-
22.00	Have assets been relifed for Medicare purpose	as2 If yas sa	a instructions				22.00
	Have changes occurred in the Medicare depreci			sals made durir	na the cost		23.00
	reporting period? If yes, see instructions.				5		
24.00	Were new leases and/or amendments to existing	g Leases entere	ed into during	this cost repo	orting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entere	ed into during	the cost repor	rting period? I	f yes, see		25.00
	instructions.						
26.00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uirea auring tr	ne cost reporti	ng period? IT	yes, see		26.00
27.00	Has the provider's capitalization policy char	naed during the	e cost reportir	na period? If y	ves submit		27.00
27.00	copy.	igou uurriig tiit	o ooot i opoi tii	ig portour in j			2// 00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit er	ntered into dur	ing the cost r	reporting		28.00
20.00	period? If yes, see instructions.		hand finada (D				20.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	ACCOUNT AND/OF	Dona runas (De	ebt Service Res	serve Fund)		29.00
30.00	Has existing debt been replaced prior to its			debt? If ves.	see		30.00
	instructions.			j ,			
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see		31.00
	instructions. Purchased Services						_
32.00	Have changes or new agreements occurred in pa	atient care ser	rvices furnishe	ed through cont	ractual		32.00
02.00	arrangements with suppliers of services? If			d through con			02.00
33.00	If line 32 is yes, were the requirements of 9			ng to competiti	ve bidding? If		33.00
	no, see instructions.						
24.00	Provi der-Based Physi ci ans					I	24.00
34.00	Are services furnished at the provider facili If yes, see instructions.	ty under an ar	rangement with	n provi der-base	ed physicians?		34.00
35.00	If line 34 is yes, were there new agreements	or amended exi	sting agreemer	nts with the pr	ovi der-based		35.00
	physicians during the cost reporting period?			•			
					Y/N	Date	
					1.00	2.00	
	Home Office Costs Were home office costs claimed on the cost re	aport2					36.00
	If line 36 is yes, has a home office cost sta	•	cenared by the	home office?			37.00
07100	If yes, see instructions.	aromorre boorr p	opulou by the				0,100
38.00	If line 36 is yes, was the fiscal year end of						38.00
00.00	the provider? If yes, enter in column 2 the 1						00.00
39.00	If line 36 is yes, did the provider render se see instructions.	ervices to othe	er chain compor	nents? If yes,			39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf ves, see			40.00
101 00	instructions.						101.00
						•	
			1.	00	2.	00	
41 00	Cost Report Preparer Contact Information	- (naoi ti			CEDDED		1 41 00
41.00	Enter the first name, last name and the title held by the cost report preparer in columns		LUCI A		GERBER		41.00
	respectively.						
42.00	Enter the employer/company name of the cost i	report	BLUE AND CO.,	LLC			42.00
	preparer.						
	Enter the telephone number and email address report preparer in columns 1 and 2, respective		502. 992. 3524		LGERBER@BLUEAN	DCO. COM	43.00

Heal th	Financial Systems	SCHNECK MEDICA	L CENTER	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 5/18/2016 3:0	pared:
		Part B				
		Date				
	PS&R Data	4.00				
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see					16. 00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	03/14/2016				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18. 00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. 00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21.00
			3.00	_		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		NI OR MANAGER			41.00
42.00	Enter the employer/company name of the cost r	report				42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	SCHNECK MEDI	CAL (CCN: 150065	Dr	eriod:	u of Form C Worksheet		2552-10
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provider	CCN: 150065		rom 01/01/2015	Part I	3-3	
						To		Date/Time		
						L		5/18/2016		7 pm
								I/P Days /		
	Component	Waskebeet A	No	of Dodo	Ded Davia			Visits / Tr	ips	
	Component	Worksheet A Line Number	NO.	of Beds	Bed Days Available		CAH Hours	Title V		
		1.00		2.00	3.00	-	4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		86	31, 3	90	0.00	5.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00		00	01,0	/0	0.00		0	1.00
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO I PF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF								0	6.00
7.00	Total Adults and Peds. (exclude observation			86	31, 3	90	0.00		0	7.00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT	31.00		7	2, 5	55	0.00		0	8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY	43.00							0	13.00
14.00	Total (see instructions)			93	33, 9	45	0.00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVIDER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE									20.00
21.00	HOME HEALTH AGENCY	101.00							0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00							0	22.00
24.00	HOSPICE	116.00		0		0				23.00
24.10	HOSPICE (non-distinct part)	30.00		0		0				24.00
25.00	CMHC - CMHC	30.00								25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER									26.25
27.00	Total (sum of lines 14-26)			93						27.00
28.00	Observation Bed Days			,,,					0	28.00
29.00	Ambulance Trips								5	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)			0		0				32.00
32.01	Total ancillary labor & delivery room			-						32.01
	outpatient days (see instructions)									
33.00	LTCH non-covered days									33.00

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	SCHNECK MEDIC		CCN: 150065		/01/2015 /31/2015	Worksheet S-3 Part I Date/Time Pre 5/18/2016 3:0	pared:
		I/P Days	/ O/P Visits	/ Trips	Fu	II Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Interns sidents	Employees On Payroll	
		6.00	7.00	8.00		. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4, 560	749					1.00
2.00	HMO and other (see instructions)	923	2, 363					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	223	0	2	23			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		73			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 783	749		39			7.00
8.00	INTENSIVE CARE UNIT	524	80	1, 1;	39			8.00
9.00	CORONARY CARE UNI T							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		116					13.00
14.00	Total (see instructions)	5, 307	945			0.00	718.77	
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE	F 001	0.40			0.00	05 47	21.00
22.00	HOME HEALTH AGENCY	5, 831	262	9, 40	57	0.00	25. 17	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0.00	0.00	23.00
24.00 24.10	HOSPICE	0 8, 750	491	10, 4	0	0.00	0.00	24.00 24.10
24.10	HOSPICE (non-distinct part) CMHC - CMHC	6,750	491	10,40	57			24.10
26.00	RURAL HEALTH CLINIC							25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER							26.25
20.25	Total (sum of lines 14-26)					0.00	743.94	
28.00	Observation Bed Days		266	1, 6	10	0.00	743.74	28.00
29.00	Ambul ance Trips	0	200	1,0	T /			29.00
30.00	Employee discount days (see instruction)	0		1	76			30.00
31.00	Employee discount days (see first detroit)			'	0			31.00
32.00	Labor & delivery days (see instructions)	0	4		8			32.00
32.00	Total ancillary labor & delivery room	0	4		0			32.00
52.01	outpatient days (see instructions)				5			02.01
22 00	LTCH non-covered days	О						33.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 5/18/2016 3:0	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 17	70 265	3, 231	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			18	35 O O O		2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	0. 00	0	1, 15	70 265	3, 231	14.00 15.00 16.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00 24.10 25.00 26.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00 0. 00					21.00 22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01

PI T.	Financial Systems AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015 To 12/31/2015		pare
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
	 PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES			1				
0	Total salaries (see instructions)	200.00	50, 947, 275	0	50, 947, 27	5 1, 547, 402. 13	32. 92	1.
0	Non-physician anesthetist Part		C	0		0 0.00	0.00	2.
0	A Non-physician anesthetist Part		C	741, 049	741, 04	9 8, 848. 00	83. 75	3.
0	B Physician-Part A -		232, 488	0	232, 48	8 1, 065. 20	218. 26	4
	Admi ni strati ve		202, 100		202, 10			
1 0	Physicians - Part A - Teaching Physician-Part B		0 6, 790, 875		6, 790, 87	0 0.00 5 38,762.80		
0	Non-physician-Part B		0,790,073	0	0, 790, 87	0 0.00		
0	Interns & residents (in an	21.00	C	0		0 0.00	0.00	7
1	approved program) Contracted interns and residents (in an approved		C	0 0		0 0.00	0.00	7
0	programs) Home office personnel		C	0		0 0.00	0. 00	8
0	SNF	44.00	C	0		0 0.00		
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		6, 425, 746	1, 385	6, 427, 13	1 163, 051. 20	39. 42	10
	Contract Labor: Direct Patient		502, 462	2 0	502, 46	2 10, 087. 82	49. 81	11
00	Care Contract Labor: Top Level management and other		C	0 0		0 0.00	0. 00	12
	management and administrative services							
00	Contract Labor: Physician-Part		239,000	0	239, 00	0 1, 902. 00	125. 66	13
00	A - Administrative Home office salaries &		C	0		0.00	0.00	14
	wage-related costs							
00	Home office: Physician Part A - Administrative		Ĺ			0 0.00	0.00	15
00	Home office and Contract Physicians Part A - Teaching		C	0		0 0.00	0.00	16
	WAGE-RELATED COSTS			1				
00	Wage-related costs (core) (see instructions)		11, 374, 581	0	11, 374, 58	1		17
00	Wage-related costs (other) (see instructions)		C	0		0		18
-	Excluded areas		1, 641, 785					19
00	Non-physician anesthetist Part A		C	0		0		20
00	Non-physician anesthetist Part		110, 586	0	110, 58	6		21
00	Physician Part A - Administrative		31, 209	0	31, 20	9		22
01	Physician Part A - Teaching		C	0		о		22
	Physician Part B		953, 944	0	953, 94	4		23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		(0		24
	approved program)							
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	504, 815	i 0	504, 81	5 13, 819. 87	36. 53	26
	Administrative & General	5.00	6, 905, 569					
00	Administrative & General under		680, 326	0	680, 32	6 2, 519. 06	270. 07	28
00	contract (see inst.) Maintenance & Repairs	6.00	C	o		0.00	0.00	29
00	Operation of Plant	7.00	1, 042, 571		1, 042, 57	1 47, 935. 33	21.75	30
	Laundry & Linen Service	8.00	43, 461		43, 46			
	Housekeeping Housekeeping under contract	9.00	853, 303 C		853, 30	3 64, 963. 60 0 0. 00		
	(see instructions)							
00 00	Dietary Dietary under contract (see	10.00	680, 957 C	-409, 225 0 0	271, 73	2 16, 968. 13 0 0. 00		
00	i nstructi ons) Cafeteri a	11.00	r	409, 225	409, 22	5 25, 554.00	16. 01	36
	Maintenance of Personnel	12.00		, 409, 225 0	407, 22	0 25, 554.00 0 0.00		
		13.00	2, 529, 782	-1, 385	2, 528, 39			
00	Nursing Administration Central Services and Supply	14.00	412, 098		412,09			

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 01/01/2015 To 12/31/2015		arad
						5/18/2016 3:0	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	973, 884	0	973, 884	43, 737. 20	22. 27	41.00
42.00 Social Service	17.00	C	0		0.00	0.00	42.00
43.00 Other General Service	18.00	228, 683	s 0	228, 683	6, 312. 80	36. 23	43.00

Heal th	Financial Systems	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015 To 12/31/2015		hared.
							5/18/2016 3:0	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		44, 836, 726	-741, 049	44, 095, 67	7 1, 502, 310. 39	29.35	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 425, 746	1, 385	6, 427, 13	1 163, 051. 20	39.42	2.00
	instructions)							
3.00	Subtotal salaries (line 1		38, 410, 980	-742, 434	37, 668, 54	6 1, 339, 259. 19	28. 13	3.00
	minus line 2)							
4.00	Subtotal other wages & related		741, 462	0	741, 46	2 11, 989. 82	61.84	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 405, 790	0	11, 405, 79	0.00	30. 28	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		50, 558, 232	-742, 434	49, 815, 79	8 1, 351, 249. 01	36.87	6.00
7.00	Total overhead cost (see		15, 960, 701	-1, 385	15, 959, 31	6 556, 128. 38	28. 70	7.00
	instructions)							
		-		-				

Heal th	Financial Systems S	SCHNECK MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS		Provider C	CN: 150065	Period: From 01/01/2015 To 12/31/2015		pared:
						Amount Reported	
	1					1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contributio					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see inst					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instruct					1, 328, 025	4.00
F 00	PLAN ADMINISTRATIVE COSTS (Paid to External Orga	ani zati on)				0	F 00
5.00	401K/TSA Plan Administration fees					0	
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00 7.00
7.00							
0.00	HEALTH AND INSURANCE COST					0 5 (4 0 7 7	0.00
8.00 9.00	Health Insurance (Purchased or Self Funded) Prescription Drug Plan					8, 564, 977 0	
9.00	Dental, Hearing and Vision Plan						
11.00	Life Insurance (If employee is owner or benefici	anu)				66, 052	
12.00	Accident Insurance (If employee is owner or benefici					00,052	
12.00	Disability Insurance (If employee is owner or be					450, 324	
14.00	Long-Term Care Insurance (If employee is owner of be					10, 717	
15.00	Workers' Compensation Insurance	b beneficially)				330, 137	
16.00	Retirement Health Care Cost (Only current year,	not the extraor	di narvi accri	al requir	ed by EASB 106	0	
10.00	Non cumulative portion)	not the extraol			cu by 1765 100.		10.00
	TAXES						
17.00	FICA-Employers Portion Only					3, 215, 706	17.00
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					0	19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER					•	
21.00	Executive Deferred Compensation (Other Than Reti instructions))	rement Cost Rep	orted on lir	nes 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					146, 166	
24.00	Total Wage Related cost (Sum of lines 1 -23)					14, 112, 104	
	Part B - Other than Core Related Cost						1
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	SCHNECK MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150065	Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Cost Center Description				Contract Labor		
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identifi	cati on:					
1.00	Total facility's contract labor and benefit c	ost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF						4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice				0	0	13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FOHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

	Financial Systems	SCHNECK MEDI				eu of Form CMS-	
HOME F	HEALTH AGENCY STATISTICAL DATA				Period: From 01/01/2015 To 12/31/2015		
				1 0010. 107 100	Home Health	5/18/2016 3: 0 PPS	7 pm
					Agency I		1
					1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	354.00		0 0.00 ployees (Full Ti		2.00
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
		(0	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.0			
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0			
7.00	Nursi ng Supervi sor			0.0			
8.00	Physical Therapy Service Physical Therapy Supervisor			0.0			
9.00 10.00	Occupational Therapy Service			0.0			
11.00	Occupational Therapy Supervisor			0.0			
12.00 13.00	Speech Pathol ogy Servi ce Speech Pathol ogy Supervi sor			0.0			
14.00	Medical Social Service			0.0	0.00	0.00	14.00
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.0			
17.00	Home Health Aide Supervisor			0.0			17.00
18.00	Other (specify)			0.0	0.00		
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost				4		19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			18020			20.00
20.00	during this cost reporting period (line 20 contains the first code).			18020			20.00
20. 01 20. 02				50031 50033			20.01
20.02			· · ·	50033			20.02
		Without Outliers	pisodes With Outliers	LUPA Epi sode	s PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	2,049	117	/ 12	16	2, 306	21.00
22.00	Skilled Nursing Visit Charges	515, 336					
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	1, 367 401, 322			5 30 90 8,820		
25.00	Occupational Therapy Visits	1, 065			9 21		
26.00	Occupational Therapy Visit Charges	312, 570			6 6, 174		
27.00 28.00	Speech Pathol ogy Vi si ts Speech Pathol ogy Vi si t Charges	33 9, 639			04 0	34 9, 933	
29.00	Medical Social Service Visits	22			2 0	24	
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	7, 975 785			26 0 3 10		
32.00	Home Health Aide Visit Charges	108, 947	8, 896	6 41	7 1, 390	119, 650	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5, 321	259	17	77	5, 831	33.00
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 355, 789	(61, 312	2 45, 62	0 0	0 1, 483, 138	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	328			4		
37.00	outlier) Total Number of Outlier Episodes		Ę		0		
38.00	Total Non-Routine Medical Supply Charges	27,925	1, 867	95	0	30, 743	38.00

	I Financial Systems SC ECTIVE PAYMENT FOR SNF STATISTICAL DATA	HNECK MEDICAL CENTER	- CCN: 150065	Pei	In Lie riod:	u of Form CMS-2 Worksheet S-7	
			0000 100000		om 01/01/2015	Date/Time Pre	
						5/18/2016 3:0	7 pm
1 00	If this facility contains a basnital based ONE	ana all nationta undan	managad ages		1.00	2.00	1.00
1.00	If this facility contains a hospital-based SNF, wor was there no Medicare utilization? Enter "Y" f	or yes in column 1 and	managed care do not				1.00
2.00	complete the rest of this worksheet. Does this hospital have an agreement under either	section 1883 or section	on 1913 for				2.00
	swing beds? Enter "Y" for yes or "N" for no in c						
	date (mm/dd/yyyy) in column 2.	Group	SNF Days	5	Swing Bed SNF	Total (sum of	
		1.00	2.00		Days 3.00	col. 2 + 3) 4.00	
3.00		RUX	2.00	0	0	0	
4.00 5.00		RUL RVX		0 0	0	0 0	
6.00		RVL		0	0	0	6.00
7.00 8.00		RHX RHL		0 0	0	0	
9.00		RMX		0	0	0	
10.00 11.00		RML RLX		0 0	0	0 0	
12.00		RUC		0	0	0	12.00
13.00 14.00		RUB RUA		0 0	0	0	
15.00		RVC		0	0	0	15.00
16.00 17.00		RVB RVA		0 0	0	0	
18.00		RHC		0	0	0	18.00
19.00 20.00		RHB RHA		0 0	0	0	
21.00		RMC		0	0	0	
22.00 23.00		RMB RMA		0 0	0	0	
24.00		RLB		0	0	0	24.00
25.00 26.00		RLA ES3		0 0	0	0	
27.00		ES2		0	0	0	27.00
28.00 29.00		ES1 HE2		0 0	0	0 0	
30.00		HE1		0	0	0	
31.00 32.00		HD2 HD1		0 0	0	0 0	
33.00		HC2		0	0	0	
34.00 35.00		HC1 HB2		0 0	0 0	0 0	
6.00 7.00		HB1 LE2		0 0	0	0	
8.00		LE1		0	0	0	38.0
39.00 10.00		LD2 LD1		0 0	0	0 0	
1.00		LC2		0	0	0	41.0
2.00		LC1 LB2		0 0	0	0	
4.00		LB1		0	0 0	0	44.0
5.00 6.00		CE2 CE1		0 0	0	0	
7.00		CD2		0	0	0	47.0
8.00 9.00		CD1 CC2		0 0	0	0	
0. 00		CC1		0	0	0	50. C
1.00 2.00		CB2 CB1		0 0	0	0	
3.00		CA2		0	0	0	53.0
4.00 5.00		CA1 SE3		0 0	0	0 0	
6. 00		SE2		0	0	0	56.0
7.00 8.00		SE1 SSC		0 0	0 0	0 0	
9.00		SSB		0	0	0	59.0
0.00 1.00		SSA I B2		0 0	0 0	0 0	
2.00		I B1		0	0	0	62.0
03.00 04.00		I A2		0 0	0 0	0 0	
5.00		BB2		0	0	0	65.00
56.00 57.00		BB1 BA2		0 0	0 0	0 0	
58.00		BA1		0	0	0	

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider CCN: 150065 Period : From 01/01/2015 Period : From 01/01/2015 Period : From 01/01/2015 Period : From 01/01/2015 0	Health Financial Systems SCHNECK M	EDICAL CENTER		In Lie	eu of Form CMS-	2552-10
To 12/31/2015 Date/Time Prepared: 5/16/2016 3:07 pm Group SNF Days Swing Bed SNF Total (sum of Days Coll (sum of Coll (sum of Days) 69, 00 70, 00 70, 00 70, 00 71, 00 72, 00 72, 00 72, 00 73, 00 74, 00 74, 00 74, 00 76, 00 77, 00 76, 00 77, 00 77	PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	CCN: 150065	Peri od:	Worksheet S-7	1
Group SNF Days Swing Bed SNF Total (sum of Days) Col. 2 + 3) 69.00 1.00 2.00 3.00 4.00 70.00 PF2 0 0 0 69.00 71.00 PF2 0 0 0 69.00 72.00 PP1 0 0 0 71.00 73.00 PP2 0 0 0 73.00 74.00 PP2 0 0 0 73.00 75.00 PP2 0 0 0 75.00 70.00 PP2 0 0 0 75.00 70.00 PP2 0 0 0 75.00 70.00 PP32 0 0 0 75.00 70.00 PP42 0 0 0 72.00 70.00 PA4 0 223 223.20.00 72.00 200.00 Total AAA 0 223 202.20 201.00					Date/Time Pre	
I.00 2.00 3.00 4.00 69.00 70.00 PE2 0 0 0 69.00 70.00 PE1 0 0 0 69.00 71.00 PP2 0 0 0 70.00 72.00 0 0 0 71.00 72.00 74.00 PC2 0 0 0 73.00 74.00 PC2 0 0 0 73.00 75.00 PE1 0 0 0 74.00 76.00 PA2 0 0 0 75.00 76.00 PA2 0 0 0 76.00 78.00 PA2 0 0 0 72.00 78.00 PA1 0 223 223 100.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00		Group	SNF Days	Swing Bed SNF		
69.00 70.00 71.00 72.00 73.00 74.00 75.00 74.00 74.00 74.00 75.00 74.00 75.00 74.00 74.00 75.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 76.00 76.00 76.00 76.00 76.00 77.00 78.00 79.00 78.00 79.00 78.00 79.00 78.00 79.00 78.00 79.00 78.00 79.00 78.00 79.00 79.00 79.00 79.00 70.00 7				Days	col. 2 + 3)	
70.00 PE1 0 0 0 70.00 71.00 PD2 0 0 0 70.00 71.00 PD2 0 0 0 71.00 72.00 PD1 0 0 0 72.00 73.00 PC2 0 0 73.00 73.00 76.00 PE1 0 0 75.00 75.00 75.00 76.00 PA2 0 0 0 76.00 77.00 78.00 <t< td=""><td></td><td></td><td>2.00</td><td>3.00</td><td>4.00</td><td></td></t<>			2.00	3.00	4.00	
17.00 PD2 0 0 0 71.00 72.00 PD1 0 0 71.00 72.00 73.00 PC2 0 0 73.00 72.00 74.00 PC1 0 0 0 73.00 74.00 PC1 0 0 0 73.00 74.00 PC1 0 0 0 73.00 75.00 PS2 0 0 0 75.00 70.00 PA2 0 0 0 75.00 77.00 PA2 0 0 0 78.00 70.01 PA4 0 223 223.199.00 223 223.199.00 223 223.199.00 223 223.00.00 223 223.199.00 223 223.00.00 223 223.00.00 223 223.00.00 223 223.00.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 200.00 201.00	69.00	PE2		0 0	0	69.00
72.00 P01 0 0 0 72.00 73.00 PC2 0 0 0 73.00 74.00 PC1 0 0 0 74.00 75.00 P22 0 0 0 74.00 76.00 P81 0 0 0 75.00 77.00 PA1 0 0 0 76.00 78.00 PA1 0 0 0 77.00 78.00 PA1 0 0 0 77.00 79.00 AAA 0 223 223 199.00 200.00 TOTAL 0 628A att 628A att 628A att 223 223 100 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility. 99915 1.00 2.00 201.00 Pari od (if applicable). Peri od Peri od Peri od Peri od Pari od (if applicable). 201.00 0 3.00 201.00 0 3.00 201.00 0 3.00 201.00 0 3.00 201.00 0	70.00	PE1		0 0	0	70.00
73.00 PC1 0 0 73.00 74.00 PC1 0 0 0 74.00 75.00 PB2 0 0 0 75.00 76.00 PB2 0 0 0 75.00 77.00 PA2 0 0 0 76.00 78.00 PA2 0 0 0 77.00 78.00 PA2 0 0 0 77.00 78.00 PA1 0 0 0 78.00 200.00 TOTAL CBSA at CBSA converting Period CBSA at CBSA converting Period Period Period Period 10 10 20.00 223 223.200.00 223 223.200.00 223 223.200.00 203.00 204.00 200.00 204.00	71.00	PD2		0 0	0	71.00
74.00 PC1 0 0 0 74.00 75.00 PB2 0 0 0 75.00 77.00 PB1 0 0 0 75.00 77.00 PP1 0 0 0 75.00 78.00 PA2 0 0 0 76.00 199.00 AAA 0 223 199.00 223 199.00 200.00 TOTAL 0 CBSA at Beginning of the Cost Reporting Period (if applicable) CBSA at Beginning of the Cost Reporting Period (if applicable) 223 200.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility. In effect at the beginning of the cost reporting period. Enter in columa 2, the code in effect on or after October 1 of the cost reporting period. Enter in columa 2, the code in effect on or after October 1 of the cost reporting period. Enter in columa 2, the code Pageneses? Pageneses? A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG expenses? A soci ated with Direct Patient Care and Rel ated expenses. For lines 202 through 207. Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet 62, Part 1. Line 7, column 3. In column 3, enter "Y" for yes or "N" for n	72.00	PD1		0 0	0	72.00
75.00 76.00 76.00 77.00 78.00 PB1 92 0 0 0 75.00 76.00 76.00 76.00 76.00 78.00 78.00 PA1 0 0 0 76.00 76.00 79.00 200.00 TOTAL PA1 0 0 0 78.00 201.00 TOTAL CBSA at Beginning of Cost Reporting Period (if applicable) CBSA on/after 0ctober 1 of the Cost Reporting Period (if applicable) CBSA on/after 0ctober 1 of the Cost Reporting Period (if applicable) 201.00 In effect at the beginning of the cost reporting period (if a rural facility, in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 In effect at the beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses? For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the precentage of total expenses for each category. total SNF revenue from Worksheet 6-2. Part 1, line 7, column 3. In column 3. enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category. (see instructions) 202.00 202.00 Staffing 0.00 0.00 203.00 202.00 Staffing 0.00 0.00 203.00 202.00 Cotfing 202.00 0.00	73.00	PC2		0 0	0	73.00
76.00 PB1 0 0 0 77.00 77.00 PA2 0 0 0 77.00 199.00 PA1 0 0 0 78.00 199.00 AAA 0 223 223 199.00 200.00 TOTAL 0 223 223 199.00 223 223 223 200.00 0 76.00 0 <td>74.00</td> <td>PC1</td> <td></td> <td>0 0</td> <td>0</td> <td>74.00</td>	74.00	PC1		0 0	0	74.00
77.00 PA2 0 0 0 77.00 78.00 PA1 0 0 0 78.00 199.00 AAA 0 223 223 199.00 200.00 TOTAL CBSA at Beginning of Cost Reporting Period (if applicable) CBSA ot/after Cost Reporting Period (if applicable) CBSA ot/after Cost Reporting Period (if applicable) 201.00 201.00 Enter In column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUC payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category. (see instructions) 0 0.00 202.00 203.00 Staffing 0 0.00 203.00 202.00 203.00 Column 3. In column 3. enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 0 0.00 202.00	75.00	PB2		0 0	0	75.00
78:00 199:00 200:00 TOTAL PA1 AA 0 0 0 223 0 23 0 20 20 0 20 20 0 20 20 0 20 20 0 20 20 20 0 20 <td>76.00</td> <td>PB1</td> <td></td> <td>0 0</td> <td>0</td> <td>76.00</td>	76.00	PB1		0 0	0	76.00
78:00 199:00 200:00 TOTAL PA1 AA 0 0 0 223 0 23 0 20 20 0 20 20 0 20 20 0 20 20 0 20 20 20 0 20 <td></td> <td>PA2</td> <td></td> <td>0 0</td> <td>0</td> <td>77.00</td>		PA2		0 0	0	77.00
199.00 200.00 AAA 0 223 223 223 223 199.00 223 200.00 TOTAL CBSA and CBSA and Period CBSA and Cost Reporting Period CBSA on/after 0cober 1 of cost Reporting Period (if applicable) 201.00 SNF SERVICES 1.00 2.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 Expenses Percentage Associated with Direct Patient Care and Related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Use increases associated with direct patient care and related expenses for each category to total SNF revenue from Worksheet 6-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increase associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0.00 0.00 202.00 203.00 Recruitment 0.00 0.00 202.00 204.00 Column 1 file (SPCIFY) 0 0.00 205.00				0 0		
200.00 TOTAL 0 223 223 200.00 200.00 TOTAL CBSA at Beginning Of Cotober 1 of the Cost Reporting Period Beginning Of October 1 of the Cost Reporting Period (if applicable) 100 201.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 202: Enter in column 1 the amount of the expense for each category. Enter in column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increase associated with direct patient care and related expenses for each category. (see instructions) 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Recruiter of employees 0 0.00 202.00 205.00 Cotoler 1 of the c				0 223	223	199 00
SNF SERVICES CBSA at Beginning of October 1 of the Cost Reporting Period (if applicable) 0 Cost Reporting Period (if applicable) 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect at the beginning of the cost reporting period (if applicable). 99915 201.00 In effect at the beginning of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? 201.00 3.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 0 0.00 203.00 203.00 Recruitment 0 0.00 203.00 203.00 203.00 203.00 204.00 204.00 204.00 205.00 204.00 205.00 205.00 203.00 205.00 205.00 205.00 205.00 206.00 205.00 205.00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1
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SNF SERVICES Period (if applicable) 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 In effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Rel ated Expenses? 1.00 2.00 3.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and rel ated expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 202.00 202.00 Retention of employees 0 0.00 203.00 204.00 203.00 Retention of employees 0 0.00 203.00 204.00 205.00 Training 0 0.00 205.00 206.00 206.00						
Anotice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses for each category. to the expense for each category. Enter in column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 0 0.00 202.00 202.00 203.00 Refression of the cost reporting period (if applicable). Image: Cost of the cost reporting period (if applicable). Percentage Associated with Direct Patient Care and Related Expenses? Image: Cost of the cost reporting period (if applicable). Image: Cost of the cost reporting period (if applicable). Image: Cost of the cost reporting period (if applicable). 201.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207. Enter in column 1 the amount of the expense for each category. Enter in column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 202.00 Staffing 0 0.00 203.00 204.00 204.00 204.00 205.00 206.00 206.00 206.00 206.00						
SNF SERVICES 1.00 2.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 Expenses Percentage Associated with Direct Patient Care and Related Expenses? Associated with Direct Patient Care and Related Expenses? A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 202.00 Staffing 0 0.00 203.00 203.00 Retruitment 0 0.00 203.00 204.00 Retruitment 0 0.00 204.00 205.00 Training 0 0.00 205.00 205.00 Training 0 0.00 205.00 206.00 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99915 99915 201.00 Image: Subscript of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? Associated with Direct Patient Care and Related Expenses? A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For Lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 0 0.00 202.00 202.00 Staffing 0 0.00 203.00 203.00 203.00 203.00 205.00 Training 0 0.00 204.00 205.00 206.00 0 0 0.00 205.00				1.00		
in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Image: Notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0 0.00 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Retrition of employees 0 0.00 203.00 205.00 Training 0 0.00 205.00 205.00 OTHER (SPECIFY) 0 0.00 205.00	SNF SERVICES					
in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses?	201.00 Enter in column 1 the SNF CBSA code or 5 character non-C	BSA code if a rur	al facility,	99915	99915	201.00
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A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 0 0.00 202.00 202.00 Staffing 0 0.00 203.00 202.00 204.00 Retention of employees 0 0.00 203.00 205.00 OTraining 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 205.00					with Direct	
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Line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated202.00Staffing00.00202.00203.00Recruitment00.00203.00204.00Retention of employees00.00204.00205.00OTraining00.00205.00206.00OTHER (SPECIFY)00.00206.00						
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203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00		ategory. (see ins	tructions)	_		
204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
206.00 OTHER (ŠPECI FY) 0 0.00 206.00	1 5					
	205. 00 Training			0 0.00	1	205.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3) 0 207.00						1
				0 0.00		

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER	In Lie	In Lieu of Form CMS-2552-10			
	TAL IDENTIFICATION DATA				CCN: 150065 CCN: 151529	Period: From 01/01/2015 To 12/31/2015	Worksheet S-9 Parts I & II	bared:
						Hospi ce I	0/10/2010 0.0/	
		Unduplicated Days				i		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	8, 552	487	1, 384	1(913	9, 952	2.00
3.00	Inpatient Respite Care	82	0	0		3 0	82	3.00
4.00	General Inpatient Care	116	4	8		0 22	142	4.00
5.00	Total Hospice Days	8, 750	491	1, 392	1(935 935	10, 176	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0		0 0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0. 00	0.00	0.00	0. (0.00	0.00	8.00
9.00	Unduplicated Census Count	276	6	20		2 16	298	9.00

