Health Financial Systems SCHNECK MEDICAL CENTER In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150065 Worksheet S Period: AND SETTLEMENT SUMMARY From 01/01/2014 Parts I-III Date/Time Prepared: 5/20/2015 3:50 pm Тө 12/31/2014 PART I - COST REPORT STATUS Provider [X] Electronically filed cost report Date: 5/20/2015 Time: 3:50 pm use only] Manually submitted cost report 2.1] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. Contractor 5. [1] Cost Report Status 6. Date Received: 10.NPR Date:

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN
 12. [0] If line 5, column 1 is 4: Enter

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 use only (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCHNECK MEDICAL CENTER (150065) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information (Signed) Officer or Administrator of Provider(s) ECR: Date: 5/20/2015 Time: 3:50 pm QDyntSBc9hfxEd6354WaJ6Ny.DiKQ0 ISCAL SORVILES YpMN40dn4q0xAQJ:X.VDUNY2Sj6ZCz 8g9m11cGvH026oA: Date: 5/20/2015 Time: 3:50 pm PI: 6KrdC3oXUjVoKvfYTTsW5Fa1ZvasN0 aPhD401iu15kgpzwXnQyaa6XCLuDuB Gy4g0s0s020Qafh2 <u>Title XVIII</u> Title V Part A Part B HIT <u>Title XIX</u> 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 Hospital 29,408 0 51,603 -169,6640 1.00 2.00 Subprovider - IPF 0 0 0

2.00 Subprovider - IRF 3.00 0 0 0 0 3.00 5.00 Swing bed - SNF 0 A n 0 5.00 Swing bed - NF 6.00 0 0 6.00 HOME HEALTH AGENCY I 9.00 0 -68 0 9.00 200.00 Total 0 29,408 51.535 -169,664 0 200.00

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

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I		CK MEDICAL TA			I: 150065	Peri od:		Workshe		2552-10
							From 01/01/ To 12/31/	/2014	Part I Date/Ti 5/20/20		
	1.00		00		3.00			4.00	3720720	/13 3.4	
1.00	Hospital and Hospital Health Care Co Street: 411 WEST TIPTON STREET	pplex Address: P0 Box:									1.00
2.00	Ci ty: SEYMOUR	State: I			e: 47274-		ty: JACKSON				2.00
		Component Na		CCN Number	CBSA Number	Provi der Type	Date Certified	T,	nt Syst 0, or	N