Heal th	Financial Systems SCHNECK MEDICAL C	ENTER		In Lie	eu of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150065	Peri od:	Worksheet S-1	0		
				From 01/01/2015				
				To 12/31/2015	Date/Time Pre 5/18/2016 3:0			
					1.00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 colum	18)	0. 325998	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				8, 535, 466	•		
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	1 2	from Medicai	1?	N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			2, 302, 552			
6.00	Medi cai d charges				40, 743, 024			
7.00	Medicaid cost (line 1 times line 6)				13, 282, 144	•		
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	nes 2 and 5; if	2, 444, 126	8.00		
	< zero then enter zero)	6						
0.00	State Children's Health Insurance Program (SCHIP) (see instructi	ons for e	ach TThe)		0	0.00		
9.00 10.00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges							
10.00	Stand-alone SCHIP cost (line 1 times line 10)							
12.00	Difference between net revenue and costs for stand-alone SCHIP (lino 11 m	inus lino 0.	if < zoro thon				
12.00	enter zero)		inus inne 4,	II < Zel U then	0	12.00		
	Other state or local government indigent care program (see instr	uctions f	or each line					
13.00	Net revenue from state or local indigent care program (Not inclu				0	13.00		
14.00	Charges for patients covered under state or local indigent care				0	•		
	10)	p g (-			
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00		
16.00	Difference between net revenue and costs for state or local indi		program (lin	ne 15 minus line	0	16.00		
	13; if < zero then enter zero)]		
	Uncompensated care (see instructions for each line)							
17.00		5	2		40, 137			
18.00	Government grants, appropriations or transfers for support of ho	• •			19, 579			
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local	i ndi gent	care program	ns (sum of lines	2, 444, 126	19.00		
	8, 12 and 16)				T + + (+ 4			
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)			
			1.00	2.00	3.00			
20.00	Total initial obligation of patients approved for charity care (at full	1, 840, 3			20.00		
20.00	charges excluding non-reimbursable cost centers) for the entire		1, 040, 3	1, 10, 007	3, 330, 431	20.00		
21.00	Cost of initial obligation of patients approved for charity care		599, 9	58 560, 084	1, 160, 042	21.00		
	times line 20)							
22.00	Partial payment by patients approved for charity care		21, 5	82, 730	104, 262	22.00		
23.00	Cost of charity care (line 21 minus line 22)		578, 42	477, 354	1, 055, 780	23.00		
					1.00			
24.00	J		nd a length o	of stay limit	N	24.00		
	imposed on patients covered by Medicaid or other indigent care p							
25.00				h of stay limit	0			
26.00	Total bad debt expense for the entire hospital complex (see inst				13, 757, 016			
27.00	Medicare bad debts for the entire hospital complex (see instruct				229, 848			
28.00				20)	13, 527, 168			
29.00								
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			5, 465, 610			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ie 30)			7, 909, 736	31.00		

ealth Financial Systems ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	SCHNECK MEDICA OF EXPENSES		F	In Lie Period: From 01/01/2015 To 12/31/2015	u of Form CMS-: Worksheet A Date/Time Pre	
					5/18/2016 3:0	
Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	1.00	2.00	3.00	4.00	col. 4) 5.00	
GENERAL SERVICE COST CENTERS		0.004.704	0.00/ 70/	0.770.007	5 547 000	
.00 00100 NEW CAP REL COSTS-BLDG & FIXT .00 00200 NEW CAP REL COSTS-MVBLE EQUIP .00 00300 OTHER CAPITAL RELATED COSTS		8, 296, 736 0 0	8, 296, 736 0 0	4, 399, 748	5, 517, 839 4, 399, 748 0	2.0
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	504, 815	13, 599, 260	14, 104, 075		14, 104, 162	4.0
. 00 00500 ADMI NI STRATI VE & GENERAL . 00 00700 OPERATI ON OF PLANT	6, 905, 569 1, 042, 571	11, 541, 864 1, 842, 069	18, 447, 433 2, 884, 640		18, 271, 477	1
.00 00800 LAUNDRY & LINEN SERVICE	43, 461	270, 842	314, 303		2, 476, 958 314, 303	
. 00 00900 HOUSEKEEPI NG	853, 303	242, 511	1, 095, 814	620	1, 096, 434	
0. 00 01000 DI ETARY	680, 957	553, 644	1, 234, 601		493, 134	
1. 00 01100 CAFETERIA 3. 00 01300 NURSI NG ADMI NI STRATI ON	2, 529, 782	0 765, 239	0 3, 295, 021	,	741, 940 3, 293, 636	
4. 00 01400 CENTRAL SERVICES & SUPPLY	412, 098	144, 124	556, 222		571, 118	
5. 00 01500 PHARMACY	1, 105, 252	1, 804, 997	2, 910, 249		2, 911, 590	
6. 00 01600 MEDICAL RECORDS & LIBRARY 8. 00 01850 PHYSICIAN PRIVATE PRACTICE	973, 884 228, 683	214, 210 2, 983			1, 188, 094 231, 666	
9. 00 01900 NONPHYSICIAN ANESTHETISTS	228, 083	2, 703	231,000			
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	6, 021, 424	868, 944	6, 890, 368		5, 508, 266	
1. 00 03100 I NTENSI VE CARE UNI T 3. 00 04300 NURSERY	885, 330 0	219, 577 0	1, 104, 907 0		1, 125, 076 337, 884	
ANCI LLARY SERVI CE COST CENTERS		0			0077001	
0. 00 05000 OPERATING ROOM	2, 596, 815	1, 543, 906			4, 229, 853	
1.00 05100 RECOVERY ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM	440, 710	7, 076 0	447, 786 0		447, 786 1, 179, 478	
3. 00 05300 ANESTHESI OLOGY	2, 928, 762	62, 342	2, 991, 104		2, 264, 902	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 327, 795	1, 354, 336	3, 682, 131		3, 696, 937	
4. 01 03630 ULTRA SOUND	233, 168	35, 200	268, 368		269, 321	
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 7.00 05700 CT SCAN	78, 824 254, 513	53, 994 230, 329	132, 818 484, 842		134, 117 485, 840	
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	118, 809	168, 623			288, 137	
0. 00 06000 LABORATORY	1, 446, 957	1, 347, 375	2, 794, 332		2, 810, 664	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 4. 00 06400 INTRAVENOUS THERAPY	0 238, 337	300, 455 5, 454	300, 455 243, 791		300, 455 248, 077	
5. 00 06500 RESPIRATORY THERAPY	815, 924	47, 122	863, 046		888, 126	
6. 00 06600 PHYSI CAL THERAPY	978, 200	18, 570	996, 770	6, 253	1, 003, 023	66.0
7. 00 06700 OCCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY	283, 835	685	284, 520		285, 561	
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY	211, 070 108, 203	2, 491 97, 434	213, 561 205, 637		213, 561 211, 996	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 038, 626			7, 505, 815	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		2, 532, 811	
3. 00 07300 DRUGS CHARGED TO PATIENTS 6. 00 03952 WOUND CARE	0 172, 208	6, 819, 682 30, 454			6, 819, 682 202, 892	
6. 02 03951 CASE MANAGEMENT	391,013	8, 118			399, 361	
6. 03 03950 PALN MANAGEMENT	1, 213, 883	329, 507	1, 543, 390	0	1, 543, 390	76.0
6. 97 07697 CARDIAC REHABILITATION	378, 763	7, 475	386, 238	8, 606	394, 844	76.9
0UTPATI ENT SERVI CE COST CENTERS 0. 00 04950 OTHER OUTPATI ENT SERVI CE COST CENTER	12, 844	467	13, 311	0	13, 311	90.0
D. 01 04951 PALLI ATI VE HEALTH	135, 704	19, 637	155, 341	0	155, 341	90.0
0. 02 09000 VEIN CENTER	401, 914	3, 730			406, 380	
0. 03 09001 0B GYN 1. 00 09100 EMERGENCY	2, 197, 531 4, 004, 443	64, 179 365, 105	2, 261, 710 4, 369, 548		2, 266, 200 4, 398, 837	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,004,443	303, 103	4, 307, 340	27,207	4, 370, 037	92.0
3. 00 04952 BEHAVOURAL HEALTH	364, 175	18, 058	382, 233	0	382, 233	93.0
OTHER REIMBURSABLE COST CENTERS 01.00 10100 HOME HEALTH AGENCY	1,000,454	141, 703	1, 142, 157	4, 676	1, 146, 833	101 0
SPECIAL PURPOSE COST CENTERS	1,000,434	141, 703	1, 142, 157	4,070	1, 140, 833	
13.00 11300 INTEREST EXPENSE		1, 444, 247				113. 0
16. 00 11600 HOSPI CE	638, 098	164, 320			802, 418	
18.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	46, 160, 081	65, 097, 700	111, 257, 781	-5, 225	111, 252, 556	ט . או ו <u>ו</u>
PO. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 0
22.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 961, 562	166, 378	3, 127, 940		3, 131, 129	192.0
94.00 07950 WELLNESS 94.02 07952 EXTERNAL SVCS MARKETING	100.045	0	001 710	780		194.0
94. 02 07952 EXTERNAL_SVCS_MARKETING 94. 03 07953 WASHINGTON_CLINIC	180, 865 182, 578	720, 847 -1, 394	901, 712 181, 184		901, 712 181, 184	
94. 04 07954 PHYSI CI AN OFFICES	721, 628	129, 444	851, 072		851, 865	
94. 05 07955 INTEGRATED MEDICINE	298, 168	42, 028	340, 196	463	340, 659	194.0
94.06 07956 SURGI CAL PROFESSI ONAL 00.00 TOTAL (SUM OF LINES 118-199)	442, 393 50, 947, 275	85, 863			528, 256 117, 188, 141	
(1) (1)	1 50 94 / 2/5	66, 240, 866	117, 188, 141	0	117 188 141	1200 0

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (SCHNECK MEDI OF EXPENSES	CAL C		CCN: 15006		i od:	eu of Form Worksheet	
						To	m 01/01/2015 12/31/2015		
	Cost Center Description	Adjustments		Expenses					<u> </u>
		(See A-8) 6.00		<u>llocation</u> 7.00					
	GENERAL SERVICE COST CENTERS	0.00	L	7.00					
	00100 NEW CAP REL COSTS-BLDG & FIXT	-439, 082		5,078,757					1
	00200 NEW CAP REL COSTS-MVBLE EQUIP	0		4, 399, 748					2
	00300 OTHER CAPITAL RELATED COSTS	0		0					3
	00400 EMPLOYEE BENEFITS DEPARTMENT	-316		4, 103, 846					4
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-1, 984, 393		6, 287, 084 2, 476, 958					5
	00800 LAUNDRY & LINEN SERVICE			314, 303					8
	00900 HOUSEKEEPI NG	0		1,096,434					9
00	01000 DI ETARY	-171		492, 963					10
00	01100 CAFETERI A	-355, 217		386, 723					11
	01300 NURSI NG ADMI NI STRATI ON	0		3, 293, 636					13
	01400 CENTRAL SERVICES & SUPPLY	0		571, 118					14
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	-39, 190		2,911,590					15
	01850 PHYSICIAN PRIVATE PRACTICE	-39, 190		1, 148, 904 231, 666					18
	01900 NONPHYSICIAN ANESTHETISTS	-741,049		231,000					19
	INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,							
00	03000 ADULTS & PEDI ATRI CS	-446	•	5, 507, 820					30
	03100 I NTENSI VE CARE UNI T	0	•	1, 125, 076					31
	04300 NURSERY	0		337, 884					43
	ANCI LLARY SERVICE COST CENTERS	///	1	2 (15 402					
	05000 OPERATING ROOM 05100 RECOVERY ROOM	-614, 361		3, 615, 492 447, 786					50
	05200 DELIVERY ROOM & LABOR ROOM	0	•	1, 179, 478					52
	05300 ANESTHESI OLOGY	-2, 187, 713		77, 189					53
	05400 RADI OLOGY-DI AGNOSTI C	-441, 881		3, 255, 056					54
01	03630 ULTRA SOUND	-1, 280		268, 041					54
02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0		134, 117					54
	05700 CT SCAN	-1, 800		484, 040					57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		288, 137					58
	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	-986		2, 809, 678 300, 455					60
	06400 I NTRAVENOUS THERAPY			248, 077					64
	06500 RESPI RATORY THERAPY			888, 126					65
	06600 PHYSI CAL THERAPY	-78		1,002,945					66
00	06700 OCCUPATI ONAL THERAPY	0		285, 561					67
	06800 SPEECH PATHOLOGY	0		213, 561					68
	06900 ELECTROCARDI OLOGY	-1, 679		210, 317					69
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		7, 505, 815					71
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS			2, 532, 811 6, 819, 682					72
	03952 WOUND CARE	0		202, 892					76
	03951 CASE MANAGEMENT	-391, 013		8, 348					76
	03950 PALN MANAGEMENT	-550, 228		993, 162					76
	07697 CARDI AC REHABI LI TATI ON	0		394, 844					76
	OUTPATIENT SERVICE COST CENTERS	-		40.04					
	04950 OTHER OUTPATIENT SERVICE COST CENTER	2 600		13, 311					90
	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	-3, 600 -240, 806		151, 741 165, 574					90 90
	09000 VEIN CENTER 09001 OB GYN	-1, 679, 831		586, 369					90
	09100 EMERGENCY	-1, 761, 614		2,637,223					91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)								92
	04952 BEHAVOURAL HEALTH	0		382, 233					93
	OTHER REIMBURSABLE COST CENTERS								
	10100 HOME HEALTH AGENCY	0	1	1, 146, 833					101
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0		0					113
	11600 HOSPI CE			802, 418					116
. 00	SUBTOTALS (SUM OF LINES 1-117)	-11, 436, 734		9, 815, 822					118
	NONREI MBURSABLE COST CENTERS								
. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0					190
	19200 PHYSICIANS' PRIVATE OFFICES	0		3, 131, 129					192
. 00	07950 WELLNESS	0		780					194
	07952 EXTERNAL SVCS MARKETING	0		901, 712					194
	07953 WASHINGTON CLINIC	0		181, 184					194 194
	07954 PHYSI CI AN OFFI CES 07955 I NTEGRATED MEDI CI NE			851, 865 340, 659					194
	07955 INTEGRATED MEDICINE 07956 SURGICAL PROFESSIONAL			340, 659 528, 256					194
1 ()61	STREET NOT ESST OWNE			528, 250)5, 751, 407					200

	Financial Systems SIFICATIONS		SCHNECK MEDI	Provi der (CN: 150065	Peri od:	ULIEU OF FOR	
						From 01/01/ To 12/31/	2015 Date/Ti	me Prepared: 016 3:07 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
. 00	CAFETERIA	11.00	409, 225	332, 715				1.00
. 00			409, 225	332, 715				1.0
	C - PROPERTY INSURANCE							
. 00	NEW CAP REL COSTS-BLDG &	1.00	0	115, 964				1.00
		0.00		(0, (40)				
. 00	NEW CAP REL COSTS-MVBLE	2.00	0	60, 640				2.00
		+		176, 604				
	D - BIO-MED	I	5	110,001				
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	87				1.00
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	648				2.00
. 00	HOUSEKEEPI NG	9.00	0	620				3.00
. 00	DI ETARY	10.00	0	473				4.00
. 00	CENTRAL SERVICES & SUPPLY	14.00	0	14, 896				5.00
. 00 . 00		15.00	0	1,341				6.00
. 00	ADULTS & PEDIATRICS	30.00 31.00	0	127, 297 20, 169				7.00
. 00	NURSERY	43.00	0	7, 963				9.0
0.00	OPERATI NG ROOM	50.00	Ő	89, 132				10.0
1.00	ANESTHESI OLOGY	53.00	0	14, 847				11.0
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 806				12.0
3.00	ULTRA SOUND	54.01	0	953				13.00
4.00	NUCLEAR MEDICINE -	54.02	0	1, 299				14.00
F 00	DIAGNOSTIC	57.00		000				45.00
5.00	CT SCAN	57.00	0	998				15.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	705				16.00
7.00	LABORATORY	60.00	0	16, 332				17.00
8.00	INTRAVENOUS THERAPY	64.00	Ö	4, 286				18.00
9.00	RESPI RATORY THERAPY	65.00	0	25, 080				19.00
0. 00	PHYSICAL THERAPY	66.00	0	6, 253				20.00
1.00	OCCUPATI ONAL THERAPY	67.00	0	1, 041				21.00
	ELECTROCARDI OLOGY	69.00	0	6, 359				22.00
3.00	WOUND CARE	76.00	0	230				23.0
4.00	CASE MANAGEMENT	76.02	0	230				24.0
5.00 6.00	VEIN CENTER	76.97 90.02	0	8, 606 736				25. 0 26. 0
7.00	OB GYN	90.02	0	4, 490				27.0
8.00	EMERGENCY	91.00	0	29, 289				28.0
	HOME HEALTH AGENCY	101.00	0	3, 291				29.0
0. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 189				30. 0
1.00	WELLNESS	194.00	0	780				31.00
	PHYSICIAN OFFICES	194.04	0	793				32.00
3.00	INTEGRATED MEDICINE	1 <u>94.</u> 05	0	463				33.00
			0	407, 682				
. 00	E - DEPRECIATION NEW CAP REL COSTS-MVBLE	2.00	0	4, 339, 108				1.00
. 00	EQUIP	2.00	0	4, 339, 100				1.00
		+		4, 339, 108				
	F - BOND INTEREST EXP	1						
. 00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 444, 247				1.00
	FLXT							
	0		0	1, 444, 247				
	G - NURSERY							
. 00	NURSERY	43.00	329, 921	0				1.00
. 00	DELIVERY ROOM & LABOR ROOM	<u>52.00</u>	<u>1, 179, 478</u> <u>1, 509, 399</u>	<u>0</u>				2.00
	H - CRNA		1, 504, 344	0				
00	NONPHYSI CI AN ANESTHETI STS	19.00	741, 049	0				1.00
	0		741, 049	— — — <u>ö</u>				
	I – HHA MSW							
00	HOME HEALTH AGENCY	1 <u>01.</u> 00	1, 385	0				1.0
	0		1, 385	0				
0.0	J - IMPLANTABLE DEVICES		_1	0 500 511				
. 00	I MPL. DEV. CHARGED TO	72.00	0	2, 532, 811				1.00
	PATI ENT	+		2, 532, 811				
	IV IV		U	∠, JJZ, ÖII				1

SI FI CATI ONS			Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet A-6 Date/Time Prepare 5/18/2016 3:07 pm
	Decreases					
Cost Center	Line #	Salary		Wkst. A-7 Ref	; 	
6.00 A - CAFETERIA	7.00	8.00	9.00	10.00		
DI ETARY	10.00	409, 225	332, 715		0	1.
0		409, 225	332, 715		-	
C - PROPERTY INSURANCE						
ADMI NI STRATI VE & GENERAL	5.00	0	176, 604		2	1.
		0	0		2	2.
O D - BIO-MED		0	176, 604			
OPERATION OF PLANT	7.00	0	407, 682		0	1.
	0.00	о	0		0	2.
	0.00	0	0		0	3.
	0.00	0	0		0	4
	0.00	0	0		0	5.
	0.00	0	0		0	6.
	0.00 0.00	0	0 0		0	7.
	0.00	0	0		0	9
	0.00	o	0		0	10
	0.00	0	0		0	11.
	0.00	0	0		0	12
	0.00	0	0		0	13
	0.00	0	0		0	14
	0.00	0	0		0	15
	0.00 0.00	0	0 0		0	16
	0.00	0	0		0	17
	0.00	0	0		0	19
	0.00	o	0		0	20
	0.00	О	0		0	21
	0.00	0	0		0	22
	0.00	0	0		0	23
	0.00	0	0		0	24
	0.00 0.00	0	0 0		0	25 26
	0.00	0	0		0	20
	0.00	o	0		0	28
	0.00	О	0		0	29
	0.00	0	0		0	30
	0.00	0	0		0	31
	0.00	0	0		0	32
TOTALS		0	0 407, 682		0	33
E - DEPRECIATION	I	9	407,002			
NEW CAP REL COSTS-BLDG &	1.00	0	4, 339, 108		9	1.
FIXT	+					
		0	4, 339, 108			
F - BOND INTEREST EXP	113.00	0	1, 444, 247	1	1	1.
		of	1, 444, 247		<u>'</u>	1.
G - NURSERY			.,, =	<u> </u>		
ADULTS & PEDIATRICS	30.00	1, 509, 399	0		0	1.
	0.00	0	0		Q	2.
TOTALS		1, 509, 399	0			
H - CRNA ANESTHESI OLOGY	52 00l	741, 049	0		0	1.
	<u>53.00</u>	741,049	00	<u>├──</u> ── ──	4	1.
I - HHA MSW		, , , , , , , , , , , , , , , , , , , ,	0	1		
NURSING ADMINISTRATION	13.00	1, 385	0		0	1.
0		1, 385	0			
J - IMPLANTABLE DEVICES						
MEDI CAL SUPPLI ES CHARGED TO	71.00	0	2, 532, 811		0	1.
PATI ENTS	+		2, 532, 811	<u>├── ── </u>	-	
Grand Total: Decreases		2, 661, 058	9, 233, 167			500.

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150065		riod: om 01/01/2015 12/31/2015		pared:
				Acqui si ti on	S		37 107 2010 3.0	
		Begi nni ng	Purchases	Donation		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	6, 320, 117	1, 031, 843		0	1, 031, 843	0	1.00
2.00	Land Improvements	4, 019, 428	49, 535		0	49, 535	4, 800	2.00
3.00	Buildings and Fixtures	80, 031, 280	1, 787, 258		0	1, 787, 258	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	6, 369, 578	19, 261		0	19, 261	0	5.00
6.00	Movable Equipment	50, 976, 893	2, 799, 524		0	2, 799, 524	1, 680, 706	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147, 717, 296	5, 687, 421		0	5, 687, 421	1, 685, 506	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	147, 717, 296	5, 687, 421		0	5, 687, 421	1, 685, 506	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	7, 351, 960	0					1.00
2.00	Land Improvements	4, 064, 163	0					2.00
3.00	Buildings and Fixtures	81, 818, 538	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	6, 388, 839	0					5.00
6.00	Movable Equipment	52, 095, 711	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	151, 719, 211	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	151, 719, 211	0					10.00

Heal th	n Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150065	Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		narod
					10 12/31/2013	5/18/2016 3:0	7 pm
			SL	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9,00	10.00	11.00	instructions) 12.00	instructions) 13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1,00	NEW CAP REL COSTS-BLDG & FIXT	8, 296, 736			0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0, 270, 700	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	8, 296, 736	0		0 0	0	3.00
		SUMMARY O					
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions) 14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1,00	NEW CAP REL COSTS-BLDG & FIXT		8, 296, 736				1.00
2.00	NEW CAP REL COSTS DEDG & TTAT	0	0,270,750				2.00
3.00	Total (sum of lines 1-2)	0	8, 296, 736				3.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 NEW CAP REL COSTS-BLDG & FIXT	99, 623, 499					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	52, 095, 712					2.00
3.00 Total (sum of lines 1-2)	151, 719, 211					3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				0 0.057 (00	54.070	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0			0 3, 957, 628		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 4, 339, 108		2.00
3.00 Total (sum of lines 1-2)	0	0		0 8, 296, 736	-54, 873	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1, 060, 038	115, 964		0 0	5, 078, 757	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0			0 0	4, 399, 748	2.00
3.00 Total (sum of lines 1-2)	1, 060, 038	176, 604		0 0	9, 478, 505	3.00

DJUST	MENTS TO EXPENSES			Provider CCN: 150065	Period: From 01/01/2015	Worksheet A-8	
					To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-226, 290	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1. (
. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		O	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
. 00	Ínvestment income - other		0		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.
. 00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)	В	-116, 943	ADMI NI STRATI VE & GENERAL	5.00	0	5.
. 00	Rental of provider space by suppliers (chapter 8)	В	-54, 873	NEW CAP REL COSTS-BLDG &	1.00	10	6.
. 00	Telephone services (pay stations excluded) (chapter	А	-4, 878	ADMI NI STRATI VE & GENERAL	5.00	0	7.
00	21) Television and radio service (chapter 21)		C		0.00	0	8.
. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -7, 699, 470		0.00	0	
I. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.
2.00	Related organization transactions (chapter 10)	A-8-1	C			0	
3.00 4.00 5.00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee		-355, 217 0	CAFETERI A	0.00 11.00 0.00	0	14.
5.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16.
. 00	patients Sale of drugs to other than		0		0.00	0	17.
3. 00	patients Sale of medical records and abstracts	В	-39, 190	MEDI CAL RECORDS & LI BRARY	16.00	0	18.
. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.
. 00 . 00	Vending machines Income from imposition of interest, finance or penalty	В	-8, 090 0	ADMINISTRATIVE & GENERAL	5.00 0.00		
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.
8. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.
. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	0	27.
. 00	Non-physician Anesthetist	A	-741,049	NONPHYSI CI AN ANESTHETI STS	19.00		28.
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 30.
. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		O	ADULTS & PEDIATRICS	30.00		30.
. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C)	0.00	0	32

Health Financial Systems		SCHNECK MEDI	CAL CENTER	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2015 To 12/31/2015		narad.
				10 12/31/2013	5/18/2016 3:07	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 EMPLOYEE SICK CHILD	В	-71	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
34.00 MISC INCOME	В	-190, 052	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 PHYSICIAN RECRUITMENT	A	-1, 653, 500	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 I HA DUES	A	-1, 821	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01 AHA DUES	A	-4, 941	ADMI NI STRATI VE & GENERAL	5.00	0	36.01
37.00 PAIN LOBBYING EXPENSE	A	-21	ADMI NI STRATI VE & GENERAL	5.00	0	37.00
38.00 TELEPHONE BENEFITS	A	-316	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	38.00
39.00 DEVELOPMENT MARKETING	A	-4,076	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
40.00 NUTRITION MARKETING	A		DI ETARY	10.00		40.00
41.00 4N MEDICAL NRSG MARKETING	A		ADULTS & PEDIATRICS	30.00		
42.00 ENDOSCOPY MARKETING	A		OPERATING ROOM	50.00		42.00
43.00 PHYSICAL THERAPY MARKETING	A		PHYSICAL THERAPY	66.00		43.00
44.00 PAIN MANAGEMENT MARKETING	A		PAIN MANAGEMENT	76.03		
45.00 VEIN CENTER MARKETING	A		VEIN CENTER	90.02		
45.01 OB/GYN MARKETING	A		OB GYN	90.03		
45.02 HOSPITALIST MARKETING	A		EMERGENCY	91.00		
45.03 BARI ATRI C NP	A		CASE MANAGEMENT	76.02		
45.04 UNNECESSARY BORROWNING	A	-157, 919	NEW CAP REL COSTS-BLDG &	1.00	11	45.04
			FLXT			
45.06		0		0.00		
45.07		0		0.00		
45.08		0		0.00		101.00
45.09		0		0.00		45.09
45. 10		0		0.00		
45. 11		0	1	0.00		
45. 12		0	1	0.00		45.12
45.13		0	1	0.00	0	45.13
50.00 TOTAL (sum of lines 1 thru 49)		-11, 436, 734				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

	Financial Syste		SCHNECK MED	I CAL CENTER			eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 150065	Period:	Worksheet A-8	3-2
					-	From 01/01/2015 To 12/31/2015	5 Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/18/2016 3: 0 Physi ci an/Prov)/pm
	WRSt. A LINE π	I denti fi er	Remuneration	Component	Component		ider Component	
			itomarior a cron	oomponone	oomportorre		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	613, 950					
2.00		ANESTHESI OLOGY	2, 187, 713			239, 400		2.00
3.00		RADI OLOGY-DI AGNOSTI C	581, 099		232, 488			
4.00		ULTRA SOUND	1, 280		0	,		4.00
5.00		CT SCAN	1, 800			271, 900		5.00
6.00		LABORATORY	230, 000					
7.00		ELECTROCARDI OLOGY	9,000		.,			7.00
8.00		CASE MANAGEMENT	216, 185					
9.00		PAIN MANAGEMENT	550, 181	550, 181	0			9.00
10.00		PALLI ATI VE HEALTH	3, 600		0	,		10.00
11.00		VEIN CENTER	240, 611	240, 611	0	211, 500		11.00
12.00		OB GYN	1, 678, 731		0	237, 100		12.00
13.00	91.00	EMERGENCY	1, 760, 873			271, 900		13.00
200.00	Wkst. A Line #	Cost Center/Physician	8, 075, 023 Unadj usted RCE		471,488 Cost of	Provi der	2,907 Physician Cost	200.00
	WKSL A LINE #	I denti fi er		Unadjusted RCE		Component	of Malpractice	
		rdentifier		Limit	Continuing	Share of col.	Insurance	
					Educati on	12	Thourance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OPERATI NG ROOM	0					1.00
2.00	53.00	ANESTHESI OLOGY	0	0			0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	139, 218	6, 961	0	0	0	3.00
4.00	54.01	ULTRA SOUND	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	229, 014	11, 451	0	0	0	6.00
7.00	69.00	ELECTROCARDI OLOGY	7, 321	366	0	0	0	7.00
8.00		CASE MANAGEMENT	0	0	0	-	-	8.00
9.00		PAIN MANAGEMENT	0	0	0	0	-	9.00
10.00		PALLIATIVE HEALTH	0	0	0	-	-	
11.00		VEIN CENTER	0	0	0	0	-	
12.00		OB GYN	0	0	0	0	-	
13.00	91.00	EMERGENCY	0	0	0	0	-	
200.00			375, 553			0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	-	
1.00		OPERATING ROOM	0					1.00
2.00		ANESTHESI OLOGY	Ö		-			2.00
3.00		RADI OLOGY-DI AGNOSTI C	0		93, 270			3.00
4.00		ULTRA SOUND	0	0				4.00
5.00		CT SCAN	0					5.00
6.00		LABORATORY	0	229, 014	986			6.00
7.00		ELECTROCARDI OLOGY	0		1, 679			7.00
8.00		CASE MANAGEMENT	0		0	216, 185		8.00
9.00		PAIN MANAGEMENT	0	0	0	550, 181		9.00
10.00		PALLIATIVE HEALTH	0	0	0	3, 600		10.00
11.00	90. 02	VEIN CENTER	0	0	0	240, 611		11.00
12.00		OB GYN	0	0	0	1, 678, 731		12.00
13.00	91.00	EMERGENCY	0		0	.,		13.00
200.00			0	375, 553	95, 935	7, 699, 470		200. 00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI			Peri od:	u of Form CMS-2 Worksheet B	2332-10
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/18/2016 3:0	7 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7) 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	5 070 757					1
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	5, 078, 757 4, 399, 748 14, 103, 846 16, 287, 084 2, 476, 958 314, 303 1, 096, 434 492, 963 386, 723 3, 293, 636	5, 078, 757 17, 736 386, 128 748, 603 25, 124 51, 869 103, 590 0 113, 075	4, 399, 748 2, 08 ⁻	1 14, 123, 663 0 1, 933, 508 2 291, 916 9 12, 169 1 238, 921 8 76, 084 0 114, 581	19, 188, 180 5, 143, 539 352, 635 1, 393, 135 692, 525 501, 304 4, 206, 080	7.00 8.00 9.00 10.00 11.00
14.00 15.00 16.00 18.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	571, 118 2, 911, 590 1, 148, 904 231, 666 0	79, 595 45, 120 35, 486 0 0	42, 51: 151, 23: 4, 390	2 115, 386 2 309, 466	808, 611 3, 417, 408 1, 461, 470 295, 696 207, 491	14.00 15.00 16.00 18.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 507, 820 1, 125, 076 337, 884	1, 100, 108 86, 255 11, 224	131, 138		8, 132, 275 1, 590, 358 441, 485	31.00
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	3, 615, 492 447, 786 1, 179, 478 77, 189 3, 255, 056 268, 041 134, 117 484, 040 288, 137 2, 809, 678 300, 455 248, 077 888, 126 1, 002, 945 285, 561 213, 561 210, 317 7, 505, 815 2, 532, 811 6, 819, 682	619, 562 0 0 432, 199 0 0 84, 486 0 66, 988 38, 698 107, 827 7, 389 0 74, 987 0 0 0 0 0	32, 72 397, 24 18, 62 26, 28, 99(3, 90 51, 83 27, 20 17, 35 48 6 44, 14 ((5 123, 397 330, 249 330, 249 5 612, 551 3 65, 286 4 22, 070 0 71, 263 2 33, 266 1 405, 142 0 0 1 66, 733 2 28, 455 8 273, 892 3 59, 099 7 30, 296 0 0 0 0 0 0	5, 515, 944 577, 758 1, 509, 727 722, 465 4, 736, 271 351, 950 156, 451 584, 293 325, 305 3, 350, 627 300, 455 433, 629 1, 182, 479 1, 402, 022 372, 906 272, 723 359, 747 7, 505, 815 2, 532, 811 6, 819, 682	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 54.\ 02\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
76. 00 76. 02 76. 03 76. 97	03952 WOUND CARE 03951 CASE MANAGEMENT 03950 PALN MANAGEMENT 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS	202, 892 8, 348 993, 162 394, 844	0 16, 517 78, 570 0	32! 43! 6, 72 3, 70	5 109, 482 4 339, 882	251, 435 134, 782 1, 418, 338 504, 597	76. 02
90.00 90.01 90.02 90.03 91.00 92.00 93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER 04951 PALLIATIVE HEALTH 09000 VEIN CENTER 09001 OB GYN 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVOURAL HEALTH	13, 311 151, 741 165, 574 586, 369 2, 637, 223 382, 233	0 0 0 168, 066 20, 040	1, 292 102, 973	0 37, 997 2 112, 534 3 615, 300 0 1, 121, 228	18, 362 189, 738 279, 400 1, 304, 642 3, 955, 507 0 518, 520	90. 01 90. 02 90. 03 91. 00 92. 00
101.00	OTHER REIMBURSABLE COST CENTERS	1, 146, 833	57, 236	2, 99	7 280, 511	1, 487, 577	101.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	802, 418 99, 815, 822	2, 230 4, 578, 708			989, 017 97, 897, 167	
192.00 194.02 194.02 194.03 194.04 194.05	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS 07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE 07956 SURGICAL PROFESSIONAL	0 3, 131, 129 780 901, 712 181, 184 851, 865 340, 659 528, 256	17, 661 337, 886 0 35, 367 74, 347 0 34, 788 0		0 0 4 50, 641 0 51, 121 6 202, 053 8 83, 486	4, 364, 546 780 989, 454 306, 652 1, 060, 244 461, 031 653, 872	194.00 194.02 194.03 194.04 194.05

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
				_	5/18/2016 3:0	7 pm
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
	for Cost	FLXT	EQUI P	BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	105, 751, 407	5, 078, 757	4, 399, 74	8 14, 123, 663	105, 751, 407	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI			Period:	u of Form CMS- Worksheet B	2552-1
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/18/2016 3:0	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	19, 188, 180					4.00
7.00	00700 OPERATION OF PLANT	1, 140, 153					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	78, 168					8.00
9.00	00900 HOUSEKEEPI NG	308, 812				4 959 999	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	153, 510 111, 123			0 48, 466 0 0	1, 059, 893 0	
13.00	01300 NURSI NG ADMI NI STRATI ON	932, 349			0 52, 904	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	179, 242		1	0 37, 240	0	
15.00	01500 PHARMACY	757, 527			0 21, 110	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	323, 960			0 16, 603	0	
18.00 19.00	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	65, 546 45, 994			0 0 0 0	0	
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10, 771			0 0		1 1 2 0
30. 00	03000 ADULTS & PEDI ATRI CS	1, 802, 623		256, 45	6 514, 707	957, 504	30. 00
31.00	03100 I NTENSI VE CARE UNI T	352, 530					
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	97,863	17, 921	10, 71	1 5, 251	0	43.00
50.00	05000 OPERATI NG ROOM	1, 222, 703	989, 196	48, 45	1 289, 874	0	50.00
51.00	05100 RECOVERY ROOM	128,070			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	334, 657		3, 83		891	
53.00	05300 ANESTHESI OLOGY	160, 147		10.11	0 0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	1, 049, 875 78, 016		40, 11	9 202, 213 0 0	0	54.0 54.0
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	34, 680			0 0	0	
57.00	05700 CT SCAN	129, 518			0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	72, 109			0 0	0	
60.00	06000 LABORATORY	742, 723			0 39, 529	0	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06400 I NTRAVENOUS THERAPY	66, 601 96, 121			0 0 0 31, 342	0	
65.00	06500 RESPIRATORY THERAPY	262, 117			0 18, 105	0	65.0
66.00	06600 PHYSI CAL THERAPY	310, 782				0	66.0
67.00	06700 OCCUPATI ONAL THERAPY	82, 661			0 3, 457	0	
68.00	06800 SPEECH PATHOLOGY	60, 454			0 0	0	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	79, 744 1, 663, 791			4 35,084 0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	561, 441			0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 511, 698	C)	0 0	0	
76.00	03952 WOUND CARE	55, 735			0 0	0	
76.02	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT	29,877			0 7, 728 0 36, 760	0	
	07697 CARDI AC REHABI LI TATI ON	314, 399 111, 853			0 36, 760 0 0	0	
/0. //	OUTPATIENT SERVICE COST CENTERS	111,000			0 0		, 0. ,
	04950 OTHER OUTPATIENT SERVICE COST CENTER	4,070			0 0	0	
90.01	04951 PALLI ATI VE HEALTH	42,059			0 0	0	
90. 02 90. 03	09000 VEIN CENTER 09001 OB GYN	61, 934 289, 196			0 0	0	
90.03	09100 EMERGENCY	876, 805		41, 66	5 78,633		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
93.00	04952 BEHAVOURAL HEALTH	114, 939	31, 996		0 9, 376	0	93.0
101 00	OTHER REIMBURSABLE COST CENTERS	220 747	01.202		0 24 770	0	101 0
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	329, 747	91, 383	1	0 26, 779	0	101. 0
113.00	11300 I NTEREST EXPENSE						113. 0
	11600 HOSPI CE	219, 232			0 1, 043		116. 0
118.00		17, 447, 154	5, 470, 355	470, 91	7 1, 567, 009	1, 059, 893	118.0
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 915	28, 198		0 8, 263	0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFICES	967, 476			0 140, 134		192.0
194.00	07950 WELLNESS	173			0 0	0	194.0
	07952 EXTERNAL SVCS MARKETING	219, 329			0 16, 547		194.0
	07953 WASHINGTON CLINIC	67,975			0 34, 785		194.0
	07954 PHYSI CLAN OFFI CES 07955 I NTEGRATED MEDI CLNE	235, 021 102, 195			0 0 20, 658		194.0 194.0
	07956 SURGI CAL PROFESSI ONAL	144, 942			0 0		194. 0
200.00	Cross Foot Adjustments						200. 0
201.00	5	0	0		0 0		201.00
202.00) TOTAL (sum lines 118-201)	19, 188, 180	6, 283, 692	470, 91	7 1, 787, 396	1, 059, 893	1202 0

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I	
				o 12/31/2015	Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/18/2016 3:0 MEDI CAL	
		ADMI NI STRATI ON			RECORDS &	
	11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 0PERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE						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
	612, 427					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	35, 652 12, 921		1, 165, 096			13.00
15. 00 01500 PHARMACY	15, 452		2, 259			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	22, 977		1, 478		1, 883, 146	
18.00 01850 PHYSI CI AN PRI VATE PRACTI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS	3, 317		28		0	
INPATIENT ROUTINE SERVICE COST CENTERS	2,030				0	19.00
30. 00 03000 ADULTS & PEDI ATRI CS	91, 546	1, 374, 675	9, 648		79, 146	30.00
31. 00 03100 I NTENSI VE CARE UNI T	16, 160		1, 057		10, 016	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 763	8 86, 541		0 0	8, 894	43.00
50. 00 05000 OPERATI NG ROOM	52, 422		34, 659	0	437, 549	50.00
51.00 05100 RECOVERY ROOM	6, 949		195		40, 315	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	20, 603 8, 377		238		42, 339 30, 717	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 643		2,799		114, 714	
54.01 03630 ULTRA SOUND	3, 293	0	200		24, 183	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 146		33		12, 383	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 184		100		211, 880 68, 633	1
60. 00 06000 LABORATORY	35, 044		2, 935		299, 307	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	(-	(4, 423	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	4, 382 17, 502		268 805		8, 700 30, 929	
66. 00 06600 PHYSI CAL THERAPY	17, 840		495		28, 313	
67. 00 06700 OCCUPATI ONAL THERAPY	4, 233	0	42		11, 413	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 205		80		3, 607	1
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1,942		198 819, 555		44, 088 54, 584	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	-	276, 555		32, 647	
73. 00 07300 DRUGS CHARGED TO PATIENTS	(-	(102, 761	
76.00 03952 WOUND CARE 76.02 03951 CASE MANAGEMENT	2, 781		198 312			76.00 76.02
76. 03 03950 PALN MANAGEMENT	14, 121	-	501			76.03
76. 97 07697 CARDI AC REHABI LI TATI ON	6, 368	0	329	0	1, 250	76.97
0UTPATI ENT SERVICE COST CENTERS 90. 00 04950 OTHER OUTPATI ENT SERVICE COST CENTER	212	2 0	2		351	90.00
90. 01 04951 PALLI ATI VE HEALTH	1, 449					90.00
90. 02 09000 VEIN CENTER	4, 058	8 0	264		11, 924	
90. 03 09001 0B GYN 91. 00 09100 EMERGENCY	18, 396		2, 374		9,816	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	52, 352	786, 153	2, 907	0	102, 856	91.00 92.00
93. 00 04952 BEHAVOURAL HEALTH	3, 980	0	758	3 0	1, 666	1
OTHER REI MBURSABLE COST CENTERS	1	0.15.010		- -	45.000	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	16, 336	245, 313	405	0	15, 288	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	11, 194		672			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	558, 255	5, 407, 521	1, 162, 378	4, 517, 831	1, 883, 146	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	30, 079		894			192.00
194.0007950 WELLNESS	(-	(194.00
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON CLINIC	3, 308		515 C			194.02 194.03
194. 04 07954 PHYSI CI AN OFFI CES	7, 978		367			194.03
194. 05 07955 I NTEGRATED MEDI CI NE	3, 151	0	708	3 0	0	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	3, 235	0	234	0	0	194.06
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	C		0	200.00
202.00 TOTAL (sum lines 118-201)	612, 427	5, 407, 521	-	-	1, 883, 146	

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I	
					To 12/31/2015	Date/Time Pre	
		OTHER GENERAL				5/18/2016 3:0	7 pm
		SERVI CE					
	Cost Center Description	PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total	
		PRI VATE PRACTI CE	ANESTHETI STS		Residents Cost & Post		
		PRACTICE			Stepdown		
					Adjustments		
		18.00	19.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
16.00	01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
18.00	01850 PHYSI CLAN PRI VATE PRACTI CE	364, 587					18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	256, 323				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	_		-		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0			14, 975, 016 2, 515, 235	
43.00	04300 NURSERY	0	0			674, 429	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	9, 378, 00		9, 378, 000	
51.00	05100 RECOVERY ROOM	0	0	753, 28		753, 287	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 256, 323	2, 221, 42 1, 178, 26		2, 221, 426 1, 178, 267	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	250, 525	7, 390, 90		7, 390, 904	
54.01	03630 ULTRA SOUND	0	0	457, 64		457, 642	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	204, 69		204, 693	54.02
57.00	05700 CT SCAN	0	0	929, 97		929, 975	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	467, 78		467, 782	1
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	0		5, 131, 29 371, 47		5, 131, 293 371, 479	
64.00	06400 I NTRAVENOUS THERAPY	0	0	681, 39		681, 396	
65.00	06500 RESPI RATORY THERAPY	0	0	1, 573, 72		1, 573, 722	
66.00	06600 PHYSI CAL THERAPY	0	0	2, 273, 10		2, 273, 101	1
67.00	06700 OCCUPATIONAL THERAPY	0	0	486, 50		486, 509	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	340, 06 690, 76		340, 069 690, 760	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				10, 043, 745	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	3, 403, 45		3, 403, 454	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	12, 951, 97		12, 951, 972	
	03952 WOUND CARE	0	0	314, 26		314, 265	
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT	0	0	203, 06 1, 927, 14		203, 060 1, 927, 140	
	07697 CARDI AC REHABI LI TATI ON	0	0	624, 39		624, 397	
	OUTPATIENT SERVICE COST CENTERS						
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	988	0	23, 98		23, 985	1
90.01	04951 PALLI ATI VE HEALTH	6, 750	0	241, 19		241, 194	
90.02 90.03	09000 VEIN CENTER 09001 OB GYN	18, 897 85, 672		376, 47 1, 710, 09		376, 477 1, 710, 096	
	09100 EMERGENCY	05, 072	0	6, 165, 21		6, 165, 213	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			-,,	0		92.00
93.00	04952 BEHAVOURAL HEALTH	0	0	681, 23	5 0	681, 235	93.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	2, 212, 82	8 0	2 212 020	101 00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	2, 212, 82	8 0	2, 212, 828	
	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	0	0	1, 239, 20	1 0	1, 239, 201	116.00
118.00		112, 307	256, 323	94, 813, 24	7 0	94, 813, 247	118.00
100.00	NONREI MBURSABLE COST CENTERS			E0.02	7	E0.027	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	140, 080	0	58, 03 6, 182, 68		58, 037 6, 182, 680	190.00 192.00
	07950 WELLNESS	0	0	95			192.00
	07952 EXTERNAL SVCS MARKETING	15, 406	0	1, 301, 02		1, 301, 027	194. 02
	07953 WASHINGTON CLINIC	29, 902	0	564, 43	9 0	564, 439	
	07954 PHYSI CI AN OFFI CES	37, 156	0	1, 340, 76		1, 340, 766	
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	14, 672 15, 064	0	672, 91 817, 34		672, 911 817, 347	
200.00		15,004	0		0 0		200.00
200.00		1	0	1	-1 0	0	1-00.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150065	Period: From 01/01/2015	Worksheet B Part I	
				To 12/31/2015		
	OTHER GENERAL SERVI CE				57 187 2016 3:0	
Cost Center Description	PHYSI CI AN PRI VATE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost	Total	
	PRACTI CE			& Post		
				Stepdown Adjustments		
	18.00	19.00	24.00	25.00	26.00	
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	364, 587	256, 323	105, 751, 4	07 0	105, 751, 407	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI		CCN: 150065 P	In Lie Period:	u of Form CMS-: Worksheet B	2552-10
ALLUCA	TION OF CAPITAL RELATED CUSIS		Provi der	F	rom 01/01/2015 o 12/31/2015	Part II Date/Time Pre 5/18/2016 3:0	pared:
			CAPI TAL REL	ATED COSTS		57 187 2010 5.0	
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	17, 736	2, 081	19, 817	19, 817	1
5.00	00500 ADMINI STRATI VE & GENERAL	10, 699	386, 128	581, 460	978, 287	2, 701	5.00
7.00	00700 OPERATION OF PLANT	13,047	748, 603	1, 626, 062		410	1
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 5, 392	25, 124 51, 869	1, 039 5, 911		17 335	1
10.00	01000 DI ETARY	2, 438	103, 590	19, 888		107	1
11.00	01100 CAFETERI A	0	0	C	, U	161	
13.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	113, 075	91, 428		994	1
14.00 15.00	01500 PHARMACY	0	79, 595 45, 120	42, 512 151, 232		162 434	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	35, 486	4, 396		383	1
	01850 PHYSICIAN PRIVATE PRACTICE	0	0	C	, si	90	
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0 0	291	19.00
30.00	03000 ADULTS & PEDIATRICS	1,530	1, 100, 108	260, 998	1, 362, 636	1, 773	30.00
31.00	03100 INTENSIVE CARE UNIT	0	86, 255	131, 138	217, 393	348	31.00
43.00	04300 NURSERY	0	11, 224	C	11, 224	130	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	158, 922	619, 562	553, 792	1, 332, 276	1, 021	50.00
51.00	05100 RECOVERY ROOM	0	0	6, 575		173	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	, si	464	1
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 432, 199	32, 725 397, 243		860 915	1
54.00 54.01	03630 ULTRA SOUND	0	432, 199	18, 623		913	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	264		31	1
57.00	05700 CT SCAN	0	0	28, 990		100	1
58. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0 128, 592	0 84, 486	3, 902 51, 321		47 569	1
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	120, 372	04,400	01, <u>52</u> 1		0	1
64.00	06400 I NTRAVENOUS THERAPY	0	66, 988	51, 831	118, 819	94	64.00
65.00	06500 RESPI RATORY THERAPY	3, 250	38, 698	27, 200		321	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	107, 827 7, 389	17, 358 483		384 112	1
68.00	06800 SPEECH PATHOLOGY	0	0	63		83	
69.00	06900 ELECTROCARDI OLOGY	1, 050	74, 987	44, 147		43	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		, si	0	
76.00	03952 WOUND CARE	25, 922	0	325	26, 247	68	
	03951 CASE MANAGEMENT	0	16, 517	435		154	
	03950 PALN MANAGEMENT 07697 CARDLAC REHABILITATION	0	78, 570 0	6, 724 3, 701		477 149	
70.77	OUTPATIENT SERVICE COST CENTERS		0	5,701	3,701		1 /0. //
	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	1, 455	1, 455	5	1
	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	0	0	1, 292	0 2 1, 292	53 158	
	09001 0B GYN	0	0	102, 973		864	1
91.00	09100 EMERGENCY	0	168, 066	28, 990		1, 574	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		00.040	44.070	0	1.10	92.00
93.00	04952 BEHAVOURAL HEALTH OTHER REI MBURSABLE COST CENTERS	0	20, 040	14, 279	34, 319	143	93.00
101.00	10100 HOME HEALTH AGENCY	0	57, 236	2, 997	60, 233	394	101.00
	SPECIAL PURPOSE COST CENTERS	1			I		
	11300 I NTEREST EXPENSE 11600 HOSPI CE	63, 393	2, 230	5, 704	71, 327	251	113.00 116.00
118.00		414, 235	4, 578, 708				118.00
	NONREIMBURSABLE COST CENTERS			.,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 661	0	17, 661		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS	120	337, 886	66, 305	404, 311		192.00 194.00
	07950 WELLNESS 07952 EXTERNAL SVCS MARKETING	0	35, 367	1, 734	37, 101		194.00
194.03	07953 WASHINGTON CLINIC	0	74, 347	C	74, 347	72	194.03
	07954 PHYSI CLAN OFFI CES	120	0	6, 326			194.04
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	0	34, 788 0	2, 098 1, 748			194.05 194.06
200.00			0	1, 740	0	174	200.00
201.00		<u> </u>	0	C	0	0	201.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015		
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118-201)	414, 475	5, 078, 757	4, 399, 74	B 9, 892, 980	19, 817	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI		CCN: 150065 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
1122007					rom 01/01/2015	Part II Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/18/2016 3:0 DI ETARY	7 pm
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.00	00500 ADMI NI STRATI VE & GENERAL	980, 988					5.00
7.00	00700 OPERATION OF PLANT	58, 292	2, 446, 414				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 996					8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	15, 788			111, 793	201 204	9.00
10. 00 11. 00	01100 CAFETERI A	7, 848 5, 681	64, 392		3, 031 0	201, 294 0	
13.00	01300 NURSI NG ADMI NI STRATI ON	47,668	-		3, 309	0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 164	49, 477	0	2, 329	0	
15.00	01500 PHARMACY	38, 729			1, 320	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	16, 563			1, 038	0	
18.00 19.00	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	3, 351 2, 351	0		0	0	
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,301	0	0	0	0	1 19.00
30.00	03000 ADULTS & PEDI ATRI CS	92, 132	683, 830	24, 938	32, 197	181, 849	30.00
	03100 INTENSIVE CARE UNIT	18, 024		2, 224	2, 524	19, 276	31.00
43.00	04300 NURSERY	5,003	6, 977	1, 042	328	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	(0.510	005 404	4 740	10,100		50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	62, 512 6, 548			18, 130 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	17, 110			0	169	
53.00	05300 ANESTHESI OLOGY	8, 188		0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 676	268, 656	3, 901	12, 647	0	54.00
54.01	03630 ULTRA SOUND	3, 989			0	0	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,773	0	0	0	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 622 3, 687		0	0	0	57.00 58.00
60. 00	06000 LABORATORY	37,973	-		2, 472	0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	3, 405			2, 1, 2	0	
64.00	06400 INTRAVENOUS THERAPY	4, 914	41, 640	0	1, 960	0	64.00
65.00	06500 RESPI RATORY THERAPY	13, 401	24, 054		1, 132	0	
66.00	06600 PHYSI CAL THERAPY	15, 889			3, 155	0	
67.00	06700 OCCUPATI ONAL THERAPY	4, 226	4, 593		216	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	3, 091 4, 077	46, 612	0 2, 045	0 2, 194	0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	85,063		2,043	2, 1,4	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	28, 704	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	77, 287	0	0	0	0	73.00
76.00	03952 WOUND CARE	2,850		0	0	0	
76.02	03951 CASE MANAGEMENT 03950 PAIN MANAGEMENT	1, 527	10, 267	0		0	
	07697 CARDI AC REHABI LI TATI ON	16, 074 5, 719		0	2, 299 0	0 0	
/0. //	OUTPATIENT SERVICE COST CENTERS	5,717		0	V	0	/0. //
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	208	0	0	0	0	90.00
	04951 PALLI ATI VE HEALTH	2, 150		0	0	0	
	09000 VEIN CENTER	3, 166		0	0	0	
	09001 OB GYN 09100 EMERGENCY	14, 786 44, 828		4, 052	0 4, 918	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	44, 020	104,470	4,032	4, 910	0	92.00
	04952 BEHAVOURAL HEALTH	5, 876	12, 457	0	586	0	1
	OTHER REIMBURSABLE COST CENTERS		-				
101.00	10100 HOME HEALTH AGENCY	16, 859	35, 578	0	1, 675	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						1112 00
	11600 HOSPI CE	11, 209	1, 386	0	65	0	113.00 116.00
118.00		891, 977				201, 294	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	200			517		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	49, 463	210, 031	0	8, 765		192.00
	07950 WELLNESS 07952 EXTERNAL SVCS MARKETING	11 212	0	0	1 025		194.00 194.02
	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	11, 213 3, 475			1, 035 2, 176		194.02
	07954 PHYSI CI AN OFFI CES	12, 016		0	2,170		194.03
	07955 I NTEGRATED MEDI CI NE	5, 225		0	1, 292		194.05
194.05	07956 SURGI CAL PROFESSI ONAL	7, 410		0	0		194.06
194.06		7,410	-				
194.06 200.00	Cross Foot Adjustments	7,410					
194.06	Cross Foot Adjustments Negative Cost Centers	980, 988	0	0 45, 793	0 111, 793		200.00 201.00

ALUCATION OF CAPTAL RELATED COSTS Provider CRI 15509 Print der CR	Health Financial Systems	SCHNECK MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
International Construction CAFTERIA Main STRATT IN SERVICES 4 File Description Description 1 0.001000000000000000000000000000000000			Provi der	CCN: 150065			
Ensit Center Description CATTERIA NUMBERING Sector 200 CENTERIA NUMBERING Sector 200 CENTERIA PLANNESS Sector 200 PHIABAC 200 PHIABAC PLANNESS Sector 200 PHIABAC PLANNESS Sector 200 1000 1000 15.00 15.00 16.00 16.00 1 100 0000 00000 PHIABAC PHIABAC 100 15.00 16.00 1 0 00000 00000 PHIABAC PHIABAC PHIABAC 1 0						Date/Time Pre	pared:
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90.02 09000 VEIN CENTER 180 5,385 0 5,385 90.02 90.03 09001 0B GYN 817 120,407 0 120,407 90.02 91.00 09000 MERGENCY 0 409,793 0 409,793 90.02 92.00 09200 0SERVATI ON BEDS (NON-DI STINCT PART) 0 53,609 0 53,609 93.00 93.00 04952 BEHAVOURAL HEALTH 0 53,609 0 130,450 101.00 101.00 OTHER REIMBURSABLE COST CENTERS 0 130,450 0 130,450 110.00 101.00 SPECIAL PURPOSE COST CENTERS 0 85,068 0 85,068 116.00 116.00 118.00 11300 INTEREST EXPENSE 0 887,127 0 8,87,127 18,807,127 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 0 29,356 190.00 190.00 190.00 194.02 079,59 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00	90.00 90.01							
91.00 09100 EMERGENCY 0 409,793 0 409,793 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 53,609 0 53,609 93.00 04952 BEHAVOURAL HEALTH 0 53,609 0 53,609 93.00 04952 BEHAVOURAL HEALTH 0 0 100 100 HOME HEALTH AGENCY 0 130,450 0 130,450 101.00 101.00 HOME HEALTH AGENCY 0 130,450 0 130,450 101.00 101.00 Internet HBURSABLE COST CENTERS 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 88,7,127 0 8,887,127 0 8,887,127 0 8,887,127 0 8,887,127 0 8,887,127 0 9,93.56 190.00 190.00 190.00 Group Sister Centers 0 9 0 9 0 9 10 0 194.00 9 194.00 194.00 9	90.02	09000 VEIN CENTER						
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 92.00 93.00 04952 BEHAVOURAL HEALTH 0 53,609 0 53,609 93.00 0THER REIMBURSABLE COST CENTERS 0 130,450 0 130,450 101.00 130,450 101.00 130,450 101.00 1000 HEALTH AGENCY 0 130,450 101.00 101.00 130,450 101.00	90.03							
93. 00 04952 BEHAVOURAL HEALTH 0 53,609 0 53,609 93. 00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 130,450 0 130,450 101.00 10100 HOME HEALTH AGENCY 0 130,450 0 130,450 101.00 1010.01 10100 HOME HEALTH AGENCY 0 130,450 0 130,450 101.00 1010.01 10100 HOME HEALTH AGENCY 0 130,01 101.00 10100 HORE HEALTH AGENCY 0 130,450 101.00 1010.01 HOME HEALTH AGENCY 0 130,450 101.00 1010.01 HOME HEALTH AGENCY 0 130,01 101.00 HOME HEALTH			0		409, 79		409, 793	91.00
OTHER REI MBURSABLE COST CENTERS 101.00 HOME HEALTH AGENCY 0 130, 450 0 130, 450 101.00 HOME HEALTH AGENCY 0 130, 450 0 130, 450 113.00 INTEREST EXPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPECIAL PURPOSE CENTERS 113.00 116.00 HOON HOSPICE 0 85,068 0 85,068 116.00 118.00 SUBTOTALS SUM OF LINES 1-117) 1,070 0 8,887,127 0 8,887,127 118.00 190.00 IPONORE MBURSABLE COST CENTERS 118.00 119.00 192.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 <	93. 00		0		53, 60	-	53, 609	
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 0 85,068 0 85,068 116.00 116.00 HOSPICE 0 85,068 0 85,068 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1,070 0 8,887,127 0 8,887,127 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,337 675,499 0 675,499 194.00 194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTERNAL SVCS MARKETING 147 71,664 0 71,664 194.00 194.03 07953 WASHINGTON CLINIC 285 126,631 0 126,631 194.00 194.04 07954 HYSICIAN OFFICES 354 19,234 0 194.00 194.05 07955 INTEGRAT		OTHER REIMBURSABLE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE 0 85,068 0 85,068 116.00 116.00 11600 HOSPICE 0 0 885,068 0 85,068 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1,070 0 8,887,127 0 8,887,127 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 1,337 675,499 0 675,499 192.00 194.00 <td>101.00</td> <td></td> <td>0</td> <td> </td> <td> 130, 45</td> <td>0 0</td> <td>130, 450</td> <td>101.00</td>	101.00		0		130, 45	0 0	130, 450	101.00
116.00 11600 HOSPICE 0 85,068 0 85,068 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1,070 0 8,887,127 0 8,887,127 118.00 NONREI MBURSABLE COST CENTERS 190.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 0 29,356 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 1,337 675,499 0 675,499 192.00 194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTENAL SVCS MARKETING 147 71,664 0 71,664 194.00 194.03 07953 WASHI NGTON CLI NI C 285 126,631 0 126,631 194.00 194.04 07954 PHYSI CI AN OFFICES 354 19,234 0 19,234 194.00 194.06 07955 INTEGRATED MEDICI NE 140 71,247 0 71,247 194.00	113 00							113.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 29, 356 0 29, 356 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 337 675, 499 0 675, 499 192.00 194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTERNAL SVCS MARKETI NG 147 71, 664 0 71, 664 194.00 194.03 07953 WASHI NGTON CLI NI C 285 126, 631 0 126, 631 194.00 194.04 07954 PHYSI CI AN OFFI CES 354 19, 234 0 194.00 194.05 07955 INTEGRATED MEDI CI NE 140 71, 247 194.00 194.06 07956 SURGI CAL PROFESSI ONAL 144 9, 544 0 9, 544 194.00	116.00	11600 HOSPI CE			85, 06		85, 068	
190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 29,356 0 29,356 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 1,337 675,499 0 675,499 192.00 194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTERNAL SVCS MARKETING 147 71,664 0 71,664 194.00 194.03 07953 WASHI NGTON CLINIC 285 126,631 0 126,631 194.00 194.04 07954 PHYSI CLAN OFFICES 354 19,234 0 194.00 194.05 07955 INTEGRATED MEDI CINE 140 71,247 0 71,247 194.00 194.06 07956 SURGI CAL PROFESSI ONAL 144 9,544 0 9,544 194.00	118.00		1,070	0	8, 887, 12	7 0	8, 887, 127	118.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 1,337 675,499 0 675,499 192.00 194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTERNAL SVCS MARKETING 147 71,664 0 71,664 194.00 194.03 07953 WASHI NGTON CLINIC 285 126,631 0 126,631 194.00 194.04 07954 PHYSI CLAN OFFICES 354 19,234 0 19,34 194.00 194.06 07955 SURGI CAL PROFESSI ONAL 144 9,544 0 9,544 194.00	100 00		0		20.25	6	20.254	190 00
194.00 07950 WELLNESS 0 9 0 9 194.00 194.02 07952 EXTERNAL SVCS MARKETING 147 71,664 0 71,664 194.00 194.03 07953 WASHI NGTON CLINIC 285 126,631 0 126,631 194.00 194.04 07954 PHYSI CLAN OFFICES 354 19,234 0 19,234 194.00 194.05 07955 INTEGRATED MEDICINE 140 71,247 0 71,247 194.00 194.06 07956 SURGI CAL PROFESSI ONAL 144 9,544 0 9,544 194.00								
194. 03 07953 WASHI NGTON CLINIC 285 126, 631 0 126, 631 194. 03 194. 04 07954 PHYSI CLAN OFFICES 354 19, 234 0 19, 234 194. 04 194. 05 07955 INTEGRATED MEDICINE 140 71, 247 0 71, 247 194. 04 194. 06 07956 SURGI CAL PROFESSI ONAL 144 9, 544 0 9, 544 194. 06	194.00	07950 WELLNESS	0			9 0	9	194.00
194. 04 07954 PHYSI CI AN OFFI CES 354 19, 234 0 19, 234 194. 04 194. 05 07955 I NTEGRATED MEDI CI NE 140 71, 247 0 71, 247 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 144 9, 544 0 9, 544 194. 06								
194. 05 07955 I NTEGRATED MEDI CI NE 140 71, 247 0 71, 247 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 144 9, 544 0 9, 544 194. 05								
194. 06 07956 SURGI CAL PROFESSI ONAL 144 9, 544 0 9, 544 194. 00								
200.00 Cross Foot Adjustments 2,669 2,669 0 2,669 200.00	194.06	07956 SURGI CAL PROFESSI ONAL			9, 54	4 0	9, 544	194.06
	200.00	D Cross Foot Adjustments		2,669	2,66	9 0	2, 669	200.00

Heal th Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150065	Period: From 01/01/2015	Worksheet B Part II	
				To 12/31/2015		pared: 7 pm
	OTHER GENERAL SERVI CE					
Cost Center Description	PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post	Total	
	TIMOTTOL			Stepdown Adjustments		
	18.00	19.00	24.00	25.00	26.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	3, 477	2, 669	9, 892, 98	30 0	9, 892, 980	202.00

ST AL	LOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	2552-
					rom 01/01/2015 o 12/31/2015		
		CAPI TAL REL	ATED COSTS			5/18/2016 3:0	pm 7 pm
	Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE	(DOLLAR	DEPARTMENT		(ACCUM.	
		FEET)	VALUE)	(GROSS		COST)	
		,		SALARI ES)		,	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	341, 624					1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP		8, 296, 738				2. (
00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 193	3, 924	50, 442, 460)		4. (
	00500 ADMINISTRATIVE & GENERAL	25, 973	1, 096, 476	6, 905, 569	-19, 188, 180	86, 563, 227	
	00700 OPERATION OF PLANT	50, 355	3,066,319	1, 042, 571		5, 143, 539	
	00800 LAUNDRY & LINEN SERVICE	1,690	1, 959	43, 461		352, 635	
	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 489 6, 968	11, 146 37, 503	853, 303 271, 732		1, 393, 135 692, 525	
	01100 CAFETERIA	0, 308	37, 503	409, 225		501, 304	
	01300 NURSI NG ADMI NI STRATI ON	7,606	172, 409	2, 528, 397		4, 206, 080	
	01400 CENTRAL SERVICES & SUPPLY	5, 354	80, 166	412, 098		808, 611	
. 00	01500 PHARMACY	3, 035	285, 182	1, 105, 252	0	3, 417, 408	15.
	01600 MEDICAL RECORDS & LIBRARY	2, 387	8, 290	973, 884		1, 461, 470	
	01850 PHYSI CI AN PRI VATE PRACTI CE	0	0	228, 683		295, 696	
	01900 NONPHYSICIAN ANESTHETISTS	0	0	741, 049	0	207, 491	19.
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	73, 999	492, 172	4, 512, 025	0	8, 132, 275	30.
	03100 I NTENSI VE CARE UNI T	5,802	247, 290	885, 330		1, 590, 358	
	04300 NURSERY	755	0	329, 921		441, 485	
	ANCILLARY SERVICE COST CENTERS				1		
	05000 OPERATING ROOM	41, 675	1,044,301	2, 596, 815		5, 515, 944	
	05100 RECOVERY ROOM	0	12, 399	440, 710		577, 758	
	05200 DELIVERY ROOM & LABOR ROOM	0	() 41 710	1, 179, 478		1, 509, 727	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	29,072	61, 710 749, 093	2, 187, 713 2, 327, 795		722, 465 4, 736, 271	
	03630 ULTRA SOUND	27,072	35, 117	233, 168		351, 950	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	497	78, 824		156, 451	
	05700 CT SCAN	0	54, 668	254, 513		584, 293	
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 358	118, 809	0	325, 305	58.
	06000 LABORATORY	5, 683	96, 778	1, 446, 957	0	3, 350, 627	
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	-	300, 455	
	06400 I NTRAVENOUS THERAPY	4, 506	97, 739	238, 337		433, 629	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2,603	51, 292	815, 924 978, 200		1, 182, 479 1, 402, 022	
	06700 OCCUPATI ONAL THERAPY	7, 253 497	32, 732 911	283, 835		372, 906	
	06800 SPEECH PATHOLOGY	0	119	203, 033		272, 723	
	06900 ELECTROCARDI OLOGY	5,044	83, 250	108, 203		359, 747	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	7, 505, 815	71.
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0 0	2, 532, 811	
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	6, 819, 682	
	03952 WOUND CARE	0	613	172, 208		251, 435	
	03951 CASE MANAGEMENT 03950 PAIN MANAGEMENT	1, 111 5, 285	820 12, 679	391, 013 1, 213, 883		134, 782 1, 418, 338	
	07697 CARDI AC REHABI LI TATI ON	5, 285	6, 979	378, 763		504, 597	
-	OUTPATIENT SERVICE COST CENTERS		0, 777	070,700	<u> </u>	001,077	, 0.
	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	2, 743	12, 844	0	18, 362	90.
	04951 PALLI ATI VE HEALTH	0	0	135, 704		189, 738	
	09000 VEIN CENTER	0	2, 437	401, 914		279, 400	
	09001 OB GYN	0	194, 179	2, 197, 531		1, 304, 642	
	09100 EMERGENCY	11, 305	54, 668	4,004,443	0	3, 955, 507	91. 92.
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 04952 BEHAVOURAL HEALTH	1 2/0	26, 927	264 175	0	518, 520	
	OTHER REIMBURSABLE COST CENTERS	1, 348	20, 727	364, 175	0	516, 520	- 73.
-	10100 HOME HEALTH AGENCY	3, 850	5, 651	1, 001, 839	0	1, 487, 577	101.
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.
	11600 HOSPI CE	150	10, 757	638, 098			
8.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	307, 988	8, 149, 253	45, 655, 266	-19, 188, 180	78, 708, 987	1118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	0	C		17, 661	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	22, 728	125, 033	2, 961, 562		4, 364, 546	
	07950 WELLNESS	0	.20,000	_, <i>,</i> , , , , , , , , , , , , , , , , ,	0		194.
	07952 EXTERNAL SVCS MARKETING	2, 379	3, 270	180, 865	i O	989, 454	
	07953 WASHINGTON CLINIC	5,001	0	182, 578		306, 652	
	07954 PHYSICIAN OFFICES	0	11, 929	721, 628	8 0	1, 060, 244	
4 05	07955 I NTEGRATED MEDI CI NE	2, 340	3, 956 3, 297	298, 168		461, 031	
	07956 SURGI CAL PROFESSI ONAL			442, 393			194.

Heal th F	inancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		pared: 7 pm
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	5, 078, 757	4, 399, 748	14, 123, 663	3	19, 188, 180	201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	14. 866511	0. 530299	0. 279996 19, 817		0. 221667 980, 988	
205.00	Unit cost multiplier (Wkst. B, Part			0.000393	3	0. 011333	205. 00

Health Financial Systems	SCHNECK MEDI				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der	F	veriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/18/2016 3: 0 CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	
	(SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	SERVED)	SERVI CE)	
GENERAL SERVI CE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.00 00500 ADMINISTRATIVE & GENERAL	2/4 722					5.00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	264, 733 1, 690					7.00 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	3, 489 6, 968					9.00 10.00
11. 00 01100 CAFETERI A	0	0	0, 900		1, 165, 758	•
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	7,606		7, 606 5, 354		67, 864 24, 596	1
15. 00 01500 PHARMACY	3, 035	0	3, 035	0	29, 413	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 18. 00 01850 PHYSI CLAN PRI VATE PRACTI CE	2, 387		2, 387 C		43, 737 6, 313	•
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	5, 402	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	73, 999	259, 259	73, 999	34, 386	174, 254	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	5, 802 755				30, 761 10, 970	•
ANCI LLARY SERVI CE COST CENTERS	155	10, 828	/30		10, 970	43.00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	41,675		41, 675 C		99, 786 13, 227	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	C	32	39, 217	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 29,072	0 40, 558	29, 072	-	15, 946 65, 943	1
54.01 03630 ULTRA SOUND	0	0	c	0	6, 269	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57.00 05700 CT SCAN	0	0		0	2, 182 7, 965	1
58.00 O5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	-	3, 248	•
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	5, 683 0	0	5, 683 C		66, 706 0	60.00 63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	4, 506 2, 603		.,		8, 341 33, 316	•
66. 00 06600 PHYSI CAL THERAPY	7, 253		_/		33, 959	•
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	497	0	497		8, 058 6, 101	1
69. 00 06900 ELECTROCARDI OLOGY	5,044	21, 264	5, 044	0	3, 701	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
76. 00 03952 WOUND CARE 76. 02 03951 CASE MANAGEMENT	1, 111	0	1, 111	0	5, 294 5, 538	76.00 76.02
76.03 03950 PALN MANAGEMENT	5, 285	0	5, 285	0	26, 879	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	C	0	12, 121	76.97
90. 00 04950 OTHER OUTPATI ENT SERVICE COST CENTER 90. 01 04951 PALLIATIVE HEALTH	0	0	C		404 2, 759	90.00 90.01
90. 02 09000 VEIN CENTER	0	0		0	7, 724	90.02
90. 03 09001 0B GYN 91. 00 09100 EMERGENCY	0 11, 305	0 42, 120	C 11, 305	0	35, 017 99, 653	90.03 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04952 BEHAVOURAL HEALTH OTHER REIMBURSABLE COST CENTERS	1, 348	0	1, 348	0	7, 575	93.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 850	0	3, 850	0	31, 096	101.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	150 230, 467				21, 308 1, 062, 643	116.00
NONREI MBURSABLE COST CENTERS		1	1			1
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 188 22, 728		1, 188 20, 147			190.00 192.00
194. 00 07950 WELLNESS	0	0	c	0	0	194.00
194. 02 07952 EXTERNAL_SVCS_MARKETING 194. 03 07953 WASHINGTON_CLINIC	2, 379 5, 001	0	2, 379 5, 001			194.02 194.03
194. 04 07954 PHYSI CLAN OFFI CES	0	0	C	0	15, 187	194.04
194. 05 07955 I NTEGRATED MEDI CI NE 194. 06 07956 SURGI CAL PROFESSI ONAL	2, 970 0	0	2, 970 C	0		194.05 194.06
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00 201.00
202.00 Cost to be allocated (per Wkst. B,	6, 283, 692	470, 917	1, 787, 396	1, 059, 893	612, 427	•
Part I)						<u> </u>

Health Fir	ancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
			_		From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVI CE)	
		FEET)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 735960	0. 989186	6. 95557	9 27.845756	0. 525347	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2, 446, 414	45, 793	111, 79	3 201, 294	5, 842	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	9. 241062	0. 096191	0. 43503	8 5. 288443	0. 005011	205. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI		CCN: 150065	In Lie Period:	u of Form CMS- Worksheet B-1	
				From 01/01/2015 To 12/31/2015		pared:
Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUI S.) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE (TI ME SPENT) 18. 00	
1.00 GENERAL SERVICE COST CENTERS						1.00
1.00 00100 NEW CAP REL COSTS -MVBLE EQUIP 4.00 00200 NEW CAP REL COSTS -MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 18.00 01850 PHYSI CI AN PRI VATE PRACTICE 19.00 01000 NOPHYSI CI AN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	685, 459 0 29, 413 0 0 0	10, 670, 420 20, 692 13, 535 253 0	1, 00	0 0 290, 839, 678 0 0 0 0	149, 019 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 18.\ 00\\ \end{array}$
30. 00 03000 ADULTS & PEDI ATRI CS	174, 254	88, 358		0 12, 223, 250		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	30, 761 10, 970	9, 681 0		0 1, 546, 883 0 1, 373, 547	0	31.00 43.00
ANCILLARY SERVICE COST CENTERS				1, 373, 347		45.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	99, 786 0	317, 418 1, 790		0 67, 581, 357 0 6, 226, 226	0	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	39, 217	0		0 6, 538, 805		52.00
53. 00 05300 ANESTHESI OLOGY	0	2, 178		0 4, 743, 914	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	65, 943	25, 638 1, 834		0 17, 716, 510 0 3, 734, 837	0	54.00 54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	301		0 1, 912, 500	0	54.02
57.00 05700 CT SCAN	0	914		0 32, 722, 760	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	270		0 10, 599, 633 0 46, 225, 053		58.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	66, 706 0	26, 882 0		0 46, 225, 053 0 683, 023	0	60.00 63.00
64.00 06400 I NTRAVENOUS THERAPY	0	2, 450		0 1, 343, 656		64.00
65. 00 06500 RESPI RATORY THERAPY	0	7, 371		0 4, 776, 693		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	33, 959	4, 531 387		0 4, 372, 594 0 1, 762, 673	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	736		0 557, 095	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 701	1, 810		0 6, 808, 902	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	7, 505, 815 2, 532, 811		0 8, 429, 997 0 5, 041, 934		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2,002,011			0	
76. 00 03952 WOUND CARE	0	1, 810		0 635, 721	0	76.00
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	0	2, 856 4, 587		0 166, 946 0 2, 714, 458		76.02 76.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	3, 012		0 193, 122	0	76.97
OUTPATIENT SERVICE COST CENTERS		47		0 54.074	404	
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER 90. 01 04951 PALLIATIVE HEALTH	0	17 0		0 54, 274 0 185, 088		
90. 02 09000 VEI N CENTER	0	2, 418		0 1, 841, 558		•
90. 03 09001 0B GYN	0	21, 744		0 1, 515, 978		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	99, 653	26, 623		0 15, 885, 133	0	91.00 92.00
93. 00 04952 BEHAVOURAL HEALTH	0	6, 940		0 257, 299	0	
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	31, 096	3, 712		0 2, 361, 093	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0	6, 154		0 2, 236, 744		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	685, 459	10, 645, 528	1,00	0 290, 839, 678	45,904	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	8, 187		0 0	57, 255	192.00
194. 00 07950 WELLNESS 194. 02 07952 EXTERNAL SVCS MARKETING	0	0 גוד ג	1	0 0		194.00 194.02
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON CLINIC	0	4, 717 0				194.02 194.03
194. 04 07954 PHYSI CI AN OFFI CES	0	3, 364		0 0	15, 187	194.04
194. 05 07955 I NTEGRATED MEDI CI NE	0	6, 480		0 0		194.05
194.06 07956 SURGICAL PROFESSIONAL 200.00 Cross Foot Adjustments	0	2, 144		0	6, 15/	194. 06 200. 00
	· I		•			•

Heal	h Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1	
					To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
						OTHER GENERAL	
	Cost Conton Description			DUADMACY	MEDLOAL	SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDICAL	PHYSI CI AN	
		ADMI NI STRATI ON		(COSTED	RECORDS &	PRI VATE	
			SUPPLY	REQUIS.)	LI BRARY	PRACTI CE	
		(DI RECT	(COSTED		(GROSS	(TIME	
		NRSING HRS)	REQUIS.)		CHARGES)	SPENT)	
		13.00	14.00	15.00	16.00	18.00	
201.	0 Negative Cost Centers						201.00
202.	Cost to be allocated (per Wkst. B,	5, 407, 521	1, 165, 096	4, 517, 83	1, 883, 146	364, 587	202.00
	Part I)						
203.		7. 888905	0. 109189	4, 517. 831000	0. 006475	2. 446581	203.00
204.	0 Cost to be allocated (per Wkst. B, Part II)	327, 102	183, 362	279, 421	80, 376	3, 477	204.00
205.	Unit cost multiplier (Wkst. B, Part	0. 477201	0. 017184	279. 421000	0. 000276	0. 023333	205.00

Health Financial Systems	SCHNECK MEDICA	AL CENTER	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150065	Period: From 01/01/2015	Worksheet B-1
			To 12/31/2015	Date/Time Prepared: 5/18/2016 3:07 pm
Cost Center Description	NONPHYSI CI AN			
	ANESTHETI STS (ASSI GNED			
	TIME)			
	19.00			
1.00 OC100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT				5.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION				11.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 18.00 01850 PHYSICIAN PRIVATE PRACTICE				16.00 18.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	1,000			19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0			30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0			31.00 43.00
ANCI LLARY SERVICE COST CENTERS				10.00
50. 00 05000 OPERATI NG ROOM	0			50.00
51.00 05100 RECOVERY ROOM	0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1,000			52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			54.00
54.01 03630 ULTRA SOUND	0			54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57.00 05700 CT SCAN	0			54. 02 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58.00
60. 00 06000 LABORATORY	0			60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0			63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0			64. 00 65. 00
66.00 06600 PHYSI CAL THERAPY	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0			67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0			68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0			72.00
73.00 07300 DRUGS CHARGED TO PATLENTS 76.00 03952 WOUND CARE	0			73.00 76.00
76. 02 03951 CASE MANAGEMENT	0			76.02
76. 03 03950 PALN MANAGEMENT	0			76.03
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0			76.97
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTERS	0			90.00
90. 01 04951 PALLI ATI VE HEALTH	0			90. 01
90. 02 09000 VEI N CENTER	0			90.02
90. 03 09001 0B GYN 91. 00 09100 EMERGENCY	0			90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93. 00 04952 BEHAVOURAL HEALTH	0			93.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS	0			101.00
113.00 11300 INTEREST EXPENSE				113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0			116. 00 118. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1,000			110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
194.0007950 WELLNESS 194.0207952 EXTERNAL SVCS MARKETING	0			194. 00 194. 02
194. 03 07953 WASHI NGTON CLI NI C	0			194. 02
194. 04 07954 PHYSI CLAN OFFI CES	0			194.04
194. 05 07955 I NTEGRATED MEDI CI NE 194. 06 07956 SURGI CAL PROFESSI ONAL	0			194. 05 194. 06
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B,	256, 323			202.00
Part I)	I			I

Health Financial Systems	SCHNECK MEDI CAL	CENTER	In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150065	Period: From 01/01/2015	Worksheet B-1	
			To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
Cost Center Description	NONPHYSI CI AN				
	ANESTHETI STS				
	(ASSI GNED				
	TIME)				
	19.00				
203.00 Unit cost multiplier (Wkst. B, Part I)	256. 323000				203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	2, 669				204.00
205.00 Unit cost multiplier (Wkst. B, Part	2. 669000				205.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Period: From 01/01/2015	Worksheet C Part I	
				To 12/31/2015	Date/Time Pre 5/18/2016 3:0	pared
		Ti †l	e XVIII	Hospi tal	PPS	<u>n piii</u>
				Costs	115	1
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
'	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			4
0. 00 03000 ADULTS & PEDIATRICS	14, 975, 016		14, 975, 01		14, 975, 016	
. 00 03100 I NTENSI VE CARE UNI T	2, 515, 235		2, 515, 23		2, 515, 235	
0. 00 04300 NURSERY	674, 429		674, 42	29 0	674, 429	43.
ANCI LLARY SERVICE COST CENTERS	0.070.000	1	0.070.0/		0 070 000	
0. 00 05000 0PERATING ROOM . 00 05100 RECOVERY ROOM	9, 378, 000		9, 378, 00		9, 378, 000	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	753, 287 2, 221, 426		753, 28		753, 287 2, 221, 426	
00 05200 DELIVERY ROOM & LABOR ROOM	1, 178, 267		2, 221, 42 1, 178, 20		2, 221, 420	
. 00 05400 RADI OLOGY DI AGNOSTI C	7, 390, 904		7, 390, 90		7, 484, 174	
. 01 03630 ULTRA SOUND	457,642		457,64		457, 642	
. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	204, 693		204, 69		204, 693	
2. 02 05450 NOCELAR MEDICINE - DIAGNOSTIC	929, 975		929, 9		929, 975	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	467, 782		467, 78		467, 782	
0. 00 06000 LABORATORY	5, 131, 293		5, 131, 29		5, 132, 279	
00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	371, 479		371, 4		371, 479	
. 00 06400 I NTRAVENOUS THERAPY	681, 396		681, 39		681, 396	
00 06500 RESPIRATORY THERAPY	1, 573, 722				1, 573, 722	
00 06600 PHYSI CAL THERAPY	2, 273, 101				2, 273, 101	
00 06700 OCCUPATI ONAL THERAPY	486, 509				486, 509	
. 00 06800 SPEECH PATHOLOGY	340,069				340, 069	
00 06900 ELECTROCARDI OLOGY	690, 760		690, 70		692, 439	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	10, 043, 745		10, 043, 74		10, 043, 745	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 403, 454		3, 403, 45		3, 403, 454	
. 00 07300 DRUGS CHARGED TO PATIENTS	12, 951, 972		12, 951, 9	72 0	12, 951, 972	
0. 00 03952 WOUND CARE	314, 265		314, 20	65 0	314, 265	76.
0. 02 03951 CASE MANAGEMENT	203, 060		203, 00		203, 060	76.
0. 03 03950 PALN MANAGEMENT	1, 927, 140		1, 927, 14	40 0	1, 927, 140	76.
0. 97 07697 CARDIAC REHABILITATION	624, 397		624, 39	97 0	624, 397	76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	23, 985		23, 98		23, 985	
0. 01 04951 PALLIATIVE HEALTH	241, 194		241, 19		241, 194	
0. 02 09000 VEIN CENTER	376, 477		376, 4		376, 477	
0. 03 09001 OB GYN	1, 710, 096		1, 710, 09		1, 710, 096	
. 00 09100 EMERGENCY	6, 165, 213		6, 165, 2 ⁻		6, 165, 213	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000,864		2, 000, 80		2, 000, 864	
00 04952 BEHAVOURAL HEALTH	681, 235		681, 23	35 0	681, 235	93.
OTHER REIMBURSABLE COST CENTERS						4
1.00 10100 HOME HEALTH AGENCY	2, 212, 828		2, 212, 82	28	2, 212, 828	101.
SPECIAL PURPOSE COST CENTERS			1	1		1
3. 00 11300 I NTEREST EXPENSE	1 000 001		1 000 0		1 000 001	113.
6.00 11600 HOSPI CE	1, 239, 201		1, 239, 20		1, 239, 201	
0.00 Subtotal (see instructions)	96, 814, 111				96, 910, 046	
11.00 Less Observation Beds	2,000,864		2,000,80		2,000,864	
2.00 Total (see instructions)	94, 813, 247	0	94, 813, 24	47 95, 935	94, 909, 182	1202.

COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/18/2016 3:0	pared:
			Titl	e XVIII	Hospi tal	PPS	7 pili
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	10, 920, 372		10, 920, 3	72		30.00
	O INTENSIVE CARE UNIT	1, 546, 883		1, 546, 88			31.00
	IO NURSERY	1, 373, 547		1, 373, 54	47		43.00
	LLARY SERVICE COST CENTERS	,		1			
	O OPERATING ROOM	13, 255, 993	54, 325, 364			0.000000	50.00
	O RECOVERY ROOM	977, 043	5, 249, 183			0.00000	
	O DELIVERY ROOM & LABOR ROOM	6, 124, 420	414, 385			0.00000	
	O ANESTHESI OLOGY	1, 044, 502	3, 699, 412			0.000000	
	O RADI OLOGY-DI AGNOSTI C	1, 110, 047	16, 606, 463			0.00000	
	O ULTRA SOUND	413, 117	3, 321, 720			0.000000	
	ONUCLEAR MEDICINE - DIAGNOSTIC	116, 695	1, 795, 805			0.000000	
	O CT SCAN	3, 346, 012	29, 376, 748			0.000000	
58.00 0580	MAGNETIC RESONANCE IMAGING (MRI)	758, 223	9, 841, 410			0.000000	
	O LABORATORY	9, 896, 290	36, 328, 763			0.000000	
	0 BLOOD STORING, PROCESSING, & TRANS.	393, 539	289, 484			0.000000	
	O I NTRAVENOUS THERAPY	272, 552	1,071,104			0.000000	
	0 RESPI RATORY THERAPY	3, 552, 248	1, 224, 445			0.000000	
	O PHYSI CAL THERAPY	682, 824	3, 689, 770			0.000000	
	0 OCCUPATI ONAL THERAPY	438, 468	1, 324, 205			0.000000	
	O SPEECH PATHOLOGY	77, 251	479, 844			0.000000	
		1, 118, 288	5, 690, 614			0.000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 674, 621	5, 755, 376			0.000000	
	O IMPL. DEV. CHARGED TO PATIENT	2, 530, 545	2, 511, 389			0.000000	
	O DRUGS CHARGED TO PATIENTS	4, 884, 046	10, 986, 376			0.000000	
	2 WOUND CARE 1 CASE MANAGEMENT	36, 280	599, 441			0.000000	
		21, 029	145, 917			0.000000	•
		719	2, 713, 739			0.000000	
	7 CARDIAC REHABILITATION ATIENT SERVICE COST CENTERS	246	192, 876	193, 12	3. 233174	0. 000000	76.9
	O OTHER OUTPATIENT SERVICE COST CENTER	0	54, 274	54, 2	0. 441924	0. 000000	90.0
	1 PALLIATIVE HEALTH	36, 428	148, 660			0.000000	
	O VEIN CENTER	30, 428	1, 841, 558			0.000000	
	1 OB GYN	0	1, 515, 978			0.000000	
	O EMERGENCY	1, 454, 373	14, 430, 760			0.000000	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	47, 191	1, 255, 687			0.000000	
	2 BEHAVOURAL HEALTH	47, 191	257, 299			0.000000	
	R REIMBURSABLE COST CENTERS	0	201,277	201,2	2.047040	0.000000	75.00
	0 HOME HEALTH AGENCY	0	2, 361, 093	2, 361, 09	73		101.00
	I AL PURPOSE COST CENTERS		2,00.,070	2,001,0	1		1
	0 INTEREST EXPENSE						1113. 0
16.00 1160		0	2, 236, 744	2, 236, 74	44		116.0
200.00	Subtotal (see instructions)	69, 103, 792	221, 735, 886				200. 0
201.00	Less Observation Beds	37,100,772	22.,,000,000				200.00
	Total (see instructions)	69, 103, 792	221, 735, 886	290, 839, 6			202.00

	inancial Systems TON OF RATIO OF COSTS TO CHARGES	SCHNECK MEDICAL	Provider CCN: 150065	Peri od:	u of Form CMS-2552- Worksheet C
COMPUTAT	TON OF RATIO OF COSTS TO CHARGES		Provider CCN. 150005	From 01/01/2015 To 12/31/2015	Part I
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient		noopritai	
		Ratio			
		11.00			
I N	VPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03	3000 ADULTS & PEDI ATRI CS				30.0
31.00 03	3100 I NTENSI VE CARE UNI T				31.0
43.00 04	4300 NURSERY				43.0
AN	NCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 138766			50.0
51.00 05	5100 RECOVERY ROOM	0. 120986			51.0
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 339730			52.0
	5300 ANESTHESI OLOGY	0. 248374			53.
	5400 RADI OLOGY-DI AGNOSTI C	0. 422441			54.
	3630 ULTRA SOUND	0. 122533			54.0
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 107029			54.
	5700 CT SCAN	0. 028420			57.
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 044132			58.
	6000 LABORATORY	0. 111028			60.
	6300 BLOOD STORING, PROCESSING, & TRANS.	0. 543875			63.
	6400 I NTRAVENOUS THERAPY	0. 507121			64.
	6500 RESPI RATORY THERAPY	0. 329458			65.0
	6600 PHYSI CAL THERAPY	0. 519852			66.
	6700 OCCUPATI ONAL THERAPY	0. 276006			67.
	6800 SPEECH PATHOLOGY	0. 610433			68.
	6900 ELECTROCARDI OLOGY	0. 101696			69.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191429			71.0
	7200 I MPL. DEV. CHARGED TO PATIENT	0. 675029			72.
	7300 DRUGS CHARGED TO PATIENTS	0. 816108			73.0
	3952 WOUND CARE	0. 494344			76.
	3951 CASE MANAGEMENT	1. 216321			76.
	3950 PALN MANAGEMENT	0. 709954			76.
	7697 CARDI AC REHABI LI TATI ON	3. 233174			76.
	JTPATIENT SERVICE COST CENTERS	5. 255174			70.
	4950 OTHER OUTPATIENT SERVICE COST CENTER	0. 441924			90.0
	4950 OTHER OUTPATTENT SERVICE COST CENTER 4951 PALLIATIVE HEALTH	1. 303131			90.0
	9000 VEIN CENTER	0. 204434			90.0
	9000 VEIN CENTER 9001 OB GYN	1. 128048			90.0
	9001 OB GYN 9100 EMERGENCY				90.0
		0.388112			
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 535726			92.
	4952 BEHAVOURAL HEALTH	2.647640			93.
	THER REIMBURSABLE COST CENTERS				101
	D100 HOME HEALTH AGENCY				101.0
	PECIAL PURPOSE COST CENTERS	1			410
	1300 INTEREST EXPENSE				113.
	1600 HOSPI CE				116.
200.00	Subtotal (see instructions)				200.
201.00	Less Observation Beds				201.
202.00	Total (see instructions)				202.0

MPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre	parod
				10 12/31/2015	5/18/2016 3:0	:pareu)7 pm
		Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.	nuj.		DI Sal I Owalice		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>				
. 00 03000 ADULTS & PEDIATRICS	14, 975, 016		14, 975, 0	16 0	14, 975, 016	30.0
. 00 03100 INTENSIVE CARE UNIT	2, 515, 235		2, 515, 23		2, 515, 235	
. 00 04300 NURSERY	674, 429		674, 42	29 0	674, 429	43.0
ANCI LLARY SERVI CE COST CENTERS						
. 00 05000 OPERATI NG ROOM	9, 378, 000		9, 378, 00		9, 378, 000	
. 00 05100 RECOVERY ROOM	753, 287		753, 28		753, 287	
. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 221, 426		2, 221, 42		2, 221, 426	
. 00 05300 ANESTHESI OLOGY	1, 178, 267		1, 178, 20		1, 178, 267	
. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 390, 904		7, 390, 90		7, 484, 174	
. 01 03630 ULTRA SOUND	457, 642		457, 64		457, 642	
. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC . 00 05700 CT SCAN	204, 693 929, 975		204, 69		204, 693 929, 975	
. 00 05700 CT SCAN . 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	467, 782		929, 9 467, 78		467, 782	
. 00 06000 LABORATORY	5, 131, 293		5, 131, 29		5, 132, 279	
. 00 063000 BLOOD STORING, PROCESSING, & TRANS.	371, 479		371, 4		371, 479	
. 00 06400 INTRAVENOUS THERAPY	681, 396		681, 39		681, 396	
. 00 06500 RESPIRATORY THERAPY	1, 573, 722				1, 573, 722	
. 00 06600 PHYSI CAL THERAPY	2, 273, 101	0			2, 273, 101	
. 00 06700 OCCUPATI ONAL THERAPY	486, 509				486, 509	
. 00 06800 SPEECH PATHOLOGY	340,069				340, 069	
. 00 06900 ELECTROCARDI OLOGY	690, 760		690, 70		692, 439	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 043, 745		10, 043, 74		10, 043, 745	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 403, 454		3, 403, 45	54 0	3, 403, 454	72. (
. 00 07300 DRUGS CHARGED TO PATIENTS	12, 951, 972		12, 951, 9	72 0	12, 951, 972	73. (
. 00 03952 WOUND CARE	314, 265		314, 20	65 0	314, 265	76. (
. 02 03951 CASE MANAGEMENT	203, 060		203, 00	50 0	203, 060	
. 03 03950 PALN MANAGEMENT	1, 927, 140		1, 927, 14		1, 927, 140	
. 97 07697 CARDIAC REHABILITATION	624, 397		624, 39	97 0	624, 397	76. 9
OUTPATIENT SERVICE COST CENTERS		[
. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	23, 985		23, 98		23, 985	
. 01 04951 PALLI ATI VE HEALTH	241, 194		241, 19		241, 194	
. 02 09000 VEI N CENTER	376, 477		376, 4		376, 477	
. 03 09001 0B GYN . 00 09100 EMERGENCY	1, 710, 096		1, 710, 09		1, 710, 096	
. 00 09100 EMERGENCY . 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 165, 213 2, 000, 864		6, 165, 2 ⁻ 2, 000, 86		6, 165, 213 2, 000, 864	
. 00 04952 BEHAVOURAL HEALTH	681, 235		681, 2		681, 235	
OTHER REI MBURSABLE COST CENTERS	001,233		001, 2.	55 0	001, 233	- 73.0
1.00 10100 HOME HEALTH AGENCY	2, 212, 828		2, 212, 82	28	2, 212, 828	101 (
SPECIAL PURPOSE COST CENTERS	2, 212, 320	I			2, 212, 320	1.01.
3. 00 11300 I NTEREST EXPENSE						1113. (
6. 00 11600 HOSPI CE	1, 239, 201		1, 239, 20	01	1, 239, 201	
0.00 Subtotal (see instructions)	96, 814, 111	0			96, 910, 046	
1.00 Less Observation Beds	2,000,864		2,000,80		2, 000, 864	
2.00 Total (see instructions)	94, 813, 247				94, 909, 182	

OMPUTATI OI	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/18/2016 3:0	
			Tit	le XIX	Hospi tal	Cost	7 pili
			Charges	0 /// //		0001	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
0.00 0300	0 ADULTS & PEDI ATRI CS	10, 920, 372		10, 920, 3	72		30.00
	O INTENSIVE CARE UNIT	1, 546, 883		1, 546, 88			31.00
	0 NURSERY	1, 373, 547		1, 373, 54	47		43.00
	LLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	O OPERATING ROOM	13, 255, 993	54, 325, 364	67, 581, 3	57 0. 138766	0.000000	50.00
	O RECOVERY ROOM	977, 043	5, 249, 183	6, 226, 22		0.00000	
	O DELIVERY ROOM & LABOR ROOM	6, 124, 420	414, 385	6, 538, 80		0.000000	•
	0 ANESTHESI OLOGY	1, 044, 502	3, 699, 412	4, 743, 9		0.000000	
	0 RADI OLOGY-DI AGNOSTI C	1, 110, 047	16, 606, 463			0.00000	
	OULTRA SOUND	413, 117	3, 321, 720	3, 734, 83		0.00000	
	ONUCLEAR MEDICINE - DIAGNOSTIC	116, 695	1, 795, 805	1, 912, 50		0.00000	
	O CT SCAN	3, 346, 012	29, 376, 748			0.00000	
	O MAGNETIC RESONANCE IMAGING (MRI)	758, 223	9, 841, 410	10, 599, 63		0.000000	
	0 LABORATORY	9, 896, 290	36, 328, 763			0.000000	
	0 BLOOD STORING, PROCESSING, & TRANS.	393, 539	289, 484	683, 02		0.000000	
	O I NTRAVENOUS THERAPY	272, 552	1, 071, 104	1, 343, 6		0.000000	
	0 RESPI RATORY THERAPY	3, 552, 248	1, 224, 445	4, 776, 69		0.000000	
	O PHYSI CAL THERAPY	682, 824	3, 689, 770	4, 372, 59		0.000000	
	0 OCCUPATIONAL THERAPY	438, 468	1, 324, 205	1, 762, 6		0.000000	
	O SPEECH PATHOLOGY	77, 251	479, 844	557, 09		0.000000	
		1, 118, 288	5, 690, 614	6, 808, 90		0.000000	
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 674, 621	5, 755, 376	8, 429, 99		0.000000	
	O IMPL. DEV. CHARGED TO PATIENT	2, 530, 545	2, 511, 389	5,041,93		0.000000	
	0 DRUGS CHARGED TO PATIENTS 2 WOUND CARE	4, 884, 046	10, 986, 376			0.000000	
	1 CASE MANAGEMENT	36, 280	599, 441	635, 72		0.000000	
		21,029	145, 917	166, 94		0.000000	
		719	2, 713, 739			0.000000	
	7 CARDIAC REHABILITATION ATIENT SERVICE COST CENTERS	246	192, 876	193, 12	3. 233174	0. 000000	76.9
	O OTHER OUTPATIENT SERVICE COST CENTER	0	E4 074	E4 2	0. 441924	0. 000000	90.0
	1 PALLIATIVE HEALTH	36, 428	54, 274 148, 660	54, 2 185, 08		0.000000	
	O VEIN CENTER	30, 428	1, 841, 558	1, 841, 5		0.000000	
	1 OB GYN	0	1, 541, 558	1, 515, 9		0.000000	
	0 EMERGENCY	1, 454, 373	14, 430, 760	15, 885, 13		0.000000	
	O OBSERVATION BEDS (NON-DISTINCT PART)	47, 191	1, 255, 687	1, 302, 8		0.000000	
	2 BEHAVOURAL HEALTH	47, 191	257, 299	257, 2		0.000000	•
	R REIMBURSABLE COST CENTERS	0	237, 277	257, 2	2.047040	0.000000	93.00
	O HOME HEALTH AGENCY	0	2, 361, 093	2, 361, 04	23		101. 0
	I AL PURPOSE COST CENTERS	U U	2, 301, 093	2, 301, 0			101.0
	0 INTEREST EXPENSE						113.0
16.001160		0	2, 236, 744	2, 236, 74	14		116. 0
00.00	Subtotal (see instructions)	69, 103, 792	221, 735, 886	290, 839, 6			200. 0
01.00	Less Observation Beds	07,103,772	221, 755,000	270,037,0			200.00
		1 1			1		1-01.0

COMPLIT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	SCHNECK MEDICAL	Provider CCN: 150065	Peri od:	u of Form CMS-255 Worksheet C
COMPUT	ATTON OF RATIO OF COSTS TO CHARGES		Provider CCN. 150005	From 01/01/2015 To 12/31/2015	
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30
31.00	03100 I NTENSI VE CARE UNI T				31
43.00	04300 NURSERY				43
	ANCI LLARY SERVI CE COST CENTERS	· · · · ·			
50.00	05000 OPERATI NG ROOM	0. 000000			50
51.00	05100 RECOVERY ROOM	0. 000000			51
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
53.00	05300 ANESTHESI OLOGY	0. 000000			53
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
54.01	03630 ULTRA SOUND	0. 000000			54
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54
57.00	05700 CT SCAN	0. 000000			5
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
60.00	06000 LABORATORY	0. 000000			60
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000			63
64.00	06400 I NTRAVENOUS THERAPY	0. 000000			64
65.00	06500 RESPI RATORY THERAPY	0. 000000			65
66.00	06600 PHYSI CAL THERAPY	0. 000000			66
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67
68.00	06800 SPEECH PATHOLOGY	0. 000000			68
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			72
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
76.00	03952 WOUND CARE	0. 000000			70
76.02	03951 CASE MANAGEMENT	0. 000000			70
76.03	03950 PALN MANAGEMENT	0. 000000			76
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0. 000000			76
00 00		0.000000			
90.00 90.01	04950 OTHER OUTPATIENT SERVICE COST CENTER 04951 PALLIATIVE HEALTH	0.000000			90
90. 01 90. 02	09000 VEIN CENTER	0.000000			90
90.02 90.03	09000 VEIN CENTER 09001 0B GYN	0.000000			90
90.03 91.00	09100 EMERGENCY	0.000000			90
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVOURAL HEALTH	0. 000000 0. 000000			92
73.00	OTHER REIMBURSABLE COST CENTERS	0.000000			9.
101 00	10100 HOME HEALTH AGENCY				10'
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			10
113 00	11300 INTEREST EXPENSE				11:
	11600 HOSPI CE				110
200. 00					200
200.00					200
201.00					

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
		Ti +1	e XVIII	Hospi tal	PPS	7 pili
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		$(col \cdot 1 - col$			
	26)		2)			
	1,00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 ADULTS & PEDIATRICS	2, 468, 275	9, 922	2, 458, 35	3 12, 292	200.00	30.00
31. 00 I NTENSI VE CARE UNI T	328, 832		328, 83			
43. 00 NURSERY	30, 373		30, 37			
200.00 Total (lines 30-199)	2, 827, 480		2, 817, 55			200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 560	912,000)			30.00
31.00 INTENSIVE CARE UNIT	524	151, 279	,			31.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	5, 084	1, 063, 279	,			200.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provi der	CCN: 150065	Peri od:	Worksheet D	
				From 01/01/2015	Part II	
				To 12/31/2015	Date/Time Pre 5/18/2016 3:0	pared
		Ti †1	e XVIII	Hospi tal	PPS	7 pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		$(col \cdot 1 \div col$		column 4)	
	Part II, col.	8)	2)	J		
	26)	, i	· ·			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-	-			
0. 00 05000 OPERATING ROOM	1, 876, 104				176, 535	50.0
51.00 05100 RECOVERY ROOM	15, 111				987	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	38, 831				37	52.0
3. 00 05300 ANESTHESI OLOGY	43, 199	4, 743, 914			3, 838	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 206, 366				40, 256	54.
54.01 03630 ULTRA SOUND	23, 798	3, 734, 837			1, 120	54.
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	2, 612				82	54.
57.00 05700 CT SCAN	44, 799	32, 722, 760	0.00136	59 2, 003, 730	2, 743	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 582	10, 599, 633	0.00099	98 360, 536	360	58.
0. 00 06000 LABORATORY	403, 316	46, 225, 053	0. 00872	25 5, 011, 032	43, 721	60.
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 594	683, 023	0.00526	52 200, 908	1, 057	63.
4.00 06400 INTRAVENOUS THERAPY	167, 882	1, 343, 656	0. 12494	130, 942	16, 360	64.
5. 00 06500 RESPI RATORY THERAPY	109, 668	4, 776, 693	0. 02295	59 1, 554, 007	35, 678	65.
6. 00 06600 PHYSI CAL THERAPY	231, 549	4, 372, 594	0. 05295	55 377, 261	19, 978	66.
7.00 06700 OCCUPATI ONAL THERAPY	17, 552	1, 762, 673	0. 00995	58 239, 382	2, 384	67.
8.00 06800 SPEECH PATHOLOGY	3, 435	557, 095	0.00616	56 50, 845	314	68.
9. 00 06900 ELECTROCARDI OLOGY	178, 850	6, 808, 902	0. 02626	616, 574	16, 196	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	216, 368	8, 429, 997	0. 02566	56 1, 347, 438	34, 583	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	73, 620	5, 041, 934	0. 01460	02 1, 249, 621	18, 247	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	361, 088	15, 870, 422	0. 02275	52 2, 521, 934	57, 379	73.
6.00 03952 WOUND CARE	29, 398	635, 721	0. 04624	14, 213	657	76.
6.02 03951 CASE MANAGEMENT	29, 506	166, 946	0. 17674	40 0	0	76.
6.03 03950 PALN MANAGEMENT	153, 946	2, 714, 458	0. 0567	13 202	11	76.
76. 97 07697 CARDI AC REHABI LI TATI ON	9, 735	193, 122	0. 05040	09 0	0	76.
OUTPATIENT SERVICE COST CENTERS		1	1			
0.00 04950 OTHER OUTPATIENT SERVICE COST CENTER					0	
0. 01 04951 PALLIATIVE HEALTH	2, 332				0	90.
20. 02 09000 VEIN CENTER	5, 385				0	90.
20. 03 09001 OB GYN	120, 407				0	90.
P1. 00 09100 EMERGENCY	409, 793				18, 852	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	331, 127				11, 073	
23. 00 04952 BEHAVOURAL HEALTH	53, 609			53 0	0	
200.00 Total (lines 50-199)	6, 175, 256	272, 401, 039		24, 473, 849	502, 448	200.

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0) ()	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0	0	31.00
43. 00 04300 NURSERY	0			0	0	43.00
200.00 Total (lines 30-199)	0			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
'	Days	5 ÷ col. 6)	Program Days			
		· · · · ·		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			·	-		
30. 00 03000 ADULTS & PEDI ATRI CS	12, 292	0.00	4, 56	0 0		30.00
31.00 03100 INTENSIVE CARE UNIT	1,139					31.00
43.00 04300 NURSERY	1,643			0 0		43.00
200.00 Total (lines 30-199)	15,074		5, 08	4 0		200.00

Health Financial Systems	SCHNECK MEDIC				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/18/2016 3:0	pared: 7 pm
		Titl	e XVIII	Hospi tal	PPS	<u>, bui</u>
Cost Center Description	Non Physician				Total Cost	
	Anestheti st	5		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	0		0 0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0)	0 0	0	54.02
57.00 05700 CT SCAN	0	0)	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	o	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66,00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03952 WOUND CARE	0	0		0 0	0	76.00
76. 02 03951 CASE MANAGEMENT	0	0		0 0	0	76.02
76. 03 03950 PALN MANAGEMENT	0	0		0 0	0	76.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	<u>ч</u>	0	1	0 0	0	/0. //
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	1	0 0	0	90.00
90. 01 04951 PALLI ATI VE HEALTH	0	0		0 0	0	
90. 02 09000 VEI N CENTER	0	0		0 0	0	90.02
90. 03 09001 OB GYN		0		0 0	0	90.02
91. 00 09100 EMERGENCY		0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0 0	0	
93. 00 04952 BEHAVOURAL HEALTH		0		0 0	0	
200.00 Total (lines 50-199)	0	0		0 0	-	200.00
	, Ч	0	Т		0	1200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provi de	r CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
					5/18/2016 3:0)7 pm
Cost Conton Decorintion	Total		tle XVIII	Hospi tal t Outpati ent	PPS Inpatient	
Cost Center Description	Outpatient	(from Wkst.	s Ratio of Cos C, to Charges	Ratio of Cost		
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and		7)	$(col. 6 \div col.$	charges	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,00	7100	10100	
50. 00 05000 OPERATI NG ROOM	0	67, 581, 3	0. 0000	0. 000000	6, 359, 098	50.00
51.00 05100 RECOVERY ROOM	0	6, 226, 2	0. 0000	0. 000000	406, 772	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 538, 8	0. 0000	0. 000000	6, 309	52.00
53.00 05300 ANESTHESI OLOGY	0			0. 000000	421, 493	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	17, 716, 5	0. 00000	0. 000000	591, 198	54.00
54.01 03630 ULTRA SOUND	0	3, 734, 8	0. 00000	0. 000000	175, 753	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	1, 912, 5	0. 00000	0. 000000	60, 268	54.02
57.00 05700 CT SCAN	0	32, 722, 7	0. 00000	0. 000000	2, 003, 730	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10, 599, 6	0. 00000	0. 000000	360, 536	58.00
60. 00 06000 LABORATORY	0	46, 225, 0	53 0.0000	0. 000000	5, 011, 032	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	683, 0	0. 00000	0. 000000	200, 908	63.00
64.00 06400 INTRAVENOUS THERAPY	0	1, 343, 6	56 0.00000			64.00
65. 00 06500 RESPI RATORY THERAPY	0	4, 776, 6	0. 00000	0. 000000	1, 554, 007	65.00
66. 00 06600 PHYSI CAL THERAPY	0	4, 372, 5	0. 00000	0. 000000	377, 261	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0				239, 382	67.00
68.00 06800 SPEECH PATHOLOGY	0	557, 0			50, 845	
69. 00 06900 ELECTROCARDI OLOGY	0					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0. 000000		
73.00 07300 DRUGS CHARGED TO PATIENTS	0				2, 521, 934	
76.00 03952 WOUND CARE	0				14, 213	
76. 02 03951 CASE MANAGEMENT	0					
76. 03 03950 PALN MANAGEMENT	0					
76. 97 07697 CARDI AC REHABI LI TATI ON	0	193, 1	0.0000	0. 000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0				0	
90. 01 04951 PALLI ATI VE HEALTH	0				0	
90. 02 09000 VEIN CENTER	0				0	1 /01 01
90. 03 09001 0B GYN	0					
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-					
	0	1 1 -			43, 569 0	
93.00 04952 BEHAVOURAL HEALTH 200.00 Total (lines 50-199)	0			0.00000	24, 473, 849	
200.00 10tal (11065 50-199)	0	272,401,0	אס	1	24, 473, 849	∠00. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	CAL CENTER Provi der	CCN: 150065	Period: From 01/01/201 To 12/31/201		-2552-10 repared: 07 pm
		Titl	e XVIII	Hospi tal	PPS	•
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	10, 919, 102		0		50.00
51.00 05100 RECOVERY ROOM	0	1, 064, 059		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	661, 901		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 673, 282		0		54.00
54.01 03630 ULTRA SOUND	0	809, 050		0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	746, 483		0		54.02
57.00 05700 CT SCAN	0	6, 950, 502		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 439, 564		0		58.00
50. 00 06000 LABORATORY	0	5, 321, 213		0		60.00
53.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	113, 233		0		63.00
54. 00 06400 I NTRAVENOUS THERAPY	0	408, 560		0		64.00
55. 00 06500 RESPI RATORY THERAPY	0	202, 738		0		65.00
56. 00 06600 PHYSI CAL THERAPY	0	290		0		66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0	96, 762		0		67.00
58. 00 06800 SPEECH PATHOLOGY	0	70, 702 0		0		68.00
59. 00 06900 ELECTROCARDI OLOGY	0	1, 510, 273		0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 055, 866		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0		72.00
	0	505, 139	1	0		
	0	5, 420, 783		0		73.00
76.00 03952 WOUND CARE	Ŭ	299, 114		-		76.00
76.02 03951 CASE MANAGEMENT	0	0		0		76.02
76.03 03950 PALN MANAGEMENT	0	174, 698		0		76.03
76. 97 07697 CARDIAC REHABILITATION	0	82, 041		0		76.97
OUTPATIENT SERVICE COST CENTERS		47.77				
20.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	47, 667		0		90.00
20. 01 04951 PALLI ATI VE HEALTH	0	75, 702		0		90.01
20. 02 09000 VEIN CENTER	0	0		0		90.02
20. 03 09001 OB GYN	0	C		0		90.03
P1. 00 09100 EMERGENCY	0	2, 293, 096		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	328, 204		0		92.00
23. 00 04952 BEHAVOURAL HEALTH	0	78, 131		0		93.00
200.00 Total (lines 50-199)	0	44, 277, 453		0		200.00

APPORTI ON	WENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015		
			Titl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To			
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS						
	000 OPERATI NG ROOM	0. 138766			0 0	1, 515, 200	
	00 RECOVERY ROOM	0. 120986			0 0	128, 736	1
	200 DELIVERY ROOM & LABOR ROOM	0. 339730			0 0	0	
	OO ANESTHESI OLOGY	0. 248374			0 0	164, 399	
	00 RADI OLOGY-DI AGNOSTI C	0. 417176			0 0	1, 115, 229	1
	30 ULTRA SOUND	0. 122533			0 0	99, 135	54.01
54.02 034	50 NUCLEAR MEDICINE - DIAGNOSTIC	0. 107029	746, 483		0 534	79, 895	54.02
	OO CT SCAN	0. 028420	6, 950, 502		0 799	197, 533	57.00
58.00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 044132	2, 439, 564		0 134	107, 663	58.00
60.00 060	000 LABORATORY	0. 111007	5, 321, 213	5	92 0	590, 692	60.00
63.00 063	00 BLOOD STORING, PROCESSING, & TRANS.	0. 543875	113, 233		0 0	61, 585	63.00
64.00 064	00 INTRAVENOUS THERAPY	0. 507121	408, 560		0 0	207, 189	64.00
65.00 065	00 RESPI RATORY THERAPY	0. 329458	202, 738		0 0	66, 794	65.00
66.00 066	00 PHYSI CAL THERAPY	0. 519852	290		0 0	151	66.00
67.00 067	OO OCCUPATI ONAL THERAPY	0. 276006	96, 762		0 0	26, 707	67.00
68.00 068	SOO SPEECH PATHOLOGY	0. 610433	0		0 0	0	68.00
69.00 069	00 ELECTROCARDI OLOGY	0. 101450	1, 510, 273		0 396	153, 217	69.00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191429	1, 055, 866		0 0	1, 257, 989	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENT	0. 675029	505, 139		0 0	340, 983	72.00
73.00 073	OO DRUGS CHARGED TO PATIENTS	0. 816108	5, 420, 783		0 24, 666	4, 423, 944	73.00
76.00 039	952 WOUND CARE	0. 494344	299, 114		0 0	147, 865	76.00
76.02 039	251 CASE MANAGEMENT	1. 216321	0		0 0	0	76.02
76.03 039	250 PALN MANAGEMENT	0. 709954	174, 698		0 0	124, 028	76.03
76.97 076	97 CARDIAC REHABILITATION	3. 233174	82, 041		0 0	265, 253	76.97
OUT	PATIENT SERVICE COST CENTERS	·		•			
	50 OTHER OUTPATIENT SERVICE COST CENTER	0. 441924	47,667		0 0	21,065	90.00
90.01 049	51 PALLIATIVE HEALTH	1. 303131	75, 702		0 0	98, 650	90.01
90.02 090	DOO VEIN CENTER	0. 204434			0 0	0	90.02
90.03 090	OT OB GYN	1. 128048	0		0 0	0	90.03
91.00 091	OO EMERGENCY	0. 388112	2, 293, 096		0 63	889, 978	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	1. 535726			0 0	504, 031	1
	52 BEHAVOURAL HEALTH	2. 647640			0 0	206, 863	
200.00	Subtotal (see instructions)		44, 277, 453		92 26, 592	12, 794, 774	
201.00	Less PBP Clinic Lab. Services-Program		,, 100	l	0 0	, , , , , ,	201.00
	Only Charges						
	Net Charges (line 200 +/- line 201)	1	1	1	92 26, 592		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/18/2016 3:0	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05200 DELIVERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 03630 ULTRA SOUND	0	0				54.00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	57				54.01
57. 00 05700 CT SCAN	0	23				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6	1			58.00
60. 00 06000 LABORATORY	66					60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	40				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	20, 130				73.00
76.00 03952 WOUND CARE	0	0				76.00
76. 02 03951 CASE MANAGEMENT	0	0				76.02
76. 03 03950 PALN MANAGEMENT	0	0				76.03
76. 97 07697 CARDIAC REHABILITATION	0	0				76.97
OUTPATIENT SERVICE COST CENTERS		_				
90.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90.00
90. 01 04951 PALLIATIVE HEALTH	0	0				90.01
90. 02 09000 VEIN CENTER	0	0				90.02
90. 03 09001 OB GYN	0	0				90.03
91. 00 09100 EMERGENCY	0	24				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93.00 04952 BEHAVOURAL HEALTH	0	0				93.00
200.00 Subtotal (see instructions)	66	20, 280				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						000 67
202.00 Net Charges (line 200 +/- line 201)	66	20, 280				202.00

APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der	CCN: 150065	Period: From 01/01/201 To 12/31/201		
			Ti t	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	-				-	
	DO OPERATING ROOM	0. 138766			0 2, 033, 10		
	DO RECOVERY ROOM	0. 120986			0 260, 16	5 0	
	DO DELIVERY ROOM & LABOR ROOM	0. 339730			0 56, 48	4 0	52.00
53.00 0530	DO ANESTHESI OLOGY	0. 248374	0		0 238, 17	9 0	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0. 417176	C		0 390, 30	5 0	54.00
54.01 0363	30 ULTRA SOUND	0. 122533	0		0 114, 67	8 0	54.01
54.02 0345	50 NUCLEAR MEDICINE - DIAGNOSTIC	0. 107029	0		0 41, 49	2 0	54.02
57.00 0570	DO CT SCAN	0. 028420	0		0 253, 13	1 0	57.00
58.00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 044132	0		0 350, 16	2 0	58.00
	DO LABORATORY	0. 111007	0		0 790, 09	4 0	60.00
63.00 0630	DO BLOOD STORING, PROCESSING, & TRANS.	0. 543875	0		0 5, 71	8 0	63.00
64.00 0640	DO INTRAVENOUS THERAPY	0. 507121	0		0 21, 43	2 0	64.00
65.00 0650	DO RESPI RATORY THERAPY	0. 329458	C		0 51, 58	3 0	65.00
66.00 0660	DO PHYSI CAL THERAPY	0. 519852	C		0 151, 63	6 0	66.00
67.00 0670	DO OCCUPATI ONAL THERAPY	0. 276006	C		0 60, 86	2 0	67.00
68.00 0680	DO SPEECH PATHOLOGY	0. 610433	0		0 48, 04	в о	68.00
69.00 0690	DO ELECTROCARDI OLOGY	0. 101450	C		0 180, 26	2 0	69.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191429	C		0 328, 48	o o	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENT	0. 675029	C		0	o o	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0. 816108	C		0 253, 46	1 0	73.00
	52 WOUND CARE	0. 494344	c c		0 30, 36		76.00
76.02 0395	51 CASE MANAGEMENT	1. 216321	0		0	o o	76.02
76.03 0395	50 PALN MANAGEMENT	0. 709954	0		0 336, 33	3 0	76.03
76.97 0769	7 CARDI AC REHABILI TATI ON	3. 233174	0		0 2, 33	9 0	76.97
OUTF	PATIENT SERVICE COST CENTERS	·		•			
90.00 0495	50 OTHER OUTPATIENT SERVICE COST CENTER	0. 441924	C	1	0 1,94	8 0	90.00
90.01 0495	51 PALLIATIVE HEALTH	1. 303131	0		0 9,08	в о	90.01
90. 02 0900	DO VEIN CENTER	0. 204434	c c		0 61, 55	5 0	90.02
90.03 0900	D1 OB GYN	1. 128048	C		0	o o	90.03
91.00 0910	DO EMERGENCY	0. 388112	C		0 73, 12	2 0	91.00
	DO OBSERVATION BEDS (NON-DISTINCT PART)	1. 535726			0 198, 84		92.00
	52 BEHAVOURAL HEALTH	2. 647640			0 45, 76		
200.00	Subtotal (see instructions)		0		0 6, 388, 63		200.00
201.00	Less PBP Clinic Lab. Services-Program		ĺ		-,,		201.00
	Only Charges						
1	Net Charges (line 200 +/- line 201)	1	c c	1	0 6, 388, 63		202.00

	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pro 5/18/2016 3:0	
			Ti t	le XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00				
	ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
	05000 OPERATI NG ROOM	0	282, 126				50.00
	05100 RECOVERY ROOM	0	31, 476				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	19, 189				52.00
	05300 ANESTHESI OLOGY	0	59, 157				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	162, 826				54.00
	03630 ULTRA SOUND	0	14, 052				54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	4, 441				54.02
	05700 CT SCAN	0	7, 194				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15, 453				58.00
	06000 LABORATORY	0	87, 706				60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	3, 110				63.00
	06400 I NTRAVENOUS THERAPY	0	10, 869				64.00
	06500 RESPI RATORY THERAPY	0	16, 994				65.00
	06600 PHYSI CAL THERAPY	0	78, 828				66.00
	06700 OCCUPATI ONAL THERAPY	0	16, 798				67.00
68.00	06800 SPEECH PATHOLOGY	0	29, 330				68.00
69.00	06900 ELECTROCARDI OLOGY	0	18, 288				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	391, 361				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	206, 852				73.00
	03952 WOUND CARE	0	15, 011				76.00
	03951 CASE MANAGEMENT	0	0				76.02
1	03950 PAIN MANAGEMENT	0					76.03
	07697 CARDI AC REHABI LI TATI ON	0	7, 562				76.97
	OUTPATIENT SERVICE COST CENTERS	1					
	04950 OTHER OUTPATIENT SERVICE COST CENTER	0					90.00
	04951 PALLI ATI VE HEALTH	0					90.01
	09000 VEIN CENTER	0	12, 584				90.02
	09001 OB GYN	0	0				90.03
	09100 EMERGENCY	0	28, 380				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	305, 364				92.00
	04952 BEHAVOURAL HEALTH	0	,				93.00
200.00	Subtotal (see instructions)	0	2, 197, 605				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						

. 00 . 00 . 00	Cost Center Description	Title XVIII	To 12/31/2015	Date/Time Prep				
. 00	Cost Center Description		Hospi tal	5/18/2016 3:07 PPS	pare 7 pm			
. 00			- Hospi tai	1.00				
00	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		I		-			
	Inpatient days (including private room days and swing-bed days, o			12, 588	1			
	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days).	5,	vate room days,	12, 292 0	2			
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed o	days)		10, 643	4			
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost 2 reporting period							
00	Total swing-bed SNF type inpatient days (including private room (reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6			
00	Total swing-bed NF type inpatient days (including private room da reporting period	ays) through December	31 of the cost	73	7			
00	Total swing-bed NF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line)	ays) after December 31	of the cost	0	8			
00	Total inpatient days including private room days applicable to the newborn days)	he Program (excluding	swing-bed and	4, 560	9			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	223	10			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enter	(including private ro	oom days) after	0	11			
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period		e room days)	0	12			
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX or after December 31 of the cost reporting period (if calendar year,			0	13			
	Medically necessary private room days applicable to the Program							
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	15 16			
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	227. 71	17			
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services a	after December 31 of 1	the cost	0.00	18			
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services tl	hrough December 31 of	the cost	129. 14	19			
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	fter December 31 of th	ne cost	0.00	20			
00	reporting period Total general inpatient routine service cost (see instructions)			14, 975, 016	21			
	Swing-bed cost applicable to SNF type services through December : 5×1 ine 17)	31 of the cost reporti	ng period (line	14, 975, 018 50, 779				
. 00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reporting	g period (line 6	0	23			
. 00	Swing-bed cost applicable to NF type services through December 3' 7×1 ine 19)	1 of the cost reportin	ng period (line	9, 427	24			
i. 00	Swing-bed cost applicable to NF type services after December 31 (of the cost reporting	period (line 8	0	25			
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (lin	ne 21 minus line 24)		60, 206 14, 914, 810				
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			14, 714, 010	21			
	General inpatient routine service charges (excluding swing-bed a	nd observation bed cha	arges)		28			
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29			
	General inpatient routine service cost/charge ratio (line 27 ÷ li	ine 28)		0. 000000				
	Average private room per diem charge (line 29 ÷ line 3)	,		0.00				
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00				
	Average per diem private room charge differential (line 32 minus	line 33)(see instruct	i ons)	0.00	34			
. 00	Average per diem private room cost differential (line 34 x line 3	31)		0.00	35			
	Private room cost differential adjustment (line 3 x line 35)	privata room aast -1:4	Forontial (Line)	0	36			
. UU	General inpatient routine service cost net of swing-bed cost and 27 minus line 36) DADT LL HOSDITAL AND SUPPOOULDERS ONLY	private room cost dif	rerential (IINe	14, 914, 810	37			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS						
3. 00	Adjusted general inpatient routine service cost per diem (see ins			1, 213. 38	38			
	Program general inpatient routine service cost (line 9 x line 38)			5, 533, 013	39			
	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	. ,		0 5, 533, 013				

					Period: From 01/01/2015		
				-	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Cost Contor Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient Cost				(col. 3 x col. 4)	
	1	1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0 0	0	42
00	INTENSIVE CARE UNIT	2, 515, 235	1, 139	2,208.2	8 524	1, 157, 139	43
00	CORONARY CARE UNI T	_, _ , _ ,		_,	-	.,,	44
00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	·					1.00	
00	Program inpatient ancillary service cost (Wks					7, 853, 784	
00	Total Program inpatient costs (sum of lines 4	11 through 48)(see instructio	ns)		14, 543, 936	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sum	of Parts L and	1, 063, 279	50
00)					1,000,277	
00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst. D, si	um of Parts II	502, 448	51
. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				1, 565, 727	52
00	Total Program inpatient operating cost exclude		lated, non-phy	sician anesth	etist, and	12, 978, 209	
	medical education costs (line 49 minus line 8						
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	irget amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, ι	pdated and co	mpounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report un	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
00	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reporti	ng period (See	50, 779	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	to after Decemb	or 21 of the c	act roporting	pariod (Saa	0	65
00	instructions) (title XVIII only)	is after Deceniu		ost reporting	perrou (see	0	00
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	50, 779	66
	CAH (see instructions)					_	
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)				0 1		
. 00	<u> </u>			,		0	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
00	Adjusted general inpatient routine service co						71
00	Program routine service cost (line 9 x line 3	,					72
. 00	Medically necessary private room cost applica		•	,			73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			art II column		74
	26, line 45)	Satine Service		S. KONCEL D, FO			'
. 00	Per diem capital-related costs (line 75 ÷ lin						76
00	Program capital -related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der rocoro	le)			78
00	Total Program routine service costs for compa	• •		· ·	us line 79)		80
00	Inpatient routine service cost per diem limit			(<u>12</u> 10 m m			81
00	Inpatient routine service cost limitation (li		· .				82
00	Reasonable inpatient routine service costs (s		is)				83
00 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
. 00	Total observation bed days (see instructions))				1, 649	87
. 00	Adjusted general inpatient routine cost per d		11			1, 213. 38	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 3:0	pared: 7 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 468, 275	14, 914, 810	0. 16549	2 2, 000, 864	331, 127	90.00
91.00 Nursing School cost	0	14, 914, 810	0.00000	2, 000, 864	0	91.00
92.00 Allied health cost	0	14, 914, 810	0.00000	2, 000, 864	0	92.00
93.00 All other Medical Education	0	14, 914, 810	0. 00000	2, 000, 864	0	93.00

	Financial Systems SCHNECK MEDICAL CATION OF INPATIENT OPERATING COST Control	Provider CCN: 150065	Period: From 01/01/2015	u of Form CMS-2 Worksheet D-1	
			To 12/31/2015	Date/Time Prep 5/18/2016 3:0	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~ ~	I NPATI ENT DAYS			10 500	
00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			12, 588 12, 292	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d davs)		10, 643	4
00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	223	
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5			
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	73	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	749	9
	newborn days)	0 0 0	0		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat		0	13
. 00	after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)		14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 643 116	
00	SWING BED ADJUSTMENT	a through December 21 a	f the east	227 71	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through December 31 o	r the cost	227.71	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	129. 14	19
00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	14, 975, 016 50, 779	
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	9, 427	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		60, 206 14, 914, 810	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0 0	
	Semi -private room charges (excluding swing-bed charges)	1. 00)		0	
	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	0 14, 914, 810	
. 50	27 minus line 36)			, , , , , , 010	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU:	STMENTS			-
				1, 213. 38	38
8. 00	Adjusted general inpatient routine service cost per diem (see	r iisti ucti uiis)	1	1, 213, 301	
9.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		908, 822 0	39

MPUT	ATION OF INPATIENT OPERATING COST		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		
						5/18/2016 3:0	
	Cost Costos Decesistics	Tatal		le XIX	Hospi tal	Cost	
	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)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	674, 429	1, 643	410. 49	116	47, 617	42.
00	Intensive Care Type Inpatient Hospital Units	2 515 225	1, 139	2 200 20	00	17/ //2	1 42
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 515, 235	1, 139	2, 208. 28	80	176, 662	2 43
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00						1.00	- 10
. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nc)		692, 865 1, 825, 966	
00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 46) (see mstructro	115)		1, 020, 900	49
. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	0	50
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51				c	52
. 00	Total Program inpatient operating cost exclu	,	lated non-phy	sician anesthe	tist and		
. 00	medical education costs (line 49 minus line		natea, non phy				
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges						54
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	ract amount (1	ino E4 minus I	ino E2)		
. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (i	The so minus i	The 53)		
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996. u	pdated and com	pounded by the		
	market basket	51	5				
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		S (111185 54 X	00), 01 1% 01	the target		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			c	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reportin	g period (See	C	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See		65
	instructions)(title XVIII only)			5			
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0) 66
00	CAH (see instructions)	a aaata thrawah	December 21 o	f the east rem	onting posied		
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 0	i the cost rep	orting period		67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	ting period	0	68
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient			,		0) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					1	70
. 00	Adjusted general inpatient routine service o						71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applic		•	ne 35)			73
. 00	Total Program general inpatient routine serv	•					74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine servíce	e costs (from W	orкsheet B, Pa	rτ II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces						79
00	Total Program routine service costs for comp		ost limitation	(line 78 minu	s line 79)		80
. 00	Inpatient routine service cost per diem limi)				81
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· .				82
. 00	Program inpatient ancillary services (see in		,				84
. 00	Utilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (sum	of lines 83 th					86
~ ~	PART IV - COMPUTATION OF OBSERVATION BED PASS						1 ~-
	Total observation bed days (see instructions)				1,649	9 87
. 00 . 00	Adjusted general inpatient routine cost per		line 2			1, 213. 38	2 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 468, 275	14, 914, 810	0. 16549	2 2, 000, 864	331, 127	90.00
91.00 Nursing School cost	0	14, 914, 810	0.00000	0 2, 000, 864	0	91.00
92.00 Allied health cost	0	14, 914, 810	0.00000	0 2, 000, 864	0	92.00
93.00 All other Medical Education	0	14, 914, 810	0. 00000	0 2, 000, 864	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	Worksheet D-3	
			From 01/01/2015		
			To 12/31/2015	Date/Time Pre	
	T: +1	o XV/111	lloopital	5/18/2016 3:0 PPS	/ pm
Cost Center Description		e XVIII Ratio of Cos	Hospital Inpatient	Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDI ATRI CS			3, 257, 118		30. (
. 00 03100 I NTENSI VE CARE UNI T			686, 855		31. (
. 00 04300 NURSERY		1			43.0
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 1387	66 6, 359, 098	882, 427	50. (
. 00 05100 RECOVERY ROOM		0. 1209	86 406, 772	49, 214	51. (
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3397	30 6, 309	2, 143	52. (
. 00 05300 ANESTHESI OLOGY		0. 2483	74 421, 493	104, 688	53.0
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4224	41 591, 198	249, 746	54.0
. 01 03630 ULTRA SOUND		0. 1225	33 175, 753	21, 536	54.0
. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 10702	29 60, 268	6, 450	54.0
. 00 05700 CT SCAN		0. 02842	20 2, 003, 730	56, 946	57.0
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.04413	32 360, 536	15, 911	58.0
. 00 06000 LABORATORY		0. 1110	28 5, 011, 032	556, 365	60. (
. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.		0. 5438	75 200, 908	109, 269	63.0
. 00 06400 I NTRAVENOUS THERAPY		0. 50712	21 130, 942	66, 403	64. (
. 00 06500 RESPI RATORY THERAPY		0. 3294		511, 980	65.0
. 00 06600 PHYSI CAL THERAPY		0. 5198		196, 120	
. 00 06700 OCCUPATI ONAL THERAPY		0. 2760		66, 071	67.
. 00 06800 SPEECH PATHOLOGY		0. 61043		31, 037	
. 00 06900 ELECTROCARDI OLOGY		0. 1016		62, 703	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1914:		1, 605, 377	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 6750		843, 530	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 8161		2, 058, 171	
. 00 03952 WOUND CARE		0. 4943		7, 026	
. 02 03951 CASE MANAGEMENT		1. 2163		0	76.
. 03 03950 PALN MANAGEMENT		0. 7099		143	
. 97 07697 CARDI AC REHABI LI TATI ON		3. 2331	74 0	0	76. 9
		0 4410	24	0	0.0
. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER		0.4419		0	90.
. 01 04951 PALLI ATI VE_HEALTH		1. 3031		0	90.
. 02 09000 VEI N CENTER		0. 2044		0	90.
. 03 09001 0B GYN		1. 1280		0	90.
. 00 09100 EMERGENCY . 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0.3881			
. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) . 00 04952 BEHAVOURAL HEALTH		1. 53572		66, 910	
0.00 Total (sum of lines 50-94 and 96-98)		2.04/04		0 7, 853, 784	
, , , , , , , , , , , , , , , , , , , ,	os $(lino 61)$		24, 473, 849	1, 853, 184	
1.00 Less PBP Clinic Laboratory Services-Program only charg		1	0		201. (

Health Financial Systems SCHNECK ME	DI CAL CENTER	CCN: 150065	Peri od:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANGILLART SERVICE COST APPORTIONWENT	PLOVIDEL	CCN. 150065	From 01/01/2015	WOLKSHEEL D-3	
	Component	t CCN: 15U065	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Ti tl	e XVIII	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	0		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 13870	56 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 12098		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 33973		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 2483		151	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4171		1, 257	1
54. 01 03630 ULTRA SOUND		0. 12253		187	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 10702		0	1
57. 00 05700 CT SCAN		0. 02842		52	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 04413		0	58.00
60. 00 06000 LABORATORY		0. 11100		5, 299	1
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5438		575	
64. 00 06400 I NTRAVENOUS THERAPY		0.50712		2	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 32945		9, 570	
66. 00 06600 PHYSI CAL THERAPY		0. 5198		29, 092	
67.00 06700 OCCUPATI ONAL THERAPY		0. 27600		0	1
68.00 06800 SPEECH PATHOLOGY		0. 61043		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 10145		87	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 19142		19, 302	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 67502		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.81610		52, 758	
76.00 03952 WOUND CARE		0. 49434		131	
76. 02 03951 CASE MANAGEMENT		1.21632		0	76.02
76. 03 03950 PALN MANAGEMENT		0. 7099	54 0	0	76.03
76. 97 07697 CARDIAC REHABILITATION		3. 2331	74 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					1
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER		0. 44192	24 0	0	90.00
90. 01 04951 PALLI ATI VE HEALTH		1. 30313	31 0	0	90.01
90. 02 09000 VEIN CENTER		0. 20443	34 0	0	90.02
90. 03 09001 OB GYN		1. 12804		0	90.03
91. 00 09100 EMERGENCY		0. 3881	12 195	76	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 53572	26 0	0	92.00
93. 00 04952 BEHAVOURAL HEALTH		2. 64764	40 0	0	
200.00 Total (sum of lines 50-94 and 96-98)			222, 954	118, 539	200.00
201.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	222, 954		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	u of Form CMS-2 Worksheet D-3	
NI ATTENT ANGLEART SERVICE COST ATTORTIONWENT	TTOVICE	CCN. 150005	From 01/01/2015	worksheet D-5	
			To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Ti t	le XIX	Hospi tal	Cost	7 pin
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
		J	9	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			299, 413		30.0
1.00 03100 INTENSIVE CARE UNIT			60, 635		31.0
3. 00 04300 NURSERY			128		43.0
ANCI LLARY SERVI CE COST CENTERS		1			
0. 00 05000 OPERATING ROOM		0. 1387		34, 563	
1.00 05100 RECOVERY ROOM		0. 1209		3, 220	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3397		249, 141	
3. 00 05300 ANESTHESI OLOGY		0. 2483		29, 223	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4171		9, 195	1
4.01 03630 ULTRA SOUND		0. 1225		2, 147	
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1070		150	
7.00 05700 CT SCAN		0. 02842		2, 804	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0441		678	
0. 00 06000 LABORATORY		0. 1110		41, 186	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5438		5, 763	•
4. 00 06400 I NTRAVENOUS THERAPY		0. 5071		5, 532	
5. 00 06500 RESPI RATORY THERAPY		0. 3294		37, 696	
6. 00 06600 PHYSI CAL THERAPY		0. 5198		2, 629	
7. 00 06700 OCCUPATI ONAL THERAPY		0.2760		737	67.0
8. 00 06800 SPEECH PATHOLOGY		0. 61043		266	
9. 00 06900 ELECTROCARDI OLOGY		0. 1014		2, 560	
1. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1. 1914		91, 715	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0.6750		0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0.81610		131, 403	
6. 00 03952 WOUND CARE		0.4943		932	
6. 02 03951 CASE MANAGEMENT		1. 2163		0	
6. 03 03950 PALN MANAGEMENT		0.7099		367	76.0
6. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		3. 2331	74 0	0	76. 9
0. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER		0. 4419	24 0	0	90.0
0. 01 04951 PALLI ATI VE HEALTH		1. 3031		886	90.0
0. 02 09000 VEIN CENTER		0. 2044		0	90.0
0. 03 09001 0B GYN		1. 1280		0	90.0
1. 00 09100 EMERGENCY		0. 3881		34, 510	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 53572		5, 562	
3. 00 04952 BEHAVOURAL HEALTH		2.6476		0,002	1
00.00 Total (sum of lines 50-94 and 96-98)			2, 155, 663	692, 865	
01.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.0
02.00 Net Charges (line 200 minus line 201)		1	2, 155, 663		202.0

Health Financial Systems SCHNECK MEDI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT SCHNECK MEDI		CCN: 150065	Peri od:	u of Form CMS-2 Worksheet D-3	
	11001 del	0011. 100000	From 01/01/2015		
	Componen	t CCN: 15U065	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
	Ti t	le XIX	Swing Beds - NF		<u>, bii</u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0		20.00
31. 00 03100 INTENSI VE CARE UNI T			0		30.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS			0		43.00
50. 00 05000 OPERATI NG ROOM		0. 1387	66 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 1209			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3397			•
53. 00 05300 ANESTHESI OLOGY		0. 2483		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4171		0	
54. 01 03630 ULTRA SOUND		0. 1225		-	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1070		-	•
57. 00 05700 CT SCAN		0. 02842		-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 04413			58.00
60. 00 06000 LABORATORY		0. 1110			•
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5438		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 50712		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 3294	58 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 5198	52 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2760	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 6104	33 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1014	50 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1914:	29 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 6750	29 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 81610	0 80	0	
76.00 03952 WOUND CARE		0. 4943	44 0	0	
76. 02 03951 CASE MANAGEMENT		1. 2163		0	76.02
76. 03 03950 PALN MANAGEMENT		0. 7099			
76. 97 07697 CARDI AC REHABI LI TATI ON		3. 2331	74 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		i		1	
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER		0.4419		-	
90. 01 04951 PALLI ATI VE HEALTH		1. 3031			
90. 02 09000 VEI N CENTER		0. 2044			
90. 03 09001 OB GYN		1. 1280		0	
91.00 09100 EMERGENCY		0. 3881		0	
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART)		1.5357		0	
93. 00 04952 BEHAVOURAL HEALTH		2. 6476		0	
200.00 Total (sum of lines 50-94 and 96-98)			0		200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	yes (IIne 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	0	I	202.00

	Financial Systems SCHNECK MEDICAL (ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150065	In Lie Period:	u of Form CMS- Worksheet E	2552-10
UALUUL	ATTOR OF ALTMODASLMENT SETTLEMENT	i ovi del	UUN. 190005	From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1			
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	a prior		0 6, 111, 961		1.00
	to October 1 (see instructions)					
1.02	DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)	g on or		1, 859, 977		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1.03
1.04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.04
2 00	discharges occurring on or after October 1 (see instructions)			240 (02		0.00
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			349, 602 0		2.00
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0		2.02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	i ng		0 58.99		3.00
	peri od (see i nstructi ons)					
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
(00	cost reporting period ending on or before 12/31/1996. (see instru			0.00		6 00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance			0.00		6.00
7 00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	dar 12		0.00		7.00
7.00	CFR §412. 105(f)(1)(iv)(B)(1)	der 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified un CFR 412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
	then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.00
	413. 75(b), 413. 79(c) (2) (i v), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot:	s under		0.00		8.01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
8. 02	instructions. The amount of increase if the hospital was awarded FTE cap slot:	s from a		0.00		8.02
	closed teaching hospital under section 5506 of ACA. (see instru	ctions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
11.00	from your records FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00	Current year allowable FTE (see instructions)			0.00		12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0.00 0.00		13.00
	or after September 30, 1997, otherwise enter zero.					
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 0.00		15.00
17.00	Adjustment for residents displaced by program or hospital closu	re		0.00		17.00
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 00 0. 000000		18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.00000		20.00
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000 0		21.00
22. 01	IME payment adjustment - Managed Care (see instructions)	100 6 1		0		22. 01
23.00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		ne mma	0.00		23.00
24 00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	·		0.00		24 00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	wer of		0.00 0.00		24.00 25.00
24 00	line 23 or line 24 (see instructions)			0,000000		26.00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26.00 27.00
28.00	IME add-on adjustment amount (see instructions)			0		28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28.01 29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient davs		3.57		30.00
	(see instructions)	- 0 -				
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			24.34 27.91		31.00 32.00
33.00	Allowable disproportionate share percentage (see instructions)			12. 24		33.00
34.00	Disproportionate share adjustment (see instructions)		I	243, 941		34.00

ALCUL	Financial Systems SCHNECK MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150065	Peri od:	u of Form CMS-2 Worksheet E	_JJZ-1
			From 01/01/2015 To 12/31/2015	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/18/2016 3: 0 PPS	7 pm
		in the Aviiii	Prior to	0n/After	
			October 1	October 1	
	Uncompensated Care Adjustment	0	1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
85. 01	Factor 3 (see instructions)		0. 00000000	0.00000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero,		756, 493	625, 002	35.02
35.03	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		565, 815	157, 104	35. 03
55. 05	amount (see instructions)		505, 815	157, 104	35.00
86.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		722, 919		36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu	gh 46)		
0. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)				
1.01	Total ESRD Medicare covered and paid discharges excluding		0		41.01
2.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
4.00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.00
	divided by line 41 divided by 7 days)				
5.00	Average weekly cost for dialysis treatments (see		0.00		45.00
6. 00	instructions) Total additional payment (line 45 times line 44 times line		о		46.00
	41.01)		0 200 400		47 0
7.00 8.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		9, 288, 400		47.00 48.00
0.00	MDH, small rural hospitals only. (see instructions)		Ū		.0.0
9.00	Total payment for inpatient operating costs (see		9, 288, 400		49.00
50.00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I		710, 547		50.00
0.00	and Pt. II, as applicable)		/10, 54/		50.00
51.00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
52.00	Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4,		0		52.00
2.00	line 49 see instructions).		0		52.00
	Nursing and Allied Health Managed Care payment		0		53.00
54.00 55.00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		54.00 55.00
5.00	line 69)		0		55.00
6. 00	Cost of physicians' services in a teaching hospital (see		0		56.00
- 00	intructions)		0		F7 00
97.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
8. 00	Ancillary service other pass through costs from Wkst. D,		0		58.00
	Pt. IV, col. 11 line 200)		0.000.047		F0 0/
59.00 50.00	Total (sum of amounts on lines 49 through 58) Primary payer payments		9, 998, 947 6, 830		59.00 60.00
51.00	Total amount payable for program beneficiaries (line 59		9, 992, 117		61.00
0.00	minus line 60)				10.0
52.00 53.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		1, 170, 964		62.00 63.00
53.00 54.00	Allowable bad debts (see instructions)		47, 407		64.00
5.00	Adjusted reimbursable bad debts (see instructions)		30, 815		65.00
6. 00	Allowable bad debts for dual eligible beneficiaries (see		26, 366		66.00
7.00	instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)		8, 851, 968		67.00
8.00	Credi ts received from manufacturers for replaced devices		0		68.00
0.00	for applicable to MS-DRGs (see instructions)		_		10 -
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.0
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70. 0
0. 50	RURAL DEMONSTRATION PROJECT		0		70. 5
0.89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 8
0. 90	instructions) HSP bonus payment HVBP adjustment amount (see		0		70. 9
5. 70	instructions)		0		, 0. 7
	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 9 ⁻
	Bundled Model 1 discount amount (see instructions)				70.92
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		77, 449 -45, 840		70. 93 70. 94
	Recovery of accel erated depreciation		10, 040		70.9

	Financial Systems SCHNECK MEDI							u of Form CMS	5-255	2-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Pr	rovi der	CCN:	150065		eriod: com 01/01/2015 p 12/31/2015	Worksheet E Part A Date/Time P 5/18/2016 3		
			Ti tl	e XVI	11		Hospi tal	PPS	. or p	/11
				-			Prior to October 1	On/After October 1		
				0			1.00	2.00		
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)				20	015	165, 703		70	0. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)				20	016	114, 419		70	0. 97
70. 98	Low Volume Payment-3						0		70	0. 98
70.99	HAC adjustment amount (see instructions)						0		70	0.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)						9, 163, 699		71	1. 00
71.01	Sequestration adjustment (see instructions)						183, 274		71	1.01
72.00	Interim payments						8, 861, 133		72	2.00
73.00	Tentative settlement (for contractor use only)						0		73	3.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)						119, 292		74	4.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2						510, 981		75	5.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)									
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)						0		90	0. 00
	Capital outlier from Wkst. L, Pt. I, line 2						0		91	1.00
	Operating outlier reconciliation adjustment amount (see instructions)						0		92	2.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)						0		93	3.00
94.00	The rate used to calculate the time value of money (see instructions)						0.00		94	4.00
95.00	Time value of money for operating expenses (see instructions)						0			5.00
96.00	Time value of money for capital related expenses (see instructions)						0			6. 00
							Prior to 10/1		1	
							1.00	2.00	_	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)					1	0		0 100	0 00
	HVBP Adjustment for HSP Bonus Payment						0		0100	J. 00
	HVBP adjustment factor (see instructions)						0.000000000	0.00000000	00 101	1.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment	i ons)					0		0 102	2.00
	HRR adjustment factor (see instructions)					1	0.0000	0.000	00103	3.00
	· · · · · · · · · · · · · · · · · · ·						2. 5000	21000		4.00

	Financial Systems DLUME CALCULATION EXHIBIT 4		SCHNECK MEDIC			Period: From 01/01/2015 To 12/31/2015		t 4
							5/18/2016 3:0	
					e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
. 00	DRG amounts other than outlier	1.00	0	0		0 0		1.
. 01	payments DRG amounts other than outlier	1.01	6, 111, 961	0	6, 111, 96	1 0	6, 111, 961	1.
02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	1, 859, 977	0		0 1, 859, 977	1, 859, 977	1.
	payments for discharges occurring on or after October 1							
03	DRG for Federal specific operating payment for Model 4 BPCL occurring prior to October 1	1. 03	0	0		o o	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCL occurring on or after October 1	1.04	0	0		o o	0	1.
00	Outlier payments for discharges (see instructions)	2.00	349, 602	0				
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	-	
00	Operating outlier reconciliation Managed care simulated	2. 01 3. 00	0	0			0	3. 4.
20	payments Indirect Medical Education Adju							<u>т</u> .
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000				5.
00	IME payment adjustment (see instructions)	22.00	0	0		0 0	-	6
01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adju	22.01	Add-on for Sec	0		0 0	0	6.
00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0 0.00000		7.
00	(see instructions) IME adjustment (see	28.00	0	0		o o	0	8.
01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		o o	0	8
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	О	0		o o	0	9
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0		0 0	0	9
	Disproportionate Share Adjustme		<u>_</u>			1		
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1224	0. 1224	0. 122	4 0. 1224		10
. 00	Disproportionate share adjustment (see instructions)	34.00	243, 941	0				
. 01	Uncompensated care payments	36.00	722, 919	0	565, 81	5 157, 104	722, 919	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	centage of ESF 46.00	o peneticiary d 0	li scharges 0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	9, 288, 400 0	0 0		4 2, 164, 546 0 0	9, 288, 400 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	9, 288, 400	0	7, 123, 85	4 2, 164, 546	9, 288, 400	15
00	Payment for inpatient program capital	50.00	710, 547	0				
00	Special add-on payments for new technologies	54.00	0	0		0 0	_	
. 01 . 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS_DDCs	55.00 68.00	0	0 0			0	17. 17.
8. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0		o o	0	18.

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4				CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 3:0	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	- Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	7, 668, 94	15 2, 330, 002	9, 998, 947	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1,00	628, 086	0	480, 81	147, 267	628, 086	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0		
21.00	Capital DRG outlier payments	2.00	82, 461	0	64, 27	18, 189	82, 461	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0		21.01
	outlier payments							
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0. 0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	710, 547	0	545, 09	165, 456	710, 547	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.02160	0. 049107		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			165, 70)3	165, 703	28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				114, 419	114, 419	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	SCHNECK MEDI		CCN: 150065	Period:	u of Form CMS-2 Worksheet E	2002-10
					From 01/01/2015 To 12/31/2015	Part A Exhibi	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6, 111, 961	6, 111, 96		6, 111, 961	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 859, 977		1, 859, 977	1, 859, 977	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	349, 602	259, 05	53 90, 550	349, 603	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0.00000		5.00
6.00 6.01	IME payment adjustment (see instructions) IIME payment adjustment for managed care (see	22. 00 22. 01	0		0 0	0	6. 00 6. 01
0.01	instructions)	22.01	0		0	0	0.01
	Indirect Medical Education Adjustment for the	e Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 1224	0. 122	0. 1224		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	243, 941	187, 02			11.00
	instructions) Uncompensated care payments	36.00	722, 919	565, 81			
	Additional payment for high percentage of ESR				107,104	122, 117	11.01
12.00		46.00	0		0 0	0	12.00
	Subtotal (see instructions)	47.00	9, 288, 400	7, 123, 85	2, 164, 546		
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.00
	Total payment for inpatient operating costs	49.00	9, 288, 400	7, 123, 85	2, 164, 546	9, 288, 400	15.00
15.00	(see instructions)						
15. 00 16. 00	(see instructions) Payment for inpatient program capital	50.00	710, 547	563, 28	30 147, 267	710, 547	16.00
		50. 00 54. 00	710, 547 0	563, 28	30 147, 267 0 0	710, 547 0	16. 00 17. 00
16. 00 17. 00 17. 01	Payment for inpatient program capital Special add-on payments for new technologies Net organ aquisition cost	54.00 55.00	710, 547 0 0	563, 28	30 147, 267 0 0 0 0	0 0	17. 00 17. 01
16. 00 17. 00	Payment for inpatient program capital Special add-on payments for new technologies Net organ aquisition cost Credits received from manufacturers for	54.00	710, 547 0 0 0	563, 28	30 147, 267 0 0 0 0 0 0 0 0	0	17.00
16. 00 17. 00 17. 01	Payment for inpatient program capital Special add-on payments for new technologies Net organ aquisition cost	54.00 55.00	710, 547 0 0 0 0	563, 28	30 147, 267 0 0 0 0 0 0 0 0 0 0	0 0	17. 00 17. 01

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150065	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 3:0	pared:
			e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	628, 086	480, 8	19 147, 267	628, 086	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	82, 461	82, 40	51 0	82, 461	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0. 0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	710, 547	563, 28	30 147, 267	710, 547	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	165, 703	165, 70	03	165, 703	28.00
29.00 Low volume adjustment on or after October 1	70.97	114, 419		114, 419	114, 419	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	77, 449	63, 49	93 13, 956	77, 449	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70.94	-45, 840	-45, 84	40 0	-45, 840	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst.	
		1.00			E, Pt. A)	
	0	1.00	2.00	3.00	4.00	00.00
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

	Financial Systems SCHNECK MEDICAL ATION OF REIMBURSEMENT SETTLEMENT SCHNECK MEDICAL	Provider CCN: 150065	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2015 To 12/31/2015	Part B Date/Time Pre	pared
		T		5/18/2016 3:0	
		Title XVIII	Hospi tal	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			20.24/	1 1
. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	ions)		20, 346 12, 794, 774	
. 00	PPS payments			9, 175, 974	
. 00	Outlier payment (see instructions)			246, 352	
. 00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0. 000	
. 00	Line 2 times line 5			0	
. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt. 1	V col 13 line 200		0	
0.00	Organ acqui si ti ons	v, cor. 10, 1110 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			20, 346	
	COMPUTATION OF LESSER OF COST OR CHARGES				
2 00	Reasonable charges			27, 184	1 1 2
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		27, 184	
	Total reasonable charges (sum of lines 12 and 13)			27, 184	
	Customary charges				
	Aggregate amount actually collected from patients liable for pa	3	ų	0	
6.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.
7.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000))		0.000000	17
	Total customary charges (see instructions)			27, 184	
	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	6, 838	
	instructions)				
0.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20.
1.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		20, 346	21
	Interns and residents (see instructions)			20, 340	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			9, 422, 326	24.
E 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 25
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		0 1, 983, 392	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			7, 459, 280	
	instructions)		2 (
	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			7 450 280	
	Subtotal (sum of lines 27 through 29) Primary payer payments			7, 459, 280 13, 228	
	Subtotal (line 30 minus line 31)			7, 446, 052	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			-	33.
	Allowable bad debts (see instructions)			224, 754	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		146, 090 225, 977	
7.00	Subtotal (see instructions)			7, 592, 142	
	MSP-LCC reconciliation amount from PS&R			307	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.
	Pioneer ACO demonstration payment adjustment (see instructions)			0	
9.98	Partial or full credits received from manufacturers for replace	ea aevices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 7, 591, 835	
	Sequestration adjustment (see instructions)			151, 837	
	Interim payments			7, 287, 783	
2.00				0	
3.00	Balance due provider/program (see instructions)			152, 215	
4.00	Protested amounts (nonallowable cost report items) in accordance §115.2	ce with CMS Pub. 15-2,	cnapter 1,	0	44.
	TO BE COMPLETED BY CONTRACTOR				
0.00	Original outlier amount (see instructions)			0	90.
				0	91.
1.00	Outlier reconciliation adjustment amount (see instructions)		1	-	
1.00 2.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150065	Period: From 01/01/2015 To 12/31/2015		pare
		Titl	e XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4,00	
00	Total interim payments paid to provider		8, 861, 1		7, 287, 783	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider			_]
01	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	
03 04				0	0	3
04 05				0	0	3
00	Provider to Program				0	1 7
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	-
52				0	0	3
53				0	0	-
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
99	3. 50-3. 98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8, 861, 13	33	7, 287, 783	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					15
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	15
02				0	0	
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5
, ,	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		119, 29	92	152, 215	6
02	SETTLEMENT TO PROGRAM		ĺ	0	0	6
00	Total Medicare program liability (see instructions)		8, 980, 4		7, 439, 998	7
				Contractor	NPR Date	
			C	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		5	1.00	2.00	8

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	Period: From 01/01/2015 To 12/31/2015		pared
		Titl	e XVIII S	wing Beds - SNF		/ piii
			t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		32, 838	3	0	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(0	2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 0
	Program to Provider		1	1		
01	ADJUSTMENTS TO PROVIDER		(0	3.0
02			(0	3.0
03 04					0	3. 3.
04				-	0	3.
00	Provider to Program					0.
50	ADJUSTMENTS TO PROGRAM		()	0	3.
51			0		0	3.
52			(0	3.
53 54					0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3.
	3. 50-3. 98)					
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)		32, 838	3	0	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider		1	l.		
01	TENTATI VE TO PROVI DER		(0	5.
02					0	5. 5.
03	Provider to Program				0	5.
50	TENTATI VE TO PROGRAM		(0	5.
51			C		0	5.
52			0		0	5.
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined pot settlement amount (balance due) based on		(0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		19, 926		31, 957	6.
02	SETTLEMENT TO PROGRAM		(0	6.
00	Total Medicare program liability (see instructions)		52, 764		31, 957	7.
)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor		J	1.00	2.00	8.

Heal th	Financial Systems SCHNECK M	EDI CAL CENTER	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150065	Peri od:	Worksheet E-1		
			From 01/01/2015 To 12/31/2015		nared	
			10 12/31/2013	5/18/2016 3:0		
		Title XVIII	Hospi tal	PPS		
		· · ·				
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	TS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL			3, 231		
1.00						
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 11,782					
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2			290, 839, 678	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col			3, 558, 431	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase	e of certified HIT technology	Wkst. S-2, Pt. I	0	7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructio	ns)		311, 837	8.00	
9.00	Sequestration adjustment amount (see instructions)			6, 237	9.00	
10.00	Calculation of the HIT incentive payment after sequestra	ition (see instructions)		305, 600	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	<u>`</u>		0/7 /00		
30.00	Initial/interim HIT payment adjustment (see instructions	.)		267, 422	30.00	
31.00	Other Adjustment (specify)		`	0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	IS)	38, 178	32.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 150065 Perid: Component CCN: 150065 Perid: To m01/01/2015 Worksheet E-2 Date/Time Prepared: 5/18/2016 3:02 pm COMPUTATION OF NET COST OF COVERED SERVICES Title XVIII Swing Beds - SNF Pert A Pert A <t< th=""><th>Heal th</th><th>Financial Systems</th><th>SCHNECK MEDICAL</th><th>CENTER</th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></t<>	Heal th	Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
Component CCN: 15U065 To 12/31/2015 Date/Time Prepared: 5/18/2016 3:07 pm Title XVIII Swing Beds - SNF PPS Part A Part B Part A Part B 0 Inpatient routine services - swing bed-SNF (see instructions) 38,390 0 1.00 2.00 Inpatient routine services (routine services - swing bed-SNF (see instructions) 38,390 0 1.00 2.00 Inpatient routine services (routine services - swing bed-SNF (see instructions) 38,390 0 1.00 2.00 Part X, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions) 38,390 0 4.00 0.00 Primary paying days 0 1.00 2.00 5.00 0.00 Utilization review - physician compensation - SNF optional method only 0 7.00 8.00 9.00 10.00 0.00 Primary payer payments (see instructions) 0 0 9.00 10.00 10.00 10.00 0.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 0 0 0 10.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BE	EDS	Provider CCN: 150065		Worksheet E-2	
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for physician professional services) 0 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 33,507 0 15.00 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 16.00 16.55 410A RURAL DEMONSTRATION PROJECT 0 16.55 17.00 Allowable bad debts (see instructions) 31,283 50,168 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 53,841 32,609 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00			n provider records)	(exclude coinsurance		-	
14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 33,507 0 15.00 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 16.00 16.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 0 16.50 16.55 410A RURAL DEMONSTRATION PROJECT 0 16.50 16.55 17.00 All owable bad debts (see instructions) 31,283 50,168 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 20,334 32,609 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 53,841 32,609 19.01 20.00 Interim payments 32,838 0 20.00 0 21.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 21.00 22.00 Bal ance due provi der/program (lin				(.,	-	
15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 33,507 0 15.00 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 16.00 16.55 Pioneer ACO demonstration payment adjustment (see instructions) 0 0 16.50 16.55 410A RURAL DEMONSTRATION PROJECT 0 16.55 17.00 Allowable bad debts (see instructions) 0 16.55 17.00 Allowable bad debts (see instructions) 31,283 50,168 17.00 18.00 Allowable bad debts (see instructions) 0 385 18.00 19.00 Total (see instructions) 0 385 18.00 19.01 Sequestration adjustment (see instructions) 53,841 32,609 19.01 20.00 Interim payments 12,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	14.00					0	14.00
16.50 Pi oneer AC0 demonstration payment adjustment (see instructions) 0 16.50 16.55 410A RURAL DEMONSTRATION PROJECT 0 16.55 17.00 Allowable bad debts (see instructions) 31,283 50,168 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 20,334 32,609 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	15.00	Subtotal (enter the lesser of line 12 minus	line 13, or line 14)	33, 507	0	15.00
16.55 410A RURAL DEMONSTRATION PROJECT 0 16.55 17.00 Al lowable bad debts (see instructions) 31,283 50,168 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 20,334 32,609 17.01 18.00 Al lowable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 0 21.00 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	FY)		0	0	16.00
17.00 All owable bad debts (see instructions) 31,283 50,168 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 20,334 32,609 17.01 18.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	16.50	Pioneer ACO demonstration payment adjustment	t (see instructions)		0	0	16.50
17.01 Adj usted reimbursable bad debts (see instructions) 20,334 32,609 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Bal ance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
18.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 385 18.00 19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	17.00	Allowable bad debts (see instructions)			31, 283	50, 168	17.00
19.00 Total (see instructions) 53,841 32,609 19.00 19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	17.01	Adjusted reimbursable bad debts (see instruc	ctions)		20, 334	32, 609	17.01
19.01 Sequestration adjustment (see instructions) 1,077 652 19.01 20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	18.00	Allowable bad debts for dual eligible benefi	ciaries (see instru	ctions)	0	385	18.00
20.00 Interim payments 32,838 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	19.00	Total (see instructions)			53, 841	32, 609	19.00
21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	19.01	Sequestration adjustment (see instructions)			1, 077	652	19.01
22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	20.00				32, 838	0	20.00
22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 19,926 31,957 22.00	21.00	Tentative settlement (for contractor use onl	y)		0	-	
23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00	22.00				19, 926	31, 957	22.00
	23.00		items) in accordance	e with CMS Pub. 15-2,	0	0	23.00
chapter 1, §115.2		chapter 1, §115.2					

Heal th	Financial Systems	SCHNECK MEDI CAL	CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 150065 Component CCN: 15U065	Period: From 01/01/2015 To 12/31/2015		epared:
			Title XIX	Swing Beds - NF	5/18/2016 3:0 Cost	J7 pili
				Part A	Part B	
				1,00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICE	S		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF			0		1.00
2.00	Inpatient routine services - swing bed-NF	. ,		0	1	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3		A and sum of Wkst D	0	1	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part			Ū	1	0.00
4.00	Per diem cost for interns and residents no			0.00	1	4.00
	instructions)		51 5 (1	
5.00	Program days			0	1	5.00
6.00	Interns and residents not in approved tead	ching program (see ins	tructions)	0	1	6.00
7.00	Utilization review - physician compensation	on - SNF optional meth	iod only	0	1	7.00
8.00	Subtotal (sum of lines 1 through 3 plus li	nes 6 and 7)	5	0	1	8.00
9.00	Primary payer payments (see instructions)			0	1	9.00
10.00	Subtotal (line 8 minus line 9)			0	1	10.00
11.00	Deductibles billed to program patients (ex	kclude amounts applica	ble to physician	0	1	11.00
	professional services)		1 5		1	
12.00	Subtotal (line 10 minus line 11)			0	1	12.00
13.00	Coinsurance billed to program patients (fr	rom provider records)	(exclude coinsurance	0	1	13.00
	for physician professional services)				1	
14.00	80% of Part B costs (line 12 x 80%)			0	1	14.00
	Subtotal (enter the lesser of line 12 minu		.)	0	1	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEC			0		16.00
16.50	Pioneer ACO demonstration payment adjustme	ent (see instructions)		0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0		17.00
17.01	Adjusted reimbursable bad debts (see instr			0		17.01
18.00	Allowable bad debts for dual eligible bene	eficiaries (see instru	ictions)	0		18.00
19.00	Total (see instructions)			0		19.00
19.01	Sequestration adjustment (see instructions	s)		0		19.01
20.00	Interim payments			0	1	20.00
21.00	Tentative settlement (for contractor use of			0	1	21.00
22.00	Balance due provider/program (line 19 minu			0	1	22.00
23.00	Protested amounts (nonallowable cost repor	rt items) in accordanc	e with CMS Pub. 15-2,	0	1	23.00
	chapter 1, §115.2					

	Financial Systems SCHNECK MEDI E SHEET (If you are nonproprietary and do not maintain	Provi der		eriod: rom 01/01/2015	u of Form CMS-2 Worksheet G	
1-t	ype accounting records, complete the General Fund column onl	y)	T		Date/Time Pre 5/18/2016 3:0	pare 7 pm
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
)	CURRENT ASSETS Cash on hand in banks	37, 976, 610	0	0	0	1 1
5	Temporary investments	8, 000, 000		0	0	
D	Notes receivable	0	0	0	0	
2	Accounts receivable	58, 379, 033		0	0	
)	Other receivable Allowances for uncollectible notes and accounts receivable	15, 625, 937		0	0	
)	Inventory	-43, 761, 049 3, 931, 111	0	0	0	
5	Prepai d expenses	1, 453, 236		0	0	
)	Other current assets	10, 530, 290		0	0	9
00	Due from other funds	0	0	0	0	10
00	Total current assets (sum of lines 1-10)	92, 135, 168	0	0	0	11
	FI XED_ASSETS	7 051 0/0				
00	Land	7, 351, 960		0	0	
00 00	Land improvements Accumulated depreciation	4, 064, 163 -2, 430, 731		0	0	
	Buildings	81, 818, 537		0	0	
	Accumulated depreciation	-36, 124, 884		0	0	
00	Leasehold improvements	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Fixed equipment	6, 388, 839		0	0	
	Accumulated depreciation	-5, 113, 255		0	0	
	Automobiles and trucks Accumulated depreciation	0	0	0	0	
	Major movable equipment	48, 019, 801		0	0	
	Accumulated depreciation	-36, 820, 854		0	0	
	Minor equipment depreciable	4, 075, 911		0	0	
	Accumulated depreciation	-3, 630, 065		0	0	
	HIT designated Assets	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 67, 599, 422	0	0	0	
	OTHER ASSETS	07, 377, 422	0	0	0	30
	Investments	8, 698, 881	0	0	0	31
00	Deposits on leases	0	0	0	0	32
	Due from owners/officers	0	0	0	0	
	Other assets	136, 027, 770		0	0	
00	Total other assets (sum of lines 31-34)	144, 726, 651		0	0	
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	304, 461, 241	0	0	0	36
	Accounts payable	2, 311, 611	0	0	0	37
00	Salaries, wages, and fees payable	10, 198, 703		0	0	
00	Payroll taxes payable	18, 343		0	0	39
00	Notes and loans payable (short term)	0	0	0	0	40
	Deferred income	0	0	0	0	
	Accelerated payments	0		0	0	42
	Due to other funds Other current liabilities	0	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	12, 528, 657		0	0	
	LONG TERM LIABILITIES	12, 320, 037	0	0	0	1 70
00	Mortgage payable	0	0	0	0	46
00	Notes payable	34, 570, 196	0	0	0	47
00	Unsecured Loans	0	0	0	0	
	Other long term liabilities	8, 222, 343		0	0	
	Total long term liabilities (sum of lines 46 thru 49 Total liabilites (sum of lines 45 and 50)	42, 792, 539		0	0	
00	CAPITAL ACCOUNTS	55, 321, 196	0	0	0	1 21
00	General fund balance	249, 140, 045				52
00	Specific purpose fund		0			53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
~~	Total fund balances (sum of lines 52 thru 58)	249, 140, 045	0	0	0	59
00				0		

Health Financial Systems		SCHNECK MEDIC	AL CENTER			In Lie	u of Form CMS	-2552-	-10
STATEMENT OF CHANGES IN FUND BALANCES				CCN: 150065		riod: om 01/01/2015	Worksheet G Date/Time Pr 5/18/2016 3:	1 epare	d:
		General	Fund	Speci al	Purp	pose Fund	Endowment Fur	d	
		1.00	2.00	3.00		4.00	5.00		
1.00Fund balances at beginning of peri2.00Net income (loss) (from Wkst. G-3,3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (sp5.00EQUITY TRANSFER6.007.008.009.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (sp13.0014.0015.0016.0017.0018.0018.00Total deductions (sum of lines 12-19, 00)Fund balance at end of period per	line 29) becify) becify)	14, 605, 104 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	217, 038, 432 17, 496, 507 234, 534, 941 14, 605, 104 249, 140, 045	4 7 1 4 5	0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 0 0 0 0 0 0 0 0	3.00	2. 3. 0 4. 0 5. 0 6. 0 7. 0 8.	00 00 00 00 00 00 00 00 00
sheet (line 11 minus line 18)		Endowment Fund		f Fund					
	-								
1.00 Fund balances at beginning of peri	od	6.00	7.00	8.00	0			1.	00
2.00 Net income (loss) (from Wkst. G-3, 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (sp 5.00 EQUITY TRANSFER 6.00 7.00 8.00 9.00	line 29)	0			0			2. 3. 4. 5. 6. 7. 8.	00 00 00 00 00 00 00 00 00
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (sp. 13.00 14.00 15.00 16.00 17.00 18.00 18.00 Total deductions (sum of lines 12-10)	-17)	0 0	(0 0			10. 11. 12. 13. 14. 15. 16. 17. 18.	00 00 00 00 00 00 00 00 00 00 00
19.00 Fund balance at end of period per sheet (line 11 minus line 18)	bal ance	0			0			19.	00

STATE	Financial Systems SCHNECK MEDICAL IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 150065	Peri od:		u of Form CMS-2 Worksheet G-2	
STATE	ILINI OF FATTLINT REVENUES AND OFERATING EAFLINGES	FIOVICEI	CCN. 150005	From 01/	01/2015 31/2015	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpa	tient	Total	
			1.00		00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		12, 612, 6	91		12, 612, 691	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER					0	4.00
5.00	Swing bed - SNF			0		0	
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0		0	6.00 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)		12, 612, 6	91		12, 612, 691	10.00
10.00	Intensive Care Type Inpatient Hospital Services		12,012,0	71		12,012,071	10.00
11.00	INTENSIVE CARE UNIT		1, 546, 8	83		1, 546, 883	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 546, 8	83		1, 546, 883	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		14, 159, 5			14, 159, 574	
18.00	Ancillary services		55, 635, 6		501, 316	260, 136, 922	
19.00	Outpatient services		4, 972, 2		339, 304	28, 311, 516	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY				361, 093	0 2, 361, 093	21.00 22.00
22.00	AMBULANCE SERVICES			Ζ,	301, 093	2, 301, 093	22.00
23.00	CMHC						23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE			0 2.	264, 150	2, 264, 150	
27.00	NON-REIMBURSABLE COST CENTERS		2, 699, 0		644, 220	11, 343, 222	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	77, 466, 3		110, 083	318, 576, 477	
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				188, 141		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00 35.00				0			34.00 35.00
35.00	Total additions (sum of lines 30-35)			0	o		35.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
37.00				0			37.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		117,	188, 141		43.00
	to Wkst. G-3, line 4)		1				1

Heal th	Financial Systems SCHNECK MED	I CAL CENTER	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 150065	Peri od: From 01/01/2015 To 12/31/2015	Worksheet G-3	pared:
				1 57 167 2010 3.0	/ piii
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		318, 576, 477	1.00
2.00	Less contractual allowances and discounts on patients' acc	ounts		186, 458, 338	2.00
3.00	Net patient revenues (line 1 minus line 2)			132, 118, 139	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		117, 188, 141	4.00
5.00	Net income from service to patients (line 3 minus line 4)			14, 929, 998	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			-15, 457	6.00
7.00	Income from investments			-2, 091, 640	7.00
8.00	Revenues from telephone and other miscellaneous communicat	ion services		6, 692	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			116, 931	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			355, 217	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			185, 722	
18.00	Revenue from sale of medical records and abstracts			40, 070	
19.00				1, 460	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			8, 090	
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			54, 873	
23.00	Governmental appropriations			0	23.00
24.00	CONTRACT REVENUE			1, 248, 888	
24.01	GRANT REVENUE			55, 922	
24.02	MI SCELLANEOUS I NCOME			2, 513, 230	
24.03	UNREALI ZED GAI N/LOSS			24, 852	
24.04	EHR INCENTIVE			61, 659	
25.00	Total other income (sum of lines 6-24)			2, 566, 509	
26.00	Total (line 5 plus line 25)			17, 496, 507	26.00
27.00	ROUNDING			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)	l	17, 496, 507	29.00

	IS OF PROVIDER-BASED HOME HEALT			Provi der	CCN: 150065	Period:	Worksheet H	
		II AGENCI COSIS		HHA CCN:		From 01/01/2015 To 12/31/2015		
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	0.00	
	Capital Related - Bldg. & Fixtures			0)	0	0	1.
00	Capital Related - Movable			0		0	0	2.
00	Equipment	0	C C			0	0	3.
00	Plant Operation & Maintenance Transportation	0					0	
	Administrative and General	239, 031		2, 373	30, 75	107, 309	0	
•	HHA REIMBURSABLE SERVICES		-		1			
0	Skilled Nursing Care	323, 249	C	0 0)	0 0	323, 249	6.
	Physical Therapy	225, 876	C	0		0 0	225, 876	7.
	Occupational Therapy	140, 098		0		0 0	140, 098	
0	Speech Pathol ogy	7, 795	C	0 0)	0 0	7, 795	
	Medical Social Services	0	C	0 0)	0 0	0	
	Home Health Aide	64, 405	C	0		0 0	64, 405	
	Supplies (see instructions)	0	C	0)	0 1, 269	1, 269	
	Drugs	0)	0 0	0	
	DME HHA NONREI MBURSABLE SERVI CES	0	C	0	<u>и</u>	0 0	0	14.
	HAA NUNREIMBURSABLE SERVICES Home Dialysis Aide Services	0	C			0 0	0) 15.
	Respiratory Therapy	0		-		0 0	0	
	Private Duty Nursing	0				0 0	0	
	Clinic	0	0			0 0	0	
	Health Promotion Activities	0	C			0 0	0	
	Day Care Program	0	C	0		0 0	0	
	Home Delivered Meals Program	0	C	0 0		0 0	0	21.
00	Homemaker Service	0	C	0		0 0	0	22.
00	All Others (specify)	0	C	0		0 0	0	23.
00	Total (sum of lines 1-23)	1, 000, 454		2, 373			1, 142, 157	24.
		Recl assi fi cati		Adjustments	Net Expenses			
		on	Trial Balance		for Allocatio			
			(col. 6 + col.7)		(col. 8 + col 9)	•		
		7.00	8.00	9.00	10.00	-		1
	GENERAL SERVICE COST CENTERS			•				
0	Capital Related - Bldg. &	0	C	0 0)	0] 1.
0	Fixtures Capital Related - Movable	0	C	0		0		2.
-	Equipment	_	_	-		-		
0	Plant Operation & Maintenance	3, 291	3, 291	0	3, 29	1		3
	Transportation	0	Ŭ Š	-		0		4.
	Administrative and General	0	379, 465	0	379, 46	5		5
	HHA REIMBURSABLE SERVICES	-	000 0 :-	-	000 -			Ι.
	Skilled Nursing Care	0						6
	Physical Therapy	0	,		,			7
	Occupational Therapy	0	140, 098		140,09			8
	Speech Pathology Medical Social Services	0 1, 385	7, 795 1, 385		7, 79 7, 38 1, 38			9
	Home Health Aide	1, 365	64, 405		64, 40		ļ	11
	Supplies (see instructions)	0			1, 26			12
	Drugs	0	r, 20,			0		13
	DME	0	-			0		14
	HHA NONREIMBURSABLE SERVICES							1
00	Home Dialysis Aide Services	0	-			0		15
	Respiratory Therapy	0	C	0		0		16
00	Private Duty Nursing	0	C	0		0		17
00 00	Clinic	0	C	0		0		18
00 00 00				n ∩)	0	1	19
00 00 00 00	Health Promotion Activities	0	L L			0		
00 00 00 00 00	Health Promotion Activities Day Care Program	0	C	0		0		20
00 00 00 00 00 00	Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0				0		20 21
00 00 00 00 00 00 00	Health Promotion Activities Day Care Program	0 0 0 0				0		20. 21. 22. 23.

Heal th	Financial Systems		SCHNECK MEDIC	CAL CENTER		In Lie	eu of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST			CCN: 150065	Period: From 01/01/2015	Worksheet H-1	
				HHA CCN:	157155	To 12/31/2015		
						Home Health	PPS	
			Capital Rela	ated Costs		Agency I		
		Not Emana			Diant	T	Cultated	_
		Net Expenses for Cost	BI dgs & Fi xtures	Movable Equipment	Plant Operation 8	Transportation	Subtotal (cols. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance	2		
		col. 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				C	1.00
2.00	Fixtures Capital Related - Movable	0		C			0	2.00
	Equi pment	0.001		-		0.1		
3.00 4.00	Plant Operation & Maintenance Transportation	3, 291 0	0	C) 3, 2'	0 0	C	3.00 4.00
5.00	Administrative and General	379, 465	0	С	3, 2	91 0	382, 756	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	323, 249	0	C		0 0	323, 249	6.00
7.00 8.00	Physical Therapy Occupational Therapy	225, 876 140, 098	0	C		0 0	225, 876 140, 098	
8.00 9.00	Speech Pathol ogy	7, 795	0	C		0 0	7, 795	
10. 00 11. 00	Medical Social Services Home Health Aide	1, 385 64, 405	0	C		0 0	1, 385 64, 405	
12.00	Supplies (see instructions)	1, 269	0	C		0 0	1, 269	
13.00 14.00	Drugs DME	0	0	C		0 0		
14.00	HHA NONREIMBURSABLE SERVICES		0		у 			14.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	C		0 0	-	
17.00	Private Duty Nursing	0	0	C		0 0	C	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	C		0 0		
20.00	Day Care Program	0	0	C	Ď	0 0	C	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	C		0 0		
23.00	All Others (specify)	0	0	C		0 0	C	23.00
24.00	Total (sum of lines 1-23)	1, 146, 833 Admi ni strati ve	U Total (cols.	C	3, 2	91 0	1, 146, 833	24.00
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	5.00	0.00					
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	382, 756						5.00
6.00 7.00	Skilled Nursing Care	161, 927 113, 150	485, 176 339, 026					6.00
8.00	Physical Therapy Occupational Therapy	70, 181	210, 279					7.00 8.00
9. 00 10. 00	Speech Pathology Medical Social Services	3, 905 694	11, 700 2, 079					9.00 10.00
11.00	Home Heal th Ai de	32, 263	96, 668					11.00
12.00 13.00	Supplies (see instructions) Drugs	636 0	1, 905 0					12.00 13.00
13.00	DME	0	0					14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic	0	0					17.00 18.00
19.00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
22.00	Homemaker Service	0	0					22.00
	All Others (specify) Total (sum of lines 1-23)	0	0 1, 146, 833					23.00 24.00
		· ·	.,,					,

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SI S			CCN: 150065 157155	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 5/18/2016 3:0	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs	ł			l	
		. ,	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	(MILEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	3, 850				0		1.00
2.00	Fixtures Capital Related - Movable Equipment		1, 840			0		2.00
3.00 4.00	Plant Operation & Maintenance Transportation (see	0	0 0	3, 850 0		0		3.00 4.00
5.00	instructions) Administrative and General	3, 850	1, 840	3, 850		0 -382, 756	764, 077	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	-	0		0 0	323, 249	6.00
7.00	Physical Therapy	0	0	0		0 0	225, 876	
8.00 9.00	Occupational Therapy Speech Pathology	0	0	0		0 0	140, 098 7, 795	
9.00 10.00	Medical Social Services	0	0	0		0 0	1, 385	
11.00	Home Heal th Aide		0	0		0 0	64, 405	
12.00	Supplies (see instructions)	0	0	0		0 0	1, 269	
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES	-						
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program		0	0		0 0	0	20.00
20.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	23.00
24.00	Total (sum of lines 1-23)	3, 850	1, 840	3, 850		0 -382, 756	764, 077	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	3, 291		0	382, 756	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 854805	0.0000	oo	0. 500939	26.00

	Financial Systems TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	SCHNECK MEDIC TERS	Provi der		Period:	Worksheet H-2	2552
				HHA CCN:		rom 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/18/2016 3:0	pare 7 pm
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
. 00	Administrative and General	0	57, 236	2, 997				
00	Skilled Nursing Care	485, 176	0	0				
00 00	Physical Therapy Occupational Therapy	339, 026	0	0				
00	Speech Pathol ogy	210, 279 11, 700	0	0				
00	Medical Social Services	2,079	0	0				
00	Home Health Aide	96, 668	0	0				
00	Supplies (see instructions)	1, 905	О	0	(1, 905	422	8
00	Drugs	0	0	0		-		
. 00	DME	0	0	0		-		
. 00	Home Dialysis Aide Services	0	0	0		-	-	
. 00	Respiratory Therapy Private Duty Nursing	0	0	0		-		
. 00 . 00	Clinic	0	0	0		-	-	
. 00	Health Promotion Activities	0	0	0		-	-	
. 00	Day Care Program	0	0	0		-	0	
. 00	Home Delivered Meals Program	0	0	0		0 0	0	17
. 00	Homemaker Service	0	0	0		0 0	0	18
. 00	All Others (specify)	0	0	0		-	0	
. 00	Total (sum of lines 1-19) (2)	1, 146, 833	57, 236	2, 997	280, 51			
. 00	Unit Cost Multiplier: column					0. 000000		21
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13.00	
00	Administrative and General	91, 383	0.00	26, 779				1
00	Skilled Nursing Care	0	0	0				
00	Physical Therapy	0	0	0	(3
00	Occupational Therapy	0	0	0	(2, 039	30, 625	4
00	Speech Pathol ogy	0	0	0	(
00	Medical Social Services	0	0	0		-		
00	Home Health Aide	0	0	0		_,		
00 00	Supplies (see instructions) Drugs	0	0	0		-	0	
. 00	DME	0	0	0		-	-	
	Home Dialysis Aide Services	0	0	0		-	0	
. 00	Respiratory Therapy	0	0	0	(0 0	0	
. 00	Private Duty Nursing	0	0	0		0 0	0	
. 00	Clinic	0	0	0		0 0	0	
. 00	Health Promotion Activities	0	0	0		0 0		
. 00	Day Care Program	0	0	0	(-	0	
. 00	Home Delivered Meals Program	0	0	0	(-	0	
. 00	Homemaker Service	0	0	0		0	0	
0.00	All Others (specify) Total (sum of lines 1-19) (2)	0 91, 383	0	0 26, 779) 0 0 16, 336	0	
	Unit Cost Multiplier: column	91, 383	0	20, 779		10, 330	245, 313	20 21
). 00 I 00		1			1	1	1	~ '
. 00	26. Line 1 divided by the sum							
	26, line 1 divided by the sum of column 26, line 20 minus							

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LOCA	ATION OF GENERAL SERVICE COSTS	TO HHA COST CENT	ERS	Provider HHA CCN:		Period: From 01/01/2015 To 12/31/2015	5/18/2016 3:0	pare
						Home Health	PPS	
					OTHER GENERA	Agency I		
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	-
		14.00	15.00	16.00	18.00	19.00	24.00	
00	Administrative and General	0	0			0 0		1.
00	Skilled Nursing Care	0	0	0		0 0	793, 665	
00	Physical Therapy	0	0			0 0	538, 013	3.
00	Occupational Therapy	0	0	0		0 0	337, 477	4.
00	Speech Pathology	0	0			0 0	18, 500	
00	Medical Social Services	0	0			0 0	3, 376	
00	Home Health Aide	0	0			0 0	173, 993	
00	Supplies (see instructions)	405	0			0 0		
00	Drugs	0	0			0 0	0	
00	DME	0	0			0 0	0	
00	Home Dialysis Aide Services	0	0			0 0	0	
00	Respiratory Therapy	0	0			0 0	0	
00	Private Duty Nursing	0	0			0 0	0	
00	Clinic	0	0			0 0	0	
00	Health Promotion Activities	0	0			0 0	0	
00	Day Care Program	0	0			0 0	0	
00	Home Delivered Meals Program	0	0			0 0 0 0	0	
00	Homemaker Service	0	-			-	0	
00	All Others (specify)	405	0			0 0	0 2, 212, 828	
00 00	Total (sum of lines 1–19) (2) Unit Cost Multiplier: column	405	0	15, 288		0 0	2, 212, 828	20
. 00	26, line 1 divided by the sum							21.
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Intern &	Subtotal	Allocated HHA	Total HHA			
		Residents Cost		A&G (see Part	Costs			
		& Post		11)				
		Stepdown						
		Adjustments						
	T	25.00	26.00	27.00	28.00			
00	Administrative and General	0	345, 072			_		1
00	Skilled Nursing Care	0	793, 665					2
0	Physical Therapy	0	538,013					3
)0)0	Occupational Therapy	0	337, 477 18, 500					4
00	Speech Pathology Medical Social Services	0						5
10	Home Heal th Ai de	0	3, 376 173, 993					7
0	Supplies (see instructions)	0	2, 732					8
0	Drugs	0	2,732			0		9
00	DME	0	0			0		10
00	Home Dialysis Aide Services	0	0			0		11
00	Respiratory Therapy	0	0			0		12
00	Private Duty Nursing	0	0			0		13
00	Clinic	0	0	0		0		14
00	Health Promotion Activities		0			0		15
	Day Care Program		0	n		0		16
	Home Delivered Meals Program	0	0	0		0		17
00	Homemaker Service	0	0	n		o		18
00 00		0	0	0		o		19
00 00 00			0	-				20
00 00 00 00	All Others (specify) Total (sum of lines 1-19) (2)	0	2, 212, 828	345.072	Z, ZIZ, 87			
00 00 00 00 00	All Others (specify) Total (sum of lines 1–19) (2)		2, 212, 828			0		
00 00 00 00	All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column		2, 212, 828	345, 072 0. 184752		0		21
00 00 00 00 00	All Others (specify) Total (sum of lines 1–19) (2)		2, 212, 828					
00 00 00 00 00	All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum		2, 212, 828			0		

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	TO HHA COST CEN	TERS STATISTICA	AL Provider HHA CCN:	CCN: 150065 157155	Period: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part II Date/Time Pre 5/18/2016 3:0	pared:
					Home Health	PPS	
	CAPITAL REL	ATED COSTS			Agency I		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	on ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATI ON OF PLANT (SQUARE FEET)	
	1.00	2.00	4.00	5A	5.00	7.00	
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology O Medical Social Services Home Health Aide O Supplies (see instructions) O Drugs O Home Dialysis Aide Services O Respiratory Therapy O Respiratory Therapy O Clinic O Haelth Promotion Activities O Day Care Program O Home Delivered Meals Program O Home Service O All Others (specify) O Total (sum of lines 1-19) O Total cost to be allocated O Unit cost multiplier 	3, 850 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	239, 031 323, 249 225, 876 140, 098 7, 795 1, 385 64, 405 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 127, 161 0 575, 684 0 402, 270 0 249, 506 0 13, 883 0 2, 467 0 114, 701 0 1, 905 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 850 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
	LAUNDRY)	1221)	SERVED)	JERVICE)	(DI RECT NRSI NG HRS)	(COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy Speech Pathology O Medical Social Services Home Health Aide Supplies (see instructions) O Drugs O Home Dialysis Aide Services O Home Dialysis Aide Services O Respiratory Therapy O Clinic O Day Care Program O Home Delivered Meals Program O Home Service O All Others (specify) O Total (sum of lines 1-19) O Total cost multiplier 		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10, 7. 5, 5. 3, 8. 11. 20 4, 0. 20 31, 0. 16, 3.	40 10, 740 35 5, 535 82 3, 882 83 183 43 43 25 4, 025 0 0 <t< td=""><td>405</td><td>$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$</td></t<>	405	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA	AL Provider HHA CCN:	CCN: 150065 157155	Period: From 01/01/2015 To 12/31/2015		
						5/18/2016 3:0	
					Home Health	PPS	
					Agency I		
			OTHER GENERAL SERVI CE				
Cost Center Description	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSICIA	M		
cost center bescription	(COSTED	RECORDS &	PRIVATE	ANESTHETI ST			
	REQUIS.) L			(ASSI GNED	5		
		(GROSS	PRACTICE (TIME	TIME)			
		CHARGES)	SPENT)				
	15.00	16.00	18.00	19.00			
1.00 Administrative and General	0	2, 361, 093	0		0	-	1.00
2.00 Skilled Nursing Care	0	0	0		0		2.00
3.00 Physical Therapy	0	0	0		0		3.00
4.00 Occupational Therapy	0	0	0		0		4.00
5.00 Speech Pathology	0	0	0		0		5.00
6.00 Medical Social Services	0	0	0		0		6.00
7.00 Home Health Aide	0	0	0		0		7.00
8.00 Supplies (see instructions)	0	0	0		0		8.00
9.00 Drugs	0	0	0		0		9.00
10.00 DME	0	0	0		0		10.00
11.00 Home Dialysis Aide Services	0	0	0		0		11.00
12.00 Respiratory Therapy	0	0	0		0		12.00 13.00
13.00 Private Duty Nursing 14.00 Clinic	0	0	0		0		13.00
15.00 Health Promotion Activities	0	0	0		0		14.00
16.00 Day Care Program	0	0	0		0		16.00
17.00 Home Delivered Meals Program	0	0	0		0		17.00
18.00 Homemaker Service	0	0			0		18.00
19.00 All Others (specify)					0		19.00
20.00 Total (sum of lines 1-19)	0	2, 361, 093	0		0		20.00
21.00 Total cost to be allocated	0	15, 288			0		21.00
22.00 Unit cost multiplier	0. 000000	0. 006475		0.0000	oo		22.00

PPORT	Financial Systems IONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 150065	Peri od:	Worksheet H-3	2552
					HHA CCN:	157155	From 01/01/2015 To 12/31/2015	Part I	pare
					Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Cost	ts Sł	ared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Anc	illary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)		s (from	+ 2)		(col. 3 ÷ col.	
					rt II)			4)	
		0	1.00		2. 00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST,	AGGREGA	TE OF TH	IE PROGRAM LIN	MITATION COST, O	R	
	BENEFICIARY COST LIMITATION								
	Cost Per Visit Computation			ael				1 050.00	
00	Skilled Nursing Care	2.00			_	940, 2			
00	Physical Therapy	3.00			C				
00	Occupational Therapy	4.00			C				
00	Speech Pathology	5.00			C	=			
00	Medical Social Services	6.00				4, 0			
00	Home Health Aide	7.00	206, 13	39		206, 1			6
00	Total (sum of lines 1-6)		2, 209, 59	91	C	2, 209, 5	91 9, 407	7	7
						Program Visi	ts		
							art B		
	Cost Center Description	Cost Limits	CBSA No. (1)) Pa	nrt A	Not Subject			
						Deducti bl es			
				_		Coi nsurance			
		0	1.00	2	2. 00	3.00	4.00	5.00	
~~	Limitation Cost Computation		10000	-			0		
00	Skilled Nursing Care		18020		C		0		8
01	Skilled Nursing Care		50031		C		63		8
02	Skilled Nursing Care		50033		C	· ·			8
03	Skilled Nursing Care		50040		C		60		8
00	Physical Therapy		18020		C		0		9
01	Physical Therapy		50031		C		33		9
02	Physical Therapy		50033		C				9
03	Physical Therapy		50040		C		29		9
. 00	Occupational Therapy		18020		C		0		10
01	Occupational Therapy		50031		C		48		10
. 02	Occupational Therapy		50033		C	., -			10
03	Occupational Therapy		50040		C		28		10
00	Speech Pathology		18020		C		0		11
. 01	Speech Pathology		50031		C		11		11
. 02	Speech Pathology		50033		C		23		11
. 03	Speech Pathology		50040		C		0		11
. 00	Medical Social Services		18020		C		0		12
. 01	Medical Social Services		50031		C		0		12
. 02	Medical Social Services		50033		C)	24		12
. 03	Medical Social Services		50040		C		0		12
. 00	Home Health Aide		18020		C		0		13
01	Home Health Aide		50031		C		14		13
. 02	Home Health Aide		50033		C	8	43		13
. 03	Home Health Aide		50040		C		5		13
00	Total (sum of lines 8-13)		1		C				14
	Cost Center Description	From Wkst. H-2	Facility Cost		ared	Total HHA		Ratio (col. 3	
		Part I, col.	(from Wkst.			Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)		s (from	+ 2)	Record)		
				Par	rt II)	· · · · ·			
		0	1.00	2	2. 00	3.00	4.00	5.00	
		ations							
. 00	Supplies and Drugs Cost Computa Cost of Medical Supplies	8.00	3, 23	27	C	3, 2	37 (0. 000000	

	FIONMENT OF PATIENT SERVICE COSTS	>		Provi der	CCN: 150065	Peri od:	Worksheet H-3	
				HHA CCN:	157155	From 01/01/2015	Part I	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	
			Program Visits		Cost of Services			
			Par	tВ		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
	-	6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		
	BENEFICIARY COST LIMITATION							-
00	Cost Per Visit Computation		2.20(0 501 701		1 1 0
. 00 . 00	Skilled Nursing Care Physical Therapy	C				0 581, 781 0 398, 047		1.0
. 00	Occupational Therapy	0				0 259, 461		3.0
. 00	Speech Pathol ogy	C				0 10,070		4.0
. 00	Medical Social Services	C				0 2,232		5.0
. 00	Home Health Aide	C	862			0 121, 706		6.0
. 00						0 1, 373, 297		7.0
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
. 00	Limitation Cost Computation							8.0
. 00	Skilled Nursing Care Skilled Nursing Care							8.0
. 02	Skilled Nursing Care							8.0
. 02	Skilled Nursing Care							8.0
. 00	D Physical Therapy							9.0
. 01								9.0
. 02	Physical Therapy							9.0
. 03	Physical Therapy							9.0
0.00	Occupational Therapy							10.0
0.01	Occupational Therapy							10.0
0.02	Occupational Therapy							10.0
0. 03 1. 00	Occupational Therapy Speech Pathology							11. (
1.00	Speech Pathology							11. (
1. 02	Speech Pathology							11.0
1.03	Speech Pathol ogy							11. (
2.00	Medical Social Services							12.0
2. 01	Medical Social Services							12. (
2. 02	Medical Social Services							12.0
2. 03	Medical Social Services							12. (
3.00	Home Health Aide							13. (
3.01	Home Health Aide							13. (
3.02								13.0
	Home Health Aide							13.0
4.00	Total (sum of lines 8-13)	Prog	ram Covered Cha	ardes	Cost of			14.0
		FIOg		ii yes	Servi ces			
			Dam	+ D		Dort P		
	Cost Center Description	Part A	Not Subject to	t B Subject to	Part A	Part B Not Subject to	Subject to	
	cost center beschiption	Tart A	Deductibles &		Tart A	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computa Cost of Medical Supplies		1					
		C	0	0		0 0		15.0

Heal th	Financial Systems		SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CCN: 150065	Peri od:	Worksheet H-3	
				HHA CCN: 157155	From 01/01/2015 To 12/31/2015	Part I Date/Time Prep	
				Title XVIII	llawa llaslah	5/18/2016 3:07 PPS	pm
				In the XVIII	Home Health Agency I	PP5	
	Cost Center Description	Total Program					
		Cost (sum of					
		cols. 9-10)					
		12.00					
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE P	ROGRAM COST, AGGRE	GATE OF THE PROGRAM LI	MITATION COST, OR		
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	581, 781					1.00
2.00	Physical Therapy	398, 047					2.00
3.00	Occupational Therapy	259, 461					3.00
4.00	Speech Pathology	10, 070					4.00
5.00	Medical Social Services	2, 232					5.00
6.00	Home Health Aide	121, 706					6.00
7.00	Total (sum of lines 1-6)	1, 373, 297					7.00
	Cost Center Description						
	· · · ·	12.00					
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
8.03	Skilled Nursing Care						8.03
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9. 01
9.02	Physical Therapy						9. 02
9.03	Physical Therapy						9.03
10.00	Occupational Therapy						10.00
10. 01	Occupational Therapy						10. 01
10. 02	Occupational Therapy						10. 02
10. 03	Occupational Therapy						10. 03
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
11.03	Speech Pathology						11.03
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
12.03	Medical Social Services						12.03
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
13.03	Home Heal th Aide						13.03
14.00	Total (sum of lines 8-13)	I I				I	14.00

Health Financial Systems		SCHNECK MEDI	CAL CE	NTER			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	TS		F	Provi der		Peri od:		Worksheet H-3	
						From 01/		Part II	l
			1	HHA CCN:	157155	10 12/	/31/2015	Date/Time Pre 5/18/2016 3:0	
				Ti tl	e XVIII	Home H	leal th	PPS	
					Agen				
Cost Center Description	Cost to Charge	Tota	al HHA	HHA Shared	Trans	fer to			
	Part I, col.	Ratio			Ancillary				
	9, line		pro	vi der	Costs (col.	1 I ndi	cated		
			rec	ords)	x col. 2)				
	0	1.00	2	. 00	3.00	4.	00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	Y SHAR	ED HOSPI	TAL DEPARTMEN	ITS			
1.00 Physical Therapy	66.00	0. 519852		0		0 col . 2	, line 2.	00	1.00
2.00 Occupational Therapy 67.00 0.276006			0		0 col . 2	, line 3.	00	2.00	
3.00 Speech Pathology 68.00 0.610433			0		0 col . 2	, line 4.	00	3.00	
4.00 Cost of Medical Supplies	71.00	1. 191429		0		0 col . 2	, line 15	5. 00	4.00
5.00 Cost of Drugs	73.00	0. 816108		0		0 col . 2	, line 16	5. 00	5.00

	Financial Systems SCHNECK MEDICAL CE ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150065	Period:	ieu of Form CMS- Worksheet H-4	
LCUL		HHA CCN:	157155	From 01/01/20	15 Part I-II	epare
		Ti tl	e XVIII	Home Health Agency I	PPS	<u>57 pi</u>
					art B	
			Part A	Not Subject Deductibles	& Deductibles &	
				Coi nsurance		
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA		1.00	2.00	3.00	
	Reasonable Cost of Part A & Part B Services					-
0	Reasonable cost of services (see instructions)			0	0 0) 1
0	Total charges			0	0 0) 2
	Customary Charges		1			
00	Amount actually collected from patients liable for payment for so	ervi ces		0	0 0) 3
00	on a charge basis (from your records) Amount that would have been realized from patients liable for pa	vmont		0	0 0	4
50	for services on a charge basis had such payment been made in acce with 42 CFR §413.13(b)	ordance		0		
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000	000 0.0000	0. 000000) 5
00	Total customary charges (see instructions)			0	0 0	
00	Excess of total customary charges over total reasonable cost (con	mplete		0	0 0	
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only i	iflipo		0	0 0	
0	1 exceeds line 6)	i i i i i i i i i i i i i i i i i i i		0		ן מ
0	Primary payer amounts			0	0 0	
				Part A	Part B	
				Services 1.00	Services 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
00	Total reasonable cost (see instructions)				0 0	
00	Total PPS Reimbursement - Full Episodes without Outliers				0 973, 021	
00	Total PPS Reimbursement - Full Episodes with Outliers				0 18,881	
00 00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0 23, 682 0 6, 407	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0 1, 444	
00	Total PPS Outlier Reimbursement - PEP Episodes				0 0	
00	Total Other Payments					
00	DME Payments				0 0	18
00	Oxygen Payments				0 0) 19
00	Prosthetic and Orthotic Payments				0 0	
00	Part B deductibles billed to Medicare patients (exclude coinsural	nce)			C	
00	Subtotal (sum of lines 10 thru 20 minus line 21)				0 1, 023, 435	
00					0 1.023.435	
00 00					0 1, 023, 435	
00	Net cost (line 24 minus line 25)				0 1, 023, 435	
00	Reimbursable bad debts (from your records)				., .,	2
00	Reimbursable bad debts for dual eligible beneficiaries (see inst	ructions))			28
00	Total costs - current cost reporting period (line 26 plus line 2	7)			0 1, 023, 435	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0 0	
50	Pioneer ACO demonstration payment adjustment (see instructions)				0 0	
00	Subtotal (see instructions) Sequestration adjustment (see instructions)				0 1, 023, 435	
01	Interim payments (see instructions)				0 20, 469	
()(1)					0 1,002,985	
						1 00
. 00 . 00 . 00	Balance due provider/program (line 31 minus lines 31.01, 32, and	33)			0 1	34
00	Balance due provider/program (line 31 minus lines 31.01, 32, and	,	6 Pub. 15-2,		0 1 0 C	

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED T M BENEFICIARIES	0 Provi HHA (N: 150065 157155		eriod: com 01/01/2015 0 12/31/2015	Worksheet H-5 Date/Time Prep 5/18/2016 3:07	oarec 7 pm
						Home Health Agency I	PPS	- p
		l npa	tient f	Part A		Par	t B	
		mm/dd/yy	уу	Amount		mm/dd/yyyy	Amount	
		1.00		2.00		3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				0		1, 002, 965 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							3. (
	Program to Provider					I		
01 02 03 04 05					0 0 0 0			3. 3. 3. 3. 3.
05	Provider to Program				U		0	э.
50					0		0	3.
50 51 52 53 54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0 0 0 0 0		0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				0		1, 002, 965	4.
0	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)							5
1	Program to Provider				0		0	-
1 12 13					0 0 0		0 0 0	5 5 5
	Provider to Program							
0 1 2					0 0 0		0 0 0	5 5 5
19 10	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on				0		0	5 6
)1	the cost report. (1) SETTLEMENT TO PROVIDER				0		1	6
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)				0	Contractor	0 1,002,966 NPR Date	6 7
						Number	(Mo/Day/Yr)	

Heal th	Financial Systems	SCHNECK MEDI CAL	_ CENTER		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150065	Peri od:	Worksheet K	
				454500	From 01/01/2015		
			Hospi ce C	CN: 151529	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
					Hospi ce I	3/10/2010 3.0	
		Salaries (from	Employee	Transportati		Other	
			nefits (from				
			Vkst. K-2)	. ,	Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				0	11, 000	1.00
2.00	Capital Related Costs-Movable Equip.				0	63, 393	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	217, 422	0		0 0	79, 859	6.00
	I NPATI ENT_CARE_SERVI CE						
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES					100	0.00
9.00	Physician Services	0	0		0 0	192	9.00
10.00	Nursing Care	284, 534	0		0 0 0 0	0	10.00
11.00 12.00	Nursing Care-Continuous Home Care	0	0		0 0 0 0	0	11.00
12.00	Physical Therapy Occupational Therapy	0	0		0 0	0	12.00
13.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
14.00	Medi cal Soci al Servi ces	0	0		0 0	0	15.00
16.00	Spiritual Counseling	47, 668	0		0 0	0	16.00
17.00	Di etary Counsel i ng	47,000	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	88, 474	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
211.00	OTHER HOSPICE SERVICE COSTS				0		200
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	9, 876	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	(20,000)	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	638, 098	0	l	0 0	164, 320	39.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-:	2552-10
	SIS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150065	Peri od:	Worksheet K	
					From 01/01/2015		
			Hospi ce	CCN: 151529	To 12/31/2015		
						5/18/2016 3:0	7 pm
		T I I I			Hospi ce I		
			Recl assi fi cati			Total (col. 8	
		1-5)	<u>on</u> 7.00	6 ± col . 7) 8.00	9,00	<u>± col. 9)</u> 10.00	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
1.00	Capital Related Costs-Bldg and Fixt.	11,000		11,0	00 0	11,000	1.00
2.00	Capital Related Costs-Blog and Fixt.	63, 393		63, 3			1
2.00 3.00	Plant Operation and Maintenance	03, 393		03, 3	0 0		3.00
3.00 4.00	Transportation - Staff	0				°	4.00
4.00 5.00	Volunteer Service Coordination	0					4.00 5.00
5.00 6.00	Administrative and General	297, 281		297, 2	-	-	6.00
0.00	I NPATI ENT CARE SERVI CE	297,201		271,2		297,201	0.00
7.00	Inpatient - General Care	0	(0 0	0	7.00
8.00	Inpatient - Respite Care	0			0 0		8.00
0.00	VI SI TI NG SERVI CES			4	0 0	, U	0.00
9.00	Physician Services	192	(1	92 C	192	9.00
10.00	Nursi ng Care	284, 534		284,5			10.00
11.00	Nursing Care-Continuous Home Care	204, 334		204, 3	0 0		11.00
12.00	Physical Therapy	0			0 0	-	
13.00	Occupational Therapy	0			0 0		13.00
14.00	Speech/ Language Pathol ogy	0					14.00
15.00	Medical Social Services	0			0 0		15.00
16.00	Spiritual Counseling	47,668		47,6	-	47,668	
17.00	Di etary Counsel i ng	47,000		, 47, 0	0 0	0	17.00
18.00	Counseling - Other	0			0 0		18.00
19.00	Home Health Aide and Homemaker	88, 474		88,4	-	88,474	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	00,474		00,4	0 0		20.00
20.00	Other	0			0 0		
21.00	OTHER HOSPICE SERVICE COSTS		· · · · ·	2		, <u> </u>	21.00
22.00	Drugs, Biological and Infusion Therapy	0	(b	0 0	0 0	22.00
23.00	Anal gesi cs	0			0 0		23.00
24.00	Sedatives / Hypnotics	0			0 0	ol o	
25.00	Other - Specify	0			0 0		25.00
26.00	Durable Medical Equipment/Oxygen	0			0 0	-	26.00
27.00	Pati ent Transportati on	9, 876		9,8	-	-	
28.00	Imaging Services	0		,, 0	0 0		28.00
29.00	Labs and Diagnostics	0			0 0		29.00
30.00	Medical Supplies	0			0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0			0 0	ol o	31.00
32.00	Radi ati on Therapy	0			0 0	-	32.00
33.00	Chemotherapy	0			0 0	-	33.00
34.00	Other	0			0 0		
54.00	HOSPICE NONREIMBURSABLE SERVICE		· · · · ·	21		, <u> </u>	54.00
35.00	Bereavement Program Costs	0	(b	0 0	0	35.00
36.00	Volunteer Program Costs	0			0 0	-	36.00
37.00	Fundrai si ng	0			0 0	0	37.00
38.00	Other Program Costs	0			0 0	-	
39.00	Total (sum of lines 1 thru 38)	802, 418	(802, 4	18 C	802, 418	39.00
				•			•

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER			In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150065	Pe	eri od:	Worksheet K-1	
				:CN: 151529		rom 01/01/2015	Date/Time Pre 5/18/2016 3:0	pared:
						Hospi ce I	3/10/2010 3.0	7 piii
		Admi ni strator	Di rector	Soci al		Supervi sors	Nurses	
		1.00	2.00	Servi ces 3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.							1 1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0	0		0	0	0	5.00
6.00	Administrative and General	0	61, 204		0	128, 238	0	
	I NPATI ENT CARE SERVI CE				-	,	-	
7.00	Inpatient - General Care	0	0		0	0	0	7.00
8.00	Inpatient - Respite Care	0	0		0	0	0	8.00
0.00	VI SI TI NG SERVI CES				-			0.00
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	284, 534	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	201,001	11.00
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	0	14.00
15.00	Medi cal Soci al Servi ces	0	0		0	0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
20.00	Other	0	0		0	0	0	1
21.00	OTHER HOSPICE SERVICE COSTS	0	0		0	U	0	21.00
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Pati ent Transportati on	0	0		0	0	0	27.00
28.00	I maging Services	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medi cal Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	
54.00	HOSPICE NONREIMBURSABLE SERVICE	U U	0		0	0	0	54.00
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundrai si ng	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
	Total (sum of lines 1 thru 38)	0	61, 204		0	128, 238	284, 534	1
07.00		, oj	01,201	I	9	.20,200	201,001	1 57.00

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 150065	Peri od:	Worksheet K-1
					From 01/01/2015	
			Hospi ce C	CN: 151529	To 12/31/2015	Date/Time Prepared:
					11	5/18/2016 3:07 pm
		Tatal	A : -!		Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists 6.00	7.00	8.00	9, 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs Brug and Trxt.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4,00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0	27,9	0	6.00
0.00	I NPATI ENT_CARE_SERVI CE	I		27,7	217,122	0.00
7.00	Inpatient - General Care		0		0 0	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
0.00	VI SI TI NG SERVI CES	I				0.00
9.00	Physi ci an Servi ces		0		0 0	9,00
10.00	Nursing Care		o		0 284, 534	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medical Social Services	, i i i i i i i i i i i i i i i i i i i	0		0 0	15.00
16.00	Spiritual Counseling		0	47,6	68 47, 668	16.00
17.00	Dietary Counseling		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		88, 474		0 88, 474	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	
	HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		0		0 0	37.00
38.00	Other Program Costs		0		0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	88, 474	75, 6	48 638, 098	39.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST		Provi der Hospi ce (CCN: 150065 CCN: 151529	Period: From 01/01/2015 To 12/31/2015		pared:
					Hospi ce I	0/10/2010 0.0	
			CAPI TAL RE	LATED COST			
		NET EXPENSES FOR COST ALLOCATI ON	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATI ON & MAI NT.	TRANSPORTATI ON	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS	÷		•			
1.00 2.00 3.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip. Plant Operation and Maintenance	11, 000 63, 393 0	11, 000	63, 3	93 0 0		1.00 2.00 3.00
4.00 5.00 6.00	Transportation - Staff Volunteer Service Coordination Administrative and General	0 0 297, 281	0 0 11, 000	63, 3	0 0 0 0 93 0	0 0 0	5.00
	I NPATI ENT CARE SERVI CE	· ·		1			1
7.00 8.00	Inpatient - General Care Inpatient - Respite Care VISITING SERVICES	0	0		0 0 0 0		
9.00	Physi ci an Servi ces	192	0		0 0	0	9.00
10.00	Nursing Care	284, 534	0		0 0		
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16. 00 17. 00	Spiritual Counseling Dietary Counseling	47, 668	0		0 0	0	
18.00	Counseling - Other	0	0			0	
19.00	Home Health Aide and Homemaker	88, 474	0		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS	T					
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	-	
23.00	Analgesics	0	0		0 0	, s	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00 26.00	Other - Specify Durable Medical Equipment/Oxygen	0	0		0 0	0	
28.00	Patient Transportation	9, 876	0			0	
28.00	I magi ng Servi ces	, 0/0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	•
30.00	Medical Supplies	0	0		0 0	0	•
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	
34.00	Other	0	0		0 0	0	34.00
25 02	HOSPICE NONREI MBURSABLE SERVICE				0		25.00
35.00 36.00	Bereavement Program Costs Volunteer Program Costs	0	0		0 0		
36.00	Fundrai si ng		0			0	
38.00	Other Program Costs	0	0		0 0	0	
	Total (sum of lines 1 thru 38)	802, 418	11, 000	63, 3	93 0		

COST ALLOCATION - HOSPICE GENERAL SERVICE COST Provider CCR: 15026 Period: From (CR: 15026) Period: To 12/31/2015 Worksheet K-4 Inspice CCR: 151529 To 12/31/2015 Start I Date (TIR Service)	Heal th	Financial Systems	SCHNECK MEDI	CAL CENT	TFR		Inlie	u of Form CMS-	2552-10
Hospic cc CK: 15152 To 12/2153 Date/Time Prepared: S18/2015 S18/2015 S18/20			Connective meet			CCN: 150065	Peri od:	Worksheet K-4	
SUBTOR SUBTOR<				Цо	cni co (CN: 151500			narad
VOLUNTEER Model of the stream of				ПО	spice (JUN. 101029	10 12/31/2015		
SERVICES SERVICES Cols. 0 - 5) & GENERAL ± col. 6) 1.00 Capit Ial Related Costs-Bidg and Fixt. 5.00 5A 6.00 7.00 2.00 Capit Ial Related Costs-Bidg and Fixt. 2.00 2.00 2.00 2.00 3.00 Plant Operation and Maintenance 4.00 7.00 3.00 4.00 0.00 Maintenance 0 371,674 371,674 3.00 4.00 0.00 Maintent - General Care 0 0 0 0 8.00 8.00 8.00 8.00 8.00 9.00 9.00 9.01 9.01 9.00 9.00 9.01 9.01 9.00 9.00 9.01 9.01 9.00 9.01 9.01 9.00 9.01 9.00 9.01				_			Hospi ce I		
COORD NATOR 0 7 5:00 5A 6:00 7:00 100 Capital Related Costs-Bid g and Fixt. 1:00 1.00 2:00 Capital Related Costs-Bid g and Fixt. 1:00 1.00 0:00 Plant operation and Maintenance 1:00 3:00 1:00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
ENERAL SERVICE COST CENTERS 5.00 5A 6.00 7.00 Capital Related Costs-Blog and Fixt. .00 .00 .01 .00 .01 .00 .01 .00 .01 .00 .01 .00 .01 .00 .01 .00				(col s.	0 - 5)	& GENERAL	± col. 6)		
GENERAL SERVICE COST CONTRES 1 1.00 Capital Related Costs-Blog and Fixt. 1 2.00 Capital Related Costs-Blog and Fixt. 3 3.00 Plant Operation and Waintenance 3 0.00 Valuates Service Coordination 0 0.00 Valuates Service Revice 0 0.00 Inpatient - General Care 0 0.00 Inpatient - General Care 0 0.00 Nursing Care-Continuous Hone Care 0 0.00 Nursing Care-Continuous Hone Care 0 0.01 Nursing Care-Continuous Hone Care 0 0.01 Opysical Therapy 0 0 0.01 Opesical Therapy 0 0 0.02 Opysical Therapy 0 0 0.03 Opesical Therapy 0					^	(00	7.00		
1.00 Capital Related Costs-Blog and Fixt. 1.00 2.00 Capital Related Costs-Blog and Fixt. 1.00 3.00 Plant Operation and Maintenance 1.00 4.00 Transportation - Staff 3.00 0.00 Main Strative and General 0 371, 674 371, 674 0.00 Inpatient - General Care 0 0 0 0 0.00 Inpatient - General Care 0 0 0 8.00 1.00 Nursing Care-Continuous Home Care 0 245, 514 530, 048 10.00 1.00 Nursing Care-Continuous Home Care 0 0 0 1.00 1.00 Nursing Care-Continuous Home Care 0 0 0 11.00 1.00 Nursing Care-Continuous Home Care 0 0 0 11.00 1.00 Nursing Care-Continuous Home Care 0 0 0 11.00 1.00 Nursing Care-Continuous Home Care 0 0 0 11.00 1.00 Detary Counseling		CENERAL SERVICE COST CENTERS	5.00	5 <i>i</i>	4	0.00	7.00		
2.00 Capit tal. Related Costs-Movable Equip. 2.00 2.00 7 0.00 Plant Operation and Maintenance. 0 3.00 4.00 7 0.00 Vinteer Service Coordination 0 371,674 6.00 4.00 0.00 Vinteer Service Coordination 0 371,674 7.00 6.00 0.00 Inpatient - General Care 0 0 0 7.00 0.00 Inpatient - General Care 0 0 0 7.00 0.00 Nursing Care-Continuous Home Care 0 0 0 0 11.00 0.00 Nursing Care-Continuous Home Care 0 0 0 0 11.00 0.00 Physical Therapy 0 0 0 0 11.00 0.00 Speech/ Language Pathol Ogy 0 0 0 11.00 0.00 Speech/ Language Pathol Ogy 0 0 0 14.00 0.00 Speech/ Language Pathol Ogy 0 0 0 21.	1 00								1 1 00
3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 0 5.00 Volunteer Service Coordination 0 6.00 Administrative and General 0 371,674 371,674 7.00 Inpatient - General Care 0 0 0 6.00 1NPATIENT CARE SERVICE 0 0 0 0 0 7.00 Inpatient - General Care 0 0 0 0 0 9.00 Physical an Services 0 192 166 358 9.00 11.00 Nursing Care 0 284,534 245,514 530,048 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 12.00 11.00 Nursing Care-Continuous Home Care 0 0 0 12.00 12.00 Physical Therapy 0 0 0 12.00 12.00 Specch/ Language Pathology 0 0 0 12.00 14.00 Specch/ Language Pathology 0 0 0 16.00 17.00									1
5.00 Volunteer Service Coordination 0 371,674 5.00 0.00 AmArt ENT CARE SERVICE 6.00 6.00 6.00 6.00 1NPATI ENT CARE SERVICE 0 0 0 0 0 6.00 0 Inpatient - Respite Care 0 0 0 0 6.00 9.00 Physician Services 0 192 166 358 0 10.00 11.00 Nursing Care 0 284,534 245,514 530,048 10.00 11.00 12.00 Physical Therapy 0 0 0 11.00 11.00 13.00 Coupational Therapy 0 0 0 13.00 16.00 15.00 16.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00	3.00								3.00
6.00 Administrative and General 0 371, 674 371, 674 6.00 INPATIENT CARE SERVICE Inpatient - General Care 0 0 0 8.00 Inpatient - General Care 0 0 0 0 8.00 Mistrike SERVICES 0 192 166 358 9.00 0.00 Nursing Care 0 0 0 0 11.00 10.00 Nursing Care-Continuous Home Care 0 0 0 0 11.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 11.00 13.00 Coupational Therapy 0 0 0 0 14.00 16.00 Sprit tual Counseling 0 4.7,668 41.131 88,799 16.00 16.00 Obter 0 0 0 0 20.00 20.00 17.00 Hetary Counseling	4.00	Transportation - Staff							4.00
INPATIENT CARE SERVICE Impatient Construct Impatient Construct Construct <td>5.00</td> <td>Volunteer Service Coordination</td> <td>0</td> <td>D</td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>	5.00	Volunteer Service Coordination	0	D					5.00
7.00 Inpatient - General Care 0<	6.00	Administrative and General	0		371, 674	371, 6	74		6.00
8.00 Inpatient - Respite Care 0 0 0 8.00 VISITNO SERVICES									
VISITING SERVICES 0 1 0 0 0 9.00 Physical an Services 0 192 166 358 9.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 10.00 10.00 10.00 11.00 11.00 12.00 Nursing Care-Continuous Home Care 0 0 0 0 11.00 13.00 Occupational Therapy 0 0 0 0 11.00 14.00 Speech/Language Pathology 0 0 0 0 11.00 15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling - Other 0 0 0 0 16.00 17.00 Biotary Counseling - Other 0 0 0 0 16.00 17.00 Hime Healt Al Aid e and Homemaker 0 0 0 0 10.00 18.00 Counseling - Other 0 0									
9.00 Physician Services 0 192 166 358 9.00 10.00 Nursing Care 0 284,534 245,514 530,048 10.00 11.00 Physical Therapy 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 11.00 13.00 Occupational Therapy 0 0 0 0 13.00 14.00 Speech/Language Pathology 0 0 0 0 13.00 15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling 0 47,668 41,131 88,799 16.00 17.00 Dietary Counseling 0 0 0 0 20.00 17.00 Home Health Aide a Homemaker 0 88,474 76,341 164,815 19.00 20.00 Other Hospice Service Costs 0 0 0 20.00	8.00		0)	0		0 0		8.00
10.00 Nursing Care-Continuous Home Care 0 284,534 245,514 530,048 11.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 11.00 13.00 Occupational Therapy 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 14.00 16.00 Spirit tual Counseling 0 47,668 41,131 88,79 16.00 17.00 Dietary Counseling 0 0 0 0 17.00 18.00 Haide and Homemaker 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 20.00 10.00 Dirtery Counseling 0 0 0 0 22.00 20.00 Drther Dogical and Infusion Therapy 0 0 0 22.00 21.00 Drther Opecify 0 0<	0.00		0	1	100	1	(/ 250		0.00
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Cocupational Therapy 0 0 0 0 13.00 13.00 Speech/Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 15.00 16.00 Dietary Counseling 0 47.668 41.131 88.799 16.00 17.00 Dietary Counseling 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 20.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 21.00 21.00 Other 0 0 0 0 22.00 22.00 Drugs, Bi ological and Infrusion Therapy 0 0 0 23.00		5	-						
12.00 Physical Therapy 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 13.00 15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling 0 47,668 41,131 88,799 16.00 17.00 Dietary Counseling 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 18.00 19.00 Home Healt h Aide and Homemaker 0 88,474 76,341 164,815 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 20.00 20.00 21.00 Drugs. Biological and Infusion Therapy 0 0 0 21.00 22.00 22.00 Drugs. Biological and Infusion Therapy 0 0 0 22.00 23.00 Aand gesics 0 0 0 22.00 24.00 Seda		5	-		204, 334 0	245, 5			
13.00 Occupational Therapy 0 0 0 13.00 14.00 Speech/Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 14.00 16.00 Spiritual Counseling 0 47.668 41.131 88.799 16.00 17.00 Dietary Counseling 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 18.00 19.00 Hemelath Aide and Homemaker 0 88.474 76.341 164.815 19.00 20.00 Putes Biological and Infusion Therapy 0 0 0 22.00 21.00 Other O 0 0 0 22.00 22.00 Castavies / Hypnotics 0 0 0 22.00 23.00 Castavies / Hypnotics 0 0 0 22.00 24.00 Deadatives / Hypno			0	1	0		0 0		1
14.00 Speech/Language Pathology 0 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 15.00 </td <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>1</td>			0		0		0 0		1
15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling 0 47,668 41,131 88,799 16.00 17.00 Dietary Counseling 0 0 0 0 16.00 18.00 Counseling - Other 0 0 0 0 17.00 18.00 Home Heal th Aide and Homemaker 0 88,474 76,341 164,815 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 20.00 21.00 Other 0 0 0 0 21.00 22.00 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 24.00 25.00 Other - Specify 0 0 0 26.00 27.00 Patient Transportation 0 9,876 8,522 18,398 27.00			0		0		0 0		
17.00 Dietary Counseling 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 88,474 76,341 164,815 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 20.00 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 22.00 24.00 Sedatives / Hypnotics 0 0 0 24.00 25.00 Other - Specify 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 26.00 26.00 Imaging Services 0 0 0 27.00 28.00 27.00 Patient Transportation 9,876 8,522 18,398 27.00 28.00 Imaging			0	b	0		0 0		15.00
18.00 Counseling - Other 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 88,474 76,341 164,815 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 20.00 0 Other 0 0 0 0 0 21.00 0 Other 0 0 0 0 0 22.00 20.00 Anal gesics 0 0 0 0 22.00 21.00 Other - Specify 0 0 0 24.00 25.00 Other - Specify 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 26.00 27.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 29.00 28.00 29.00 Labs and Diagnostics 0 0 0 0 29.00 30.00	16.00	Spiritual Counseling	0	D	47, 668	41, 1	31 88, 799		16.00
19.00 Home Heal th Ai de and Homemaker 0 88, 474 76, 341 164, 815 19.00 20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 21.00 0 OTHER HOSPICE SERVICE COSTS 0 0 0 0 22.00 22.00 Anal gesics 0 0 0 0 22.00 24.00 Sedatives / Hypnotics 0 0 0 24.00 25.00 Other - Specify 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 26.00 27.00 Patient Transportation 0 9, 876 8, 522 18, 398 27.00 28.00 Imaging Services 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 30.00 29.00 Labs and Diagnostics 0 0 0 31.00 31.00 Outpatient Services	17.00	Di etary Counsel i ng	0)	0		0 0		17.00
20.00 HH Ai de & Homemaker - Cont. Home Care 0		5	0	1	0		0 0		
21.00 Other O			0	1	88, 474	76, 3			
OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 22.00 23.00 Anal gesics 0 0 0 23.00 23.00 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 24.00 24.00 0 0 0 0 24.00 25.00 24.00 0 0 0 0 25.00 25.00 0 0 0 0 0 25.00 25.00 26.00 25.00 26.00 27.00 28.00 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 28.00 29.00 28.00 29.00 20.00 29.00 30.00 30.00 31.00 32.00 30.00 31.00 32.00 33.00 30.00 31.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00			-		0		0		
22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 26.00 27.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 29.00 29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 29.00 30.00 Radiation Therapy 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 44.00 Other 0 0 0	21.00		0)	0		0 0		21.00
23.00 Anal gesics 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 24.00 25.00 Other - Specify 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 25.00 26.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 29.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Adiation Therapy 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol	22.00				0	1	0 0		222.00
24.00 Sedatives / Hypnotics 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 26.00 26.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 34.00 Other 0 0 0 0 34.00 40 0 0 0 0 0 35.00 35.00 Bereavement Program Costs 0 0 0 36.00 </td <td></td> <td></td> <td></td> <td></td> <td>•</td> <td></td> <td>0</td> <td></td> <td></td>					•		0		
25.00 Other - Specify 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 26.00 27.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 29.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 30.00 32.00 Radiation Therapy 0 0 0 0 31.00 32.00 Chemotherapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Uther 0 0 0 0 34.00 HOSPICE NONREI MBURSABLE SERVICE 50.00 0 0 0 35.00 35.00 Bereavement Program Costs 0 0			0		0				1
26.00 Durable Medical Equipment/Oxygen 0 0 0 0 26.00 27.00 Patient Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 0 28.00 28.00 Labs and Diagnostics 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 31.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 0 0 0 34.00 40.01 HOSPICE NONREI MBURSABLE SERVICE 0 0 0 35.00 36.00 Vol unteer Program Costs		51	0	0	0				
27.00 Pati ent Transportation 0 9,876 8,522 18,398 27.00 28.00 Imaging Services 0 0 0 28.00 29.00 Labs and Di agnostics 0 0 0 28.00 29.00 Labs and Di agnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 30.00 31.00 Outpati ent Services (including E/R Dept.) 0 0 0 31.00 32.00 Radi ati on Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 32.00 33.00 Other 0 0 0 0 34.00 HOSPICE NONREI MBURSABLE SERVICE HOSPICE NONREI MBURSABLE SERVICE Totol 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 38.00 38.00 Other Progr			0		0		0 0		
29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 HOSPICE NONREI MBURSABLE SERVICE 55.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00	27.00		0	D	9, 876	8, 5	22 18, 398		27.00
30.00 Medical Supplies 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 HOSPICE NONREI MBURSABLE SERVICE ***********************************	28.00	I maging Services	0	D	0		0 0		28.00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 HOSPICE NONREI MBURSABLE SERVICE 0 0 0 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00			0	D	0		0 0		
32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 HOSPICE NONREI MBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00			0	D	0		0 0		
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 HOSPICE NONREI MBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00			0	0	0		0		1
34.00 Other O O O O 34.00 HOSPI CE NONREI MBURSABLE SERVI CE 35.00 Bereavement Program Costs O O O 35.00 36.00 Vol unteer Program Costs O O O 36.00 37.00 Fundrai si ng O O O 37.00 38.00 Other Program Costs O O O 38.00			0	2	0		0		
HOSPI CE NONREI MBURSABLE SERVI CE 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00			-		-				1
35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00	34.00		0	<u>и</u>	0		0 0		34.00
36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 38.00	35 00		0		0		0 0		35 00
37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 38.00				1					1
38.00 Other Program Costs 0 0 0 38.00			0	b	0		-		
39.00 Total (sum of lines 1 thru 38) 0 802,418 802,418 39.00	38.00	5	0		0		0 0		38.00
	39.00	Total (sum of lines 1 thru 38)	0) 8	302, 418		802, 418		39.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150065	Peri od:	Worksheet K-4	
				454500	From 01/01/2015	Part II	
			Hospi ce C	CCN: 151529	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
					Hospi ce I	3/10/2010 3.0	
		CAPI TAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT		VOLUNTEER	
		FIXTURES (SQ.	EQUI PMENT (\$	OPERATION &	TRANSPORTATI ON (MI LEAGE)	SERVICES	
		FT.)	VALUE)	MAINT. (SQ.	(WILEAGE)	COORDI NATOR	
		11.)	VALUL)	FT.)		(HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	150					1.00
2.00	Capital Related Costs-Movable Equip.	0	10, 757				2.00
3.00	Plant Operation and Maintenance	0	0	15	50		3.00
4.00	Transportation - Staff	0	0		0 0		4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	150	10, 757	1	50 0	0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0		0 0	0	
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VI SI TI NG SERVI CES			1			
9.00	Physi ci an Servi ces	0	0		0 0	0	
10.00	Nursing Care	0	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	
	Di etary Counsel i ng	0	0		0 0	0	
18.00	Counseling - Other	0	0		0 0	0	
19.00	Home Health Aide and Homemaker	0	0		0 0	0	•
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
21.00	Other OTHER HOSPICE SERVICE COSTS	0	0		0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
22.00	Anal gesi cs	0	0		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
24.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Patient Transportation	0	0		0 0	0	
28.00	I magi ng Servi ces	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medi cal Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00	Radi ati on Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	
34.00	Other	0	0		0 0	0	
500	HOSPI CE NONREI MBURSABLE SERVI CE		0		- 0	0	1
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
37.00		1	-		1		1
38.00	Other Program Costs	0	0		0 0	0	38.00
	Other Program Costs Cost to be Allocated (per Wkst. K-4, Part I)	0 11, 000	0 63, 393		0 0 0 0	0	

Heal th	Financial Systems	SCHNECK MEDICA	L CENTER	In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der (Hospi ce CC	Period: From 01/01/2015 To 12/31/2015	Worksheet K-4 Part II Date/Time Pre 5/18/2016 3:0	pared:
				Hospi ce I	37 107 2010 3.0	// piii
		RECONCILIATIONAD	MINI STRATI VE	nospree r		
			& GENERAL			
			(ACC. COST)			
		6A	6.00			
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.	0				1.00
2.00	Capital Related Costs-Movable Equip.	0				2.00
3.00	Plant Operation and Maintenance	0				3.00
4.00	Transportation - Staff	0				4.00
5.00	Volunteer Service Coordination					5.00
6.00	Administrative and General	-371, 674	430, 744	 		6.00
	I NPATI ENT CARE SERVI CE	-	-			
7.00	Inpatient - General Care	0	0			7.00
8.00	Inpatient - Respite Care	0	0			8.00
	VI SI TI NG SERVI CES		100			
9.00	Physi ci an Servi ces	0	192			9.00
10.00	Nursing Care	0	284, 534			10.00
11.00	Nursing Care-Continuous Home Care	0	0			11.00
12.00	Physical Therapy	0	0			12.00
13.00	Occupational Therapy	0	0			13.00
14.00	Speech/ Language Pathol ogy	0	0			14.00
15.00	Medical Social Services	0	0			15.00
16.00	Spiritual Counseling	0	47, 668			16.00
17.00	Dietary Counseling	0	0			17.00
18.00 19.00	Counseling - Other Home Health Aide and Homemaker	0	88, 474			18.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	88, 474			20.00
20.00	Other	0	0			20.00
21.00	OTHER HOSPICE SERVICE COSTS	U	0			21.00
22.00	Drugs, Biological and Infusion Therapy	0	0			22.00
22.00	Anal gesi cs	0	0			23.00
24.00	Sedatives / Hypnotics	0	0			24.00
25.00	Other - Specify	0	0			25.00
26.00	Durable Medical Equipment/Oxygen	0	0			26.00
27.00	Patient Transportation	0	9, 876			27.00
28.00	Imaging Services	0	0,0,0			28.00
29.00	Labs and Diagnostics	0	0			29.00
30.00	Medi cal Supplies	0	0			30.00
31.00	Outpatient Services (including E/R Dept.)	0	0			31.00
32.00	Radi ati on Therapy	0	0			32.00
33.00	Chemotherapy	0	Ő			33.00
34.00	Other	0	Ő			34.00
	HOSPI CE NONREI MBURSABLE SERVI CE					1
35.00	Bereavement Program Costs	0	0			35.00
36.00	Volunteer Program Costs	0	0			36.00
37.00	Fundrai si ng	0	0			37.00
38.00	Other Program Costs	0	0			38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		371, 674			39.00
	Unit Cost Multiplier	1 1	0.862865			40.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE (COSTS TO HOSPICE COST	CENTERS		CCN: 150065 CCN: 151529	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/18/2016 3:0	pared:
					Hospi ce I		
			CAPI TAL REI	ATED COSTS			
Cost Center Descri	ption	Hospice Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00Administrative and Gener2.00Inpatient - General Care		0	2, 230	5, 7	04 60, 877 0 0	68, 811 0	1.00
3.00 Inpatient - Respite Care		0	0		0 0	0	3.00
4.00 Physician Services		358	0		0 0	358	4.00
5.00 Nursing Care		530, 048	0		0 79,669	609, 717	5.00
6.00 Nursing Care-Continuous	Home Care	0	0		0 0	0	6.00
7.00 Physical Therapy		0	0		0 0	0	7.00
8.00 Occupational Therapy		0	0		0 0	0	8.00
9.00 Speech/ Language Pathol of	av	0	0		0 0	0	9,00
10.00 Medical Social Services	35	0	0		0 0	0	10.00
11.00 Spiritual Counseling		88, 799	0		0 13, 347	102, 146	11.00
12.00 Di etary Counsel i ng		0	0		0 0	0	12.00
13.00 Counseling - Other		0	0		0 0	0	13.00
14.00 Home Health Aide and Hom	nemaker	164, 815	0		0 24,772	189, 587	14.00
15.00 HH Aide & Homemaker - Co		0	0		0 0	0	15.00
16.00 Other		0	0		0 0	0	16.00
17.00 Drugs, Biological and Ir	fusion Therapy	0	0		0 0	0	17.00
18.00 Anal gesi cs		0	0		0 0	0	18.00
19.00 Sedatives / Hypnotics		0	0		0 0	0	19.00
20.00 Other - Specify		0	0		0 0	0	20.00
21.00 Durable Medical Equipmer	it/0xvaen	0	0		0 0	0	21.00
22.00 Patient Transportation	93	18, 398	0		0 0	18, 398	22.00
23.00 Imaging Services		0	0		0 0	0	23.00
24.00 Labs and Diagnostics		0	0		0 0	0	24.00
25.00 Medical Supplies		0	0		0 0	0	25.00
26.00 Outpatient Services (inc	ludina E/R Dept.)	0	0		0 0	0	26.00
27.00 Radiation Therapy	3 1 /	0	0		0 0	0	27.00
28.00 Chemotherapy		0	0		0 0	0	28.00
29.00 Other		0	0		0 0	0	29.00
30.00 Bereavement Program Cost	S	0	0		0 0	0	30.00
31.00 Volunteer Program Costs		0	0		0 0	0	31.00
32.00 Fundrai si ng		0	0		0 0	0	32.00
33.00 Other Program Costs		0	0		0 0	0	33.00
34.00 Total (sum of lines 1 th	ıru 33) (2)	802, 418	2, 230	5, 7	04 178, 665	989, 017	34.00
35.00 Unit Cost Multiplier (se	, , ,					0. 000000	35.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150065	Peri od:	Worksheet K-5	
					From 01/01/2015		
			Hospi ce C	CN: 151529	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
					Hospi ce I	571672010 3.0	n pili
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
	Cost Center Description	& GENERAL	PLANT	LINEN SERVIC		DIEMAN	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	15, 253	3, 560		0 1, 043	0	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	79	0		0 0	0	4.00
5.00	Nursing Care	135, 155	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	22, 642	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	42, 025	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	4,078	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	
34.00	Total (sum of lines 1 thru 33) (2)	219, 232	3, 560		0 1, 043	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150065 CCN: 151529	Period: From 01/01/2015 To 12/31/2015		pared:
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	2,633			0 0		1.00
2.00	Inpatient - General Care	2,000			0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursi ng Care	4, 474	0		0 0	14, 483	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathology	0	0		0 0	0	9,00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	1,013	0		0 0	0	11.00
12.00	Dietary Counseling	0			0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	3, 074	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0	6	72 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0	,	0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	11, 194	0	6	72 0	14, 483	
35.00	Unit Cost Multiplier (see instructions)	I	I		1	l	35.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der Hospi ce (Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/18/2016 3:0	
					Hospi ce I		
		OTHER GENERAL SERVI CE					
	Cost Center Description	PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS		Intern & Residents Cost & Post Stepdown Adjustments	25)	
		18.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	0	C	91, 30	0		1.00
2.00	Inpatient - General Care	0	C		0 0	0	2.00
3.00	Inpatient - Respite Care	0	C		0 0	0	3.00
4.00	Physician Services	0	C	43		437	4.00
5.00	Nursing Care	0	C	763, 82	9 0	763, 829	5.00
6.00	Nursing Care-Continuous Home Care	0	C		0 0	0	6.00
7.00	Physi cal Therapy	0	C		0 0	0	7.00
8.00	Occupational Therapy	0			0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0			0 0	0	9.00
10.00	Medical Social Services	0		105.00	0 0	0	10.00
11.00	Spiritual Counseling	0		125, 80	0	125, 801	11.00
12.00	Dietary Counseling	0			0 0	0	12.00
13.00 14.00	Counseling - Other Home Health Aide and Homemaker	0		234, 68	0 0	0 234, 686	13.00 14.00
14.00	HH Ai de & Homemaker - Cont. Home Care	0		234,00	0 0	234,000	14.00
16.00	Other	0			0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0			0 0	0	17.00
18.00	Anal gesi cs	0				0	18.00
19.00	Sedatives / Hypnotics	0			0 0	0	19.00
20.00	Other - Specify	0			0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0			0 0	0 0	21.00
22.00	Patient Transportation	0		22, 47	6 0	22, 476	
23.00	I maging Services	0		,	0 0	0	23.00
24.00	Labs and Diagnostics	0	l c		0 0	0	24.00
25.00	Medical Supplies	0	C	67	2 0	672	25.00
26.00	Outpatient Services (including E/R Dept.)	0	C C)	0 0	0	26.00
27.00	Radiation Therapy	0	C)	0 0	0	27.00
28.00	Chemotherapy	0	c c)	0 0	0	28.00
29.00	Other	0	с с)	0 0	0	29.00
30.00	Bereavement Program Costs	0	C		0 0	0	30.00
31.00	Volunteer Program Costs	0	C		0 0	0	31.00
32.00	Fundrai si ng	0	C		0 0	0	32.00
33.00	Other Program Costs	0	C		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	[C	1, 239, 20	1 0	1, 239, 201	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150065	Period:	Worksheet K-5	
			Hospi co. C	CN: 151529	From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	narod
			nospi ce c	GN. 151529	10 12/31/2015	5/18/2016 3:0	pareu. 7 pm
					Hospi ce I		
	Cost Center Description	Allocated	Total Hospice		· · · ·		
		Hospi ce A&G	Costs (cols.				
		(See Part II)	26 ± 27)				
	T	27.00	28.00				
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	-				2.00
3.00	Inpatient - Respite Care	0	0				3.00
4.00	Physician Services	35					4.00
5.00	Nursing Care	60, 752	824, 581				5.00
6.00	Nursing Care-Continuous Home Care	0	0				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech/ Language Pathol ogy	0	0				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Spiritual Counseling	10,006	135, 807				11.00
12.00	Dietary Counseling	0	0				12.00
13.00	Counseling - Other	0	0				13.00
14.00	Home Health Aide and Homemaker	18, 666	253, 352				14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0				15.00
16.00	Other	0	0				16.00
17.00	Drugs, Biological and Infusion Therapy	0	0				17.00
	Anal gesi cs	0	0				18.00
	Sedatives / Hypnotics	0	0				19.00
	Other - Specify	0	0				20.00
21.00	Durable Medical Equipment/Oxygen	0	0				21.00
22.00	Patient Transportation	1, 788	24, 264				22.00
23.00	Imaging Services	0	-				23.00
24.00	Labs and Diagnostics	0	-				24.00
25.00	Medical Supplies	53	725				25.00
26.00	Outpatient Services (including E/R Dept.)	0	0				26.00
27.00	Radiation Therapy	0	0				27.00
28.00	Chemotherapy	0	0				28.00
29.00	Other	0	0				29.00
30.00	Bereavement Program Costs	0	0				30.00
31.00	Volunteer Program Costs	0	0				31.00
32.00	Fundrai si ng	0	0				32.00
33.00	Other Program Costs	0	0				33.00
	Total (sum of lines 1 thru 33) (2)		1, 239, 201				34.00
	Unit Cost Multiplier (see instructions)	0.079536					35.00

Heal th	Financial Systems	SCHNECK MEDIC	CAL CENTER		In Lie	eu of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (CCN: 150065 CCN: 151529	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part II Date/Time Pre 5/18/2016 3:0	pared:
					Hospi ce I		
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARI ES) 4.00	5A	5.00	
1.00	Administrative and General	1.00	10, 757				1.00
2.00	Inpatient - General Care	0	10, 737		0 0		2.00
2.00	Inpatient - Respite Care	0	0			0	3.00
3.00 4.00	Physician Services	0	0			358	4.00
4.00 5.00	Nursing Care	0	0	284, 53		609, 717	5.00
5.00 6.00	Nursing Care-Continuous Home Care	0	0	204, 03	0 0	009,717	6.00
8.00 7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
9.00 10.00	Medical Social Services	0	0			0	10.00
10.00	Spiritual Counseling	0	0	47,66		102, 146	
12.00	Dietary Counseling	0	0	47,00		102, 148	12.00
12.00	Counseling - Other	0	0			0	12.00
13.00	Home Health Aide and Homemaker	0	0	88, 47		189, 587	14.00
14.00	HH Aide & Homemaker - Cont. Home Care	0	0	00,47	0 0	0, 109, 307	15.00
15.00	Other	0	0		0 0	0	16.00
10.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
17.00	Anal gesi cs	0	0			0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	1
20.00	Other - Specify	0	0		0 0	0	20.00
20.00	Durable Medical Equipment/Oxygen	0	0			0	
22.00	Pati ent Transportati on	0	0			18, 398	
23.00	I magi ng Servi ces	0	0		0 0	0	
24.00	Labs and Di agnosti cs	0	0			0	
24.00	Medi cal Supplies	0	0			0	
26.00	Outpatient Services (including E/R Dept.)	0	0			0	26.00
27.00	Radiation Therapy	0	0			0	27.00
27.00	Chemotherapy	0	0		0 0	0	27.00
28.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0				30.00
30.00	Volunteer Program Costs	0	0			0	31.00
32.00	Fundrai si ng	0	0			0	32.00
33.00	Other Program Costs	0	0			0	
34.00	Total (sum of lines 1 thru 33) (2)	150	10, 757	638, 09	200	989, 017	
34.00	Total cost to be allocated	2, 230	5, 704			219, 232	
	Unit Cost Multiplier (see instructions)	14. 866667	0. 530259			0. 221667	
50.00	Tomic observaturprier (see rinstructions)	14.00007	0. 330239	0.2/995		0.221007	1 30.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST STICAL BASIS			CCN: 150065	Period: From 01/01/2015	Worksheet K-5	
STATIS	STICAL BASIS		Hospi ce (CCN: 151529	To 12/31/2015		
					Hospi ce I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVICE)	
		FEET)	LAUNDRY)	0.00	10.00	11.00	
1 00	Administratives and Conserved	7.00	8.00	9.00	10.00	11.00	1 00
1.00 2.00	Administrative and General Inpatient - General Care	150 0	0	1	50 0 0 0	5, 012 0	1.00 2.00
2.00	Inpatient - General Care	0	0				2.00
3.00 4.00	Physician Services	0	0			0	4.00
4.00 5.00	Nursi ng Care	0	0		0 0	8, 515	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0,515	6.00
7.00	Physi cal Therapy	0	0			0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	1, 929	
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	5, 852	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0)	0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0)	0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radi ati on Therapy	0	0		0 0	0	27.00
28.00 29.00	Chemotherapy Other	0	0		0 0	0	28.00 29.00
29.00	Bereavement Program Costs	0	0		0 0	0	30.00
30.00	Volunteer Program Costs	0	0				30.00
32.00	Fundrai si ng	0	0			0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	150	0	1	50 0	21, 308	
35.00	Total cost to be allocated	3, 560	0	1		11, 194	
	Unit Cost Multiplier (see instructions)	23. 733333	0. 000000				
		1					

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS-:	2552-10
ALLOCA	NTION OF GENERAL SERVICE COSTS TO HOSPICE COST STICAL BASIS			CCN: 150065 CCN: 151529	Fr	eriod: rom 01/01/2015	Worksheet K-5 Part II Date/Time Pre 5/18/2016 3:0	pared:
						Hospi ce I		<u>, bui</u>
							OTHER GENERAL SERVI CE	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY (COSTED		MEDI CAL RECORDS &	PHYSI CI AN PRI VATE	
		(DI RECT NRSI NG HRS)	SUPPLY (COSTED REQUIS.)	REQUIS.)		LI BRARY (GROSS CHARGES)	PRACTICE (TIME SPENT)	
1 00	Administrative and Cananal	13.00	14.00	15.00	0	16.00	18.00	1.00
1.00	Administrative and General	-	-			-		
2.00	Inpatient - General Care	0	0		0	0	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00 5.00	Physician Services	0	0		0	0	0	4.00 5.00
5.00 6.00	Nursing Care Nursing Care-Continuous Home Care	0	0		0	2, 236, 744 0	0	6.00
7.00	Physi cal Therapy	0	0		0	0	0	7.00
8.00	Occupational Therapy	0	0		0	0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0	0	0	9.00
10.00	Medical Social Services	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	11.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
13.00	Counseling - Other	0	0		0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	1	0	0	0	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Pati ent Transportati on	0	0		0	0	0	22.00
23.00	I magi ng Servi ces	0	0		0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	0	6, 154		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00 29.00	Chemotherapy	0	0		0	0	0	28.00 29.00
29.00	Other Bergevenent Program Costs	0	0		0	0	0	29.00 30.00
30.00	Bereavement Program Costs Volunteer Program Costs	0	0		0	0	0	30.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
32.00	Other Program Costs		0		0	0	0	32.00
34.00	Total (sum of lines 1 thru 33) (2)	0	6, 154		0	2, 236, 744	0	34.00
35.00	Total cost to be allocated	0	672		0	14, 483	0	35.00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 109197	0.0000	-	0. 006475		

Health Financial Systems		SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE C	COSTS TO HOSPICE COST	CENTERS	Provider CCN: 150065	Peri od:	Worksheet K-5	5
STATI STI CAL BASI S			U	From 01/01/2015	Part II	
			Hospi ce CCN: 151529	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	epared:)7 nm
				Hospi ce I	37 107 2010 3.0	
Cost Center Descrip	ntion	NONPHYSI CI AN		110501001		
		ANESTHETI STS				
		(ASSI GNED				
		TIME)				
		19.00				
1.00 Administrative and Genera	al	0				1.00
2.00 Inpatient - General Care		0				2.00
3.00 Inpatient - Respite Care		0				3.00
4.00 Physician Services		0				4.00
5.00 Nursing Care		0				5.00
6.00 Nursing Care-Continuous I	Home Care	0				6.00
7.00 Physical Therapy		0				7.00
8.00 Occupational Therapy		0				8.00
9.00 Speech/ Language Pathol of	av	0				9.00
10.00 Medical Social Services	93	0				10.00
11.00 Spiritual Counseling		0				11.00
12.00 Di etary Counsel i ng		0				12.00
13.00 Counseling - Other		0				13.00
14.00 Home Heal th Aide and Home	emaker	0				14.00
15.00 HH Aide & Homemaker - Co		0				15.00
16.00 Other		0				16.00
17.00 Drugs, Biological and In	fusion Therapy	0				17.00
18.00 Analgesics	rust on the upy	0				18.00
19.00 Sedatives / Hypnotics		0				19.00
20.00 Other - Specify		0				20.00
21.00 Durable Medical Equipment	t/Oxygen	0				21.00
22.00 Patient Transportation	e, en gen	0				22.00
23. 00 Imaging Services		0				23.00
24.00 Labs and Diagnostics		0				24.00
25.00 Medical Supplies		0				25.00
26.00 Outpatient Services (incl	luding E/R Dent)	0				26.00
27. 00 Radi ati on Therapy	aaring Eric Dopt.)	0				27.00
28.00 Chemotherapy		0				28.00
29.00 Other		0				29.00
30.00 Bereavement Program Costs	s	0				30.00
31.00 Volunteer Program Costs	0	0				31.00
32.00 Fundrai si ng		0				32.00
33.00 Other Program Costs		0				33.00
34.00 Total (sum of lines 1 th	ru 33) (2)	0				34.00
35.00 Total cost to be allocate	, , ,	0				35.00
36.00 Unit Cost Multiplier (see		0. 000000				36.00
						1 00.00

Heal th	Financial Systems	SCHNECK MEDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150065	Peri od:	Worksheet K-5	
			lloopi oo (CON. 151500	From 01/01/2015 To 12/31/2015		norod.
			Hospi ce (CCN: 151529	To 12/31/2015	Date/Time Pre 5/18/2016 3:0	
					Hospi ce I	0/10/2010 0.0	<u>, bii</u>
	Cost Center Description	Wk	st. C, Part	Cost to Char	ge Total Hospice	Hospi ce Shared	
		1	, col. 11	Ratio	Charges	Ancillary	
			line		(Provi der	Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00			0	1.00
2.00	OCCUPATIONAL THERAPY		67.00			0	2.00
3.00	SPEECH PATHOLOGY		68.00			0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00		0 80	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00
6.00	LABORATORY		60.00		28 0	0	
6.01	BLOOD LABORATORY		60. 01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	1. 1914	29 0	0	7.00
8.00	BEHAVOURAL HEALTH		93.00	2.6476	40 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C		55.00				9.00
10.00	WOUND CARE		76.00	0. 4943	44 0	0	10.00
10. 02	CASE MANAGEMENT		76.02	1. 2163	21 0	0	10.02
10.03	PAIN MANAGEMENT		76.03	0. 7099	54 0	0	10.03
10. 97	CARDI AC REHABI LI TATI ON		76.97	3. 2331	74 0	0	10.97
11.00	Totals (sum of lines 1-10)					0	11.00

Health Financial Systems SCHNECK MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150065	Period:	Worksheet K-6	
	Hospi ce (CCN: 151529	From 01/01/2015 To 12/31/2015		
			Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				1, 239, 201	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				10, 176	2.00
3.00 Average cost per diem (line 1 divided by line 2)				121. 78	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	8, 750				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	1, 065, 575				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		49	91		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)		59, 79	94		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	1, 392				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	169, 518				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)		10)7		10.00
11.00 Aggregate NF cost (line 3 times line 10)		13, 03	30		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			935		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			113, 864		13.00

ALCUL	Financial Systems SCHNECK MEDICA ATION OF CAPITAL PAYMENT SCHNECK MEDICA	Provider CCN: 150065	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	5/18/2016 3:0 PPS	/ pm
			nospi tai	115	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
00	Capital DRG other than outlier			628, 086	1.
01	Model 4 BPCI Capital DRG other than outlier			0	1.
00	Capital DRG outlier payments			82, 461	2.
01	Model 4 BPCI Capital DRG outlier payments			0	2.
00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	32.78	3.
00	Number of interns & residents (see instructions)			0.00	4.
00	Indirect medical education percentage (see instructions)			0.00	5.
00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of lines 1 and 1.01	, columns 1 and	0	6.
00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	, part A line	0.00	7.
00	Percentage of Medicaid patient days to total days (see instru	ictions)		0.00	8.
00	Sum of lines 7 and 8			0.00	9.
. 00	Allowable disproportionate share percentage (see instructions	5)		0.00	10.
. 00	Disproportionate share adjustment (see instructions)			0	1
. 00	Total prospective capital payments (see instructions)			710, 547	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
~~	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			-	-
00 00	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line 4)	vetrueti ope)		0 0.00	
	Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary		ling (0.00	
00		CITCUMStances (ITTHE Z X		0	
00 00				0	
00 00 00	Capital minimum payment level (line 5 plus line 7)	cable)			
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00 00 00 00 00 00 00 00 00 00 00 00 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to co Carryover of accumulated capital minimum payment level over co Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over co	capital payments (line 8 capital payment (from pri ayments (line 10 plus lin the amount on this line	or year e 11))	0 0 0 0	10. 11. 12. 13.
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00 00 00 00 00 00 00 00 00 00 00 00 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to co Carryover of accumulated capital minimum payment level over co Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over co	capital payments (line 8 capital payment (from pri ayments (line 10 plus lin the amount on this line capital payment for the f	or year e 11))	0 0 0 0	10. 11. 12. 13. 14. 15.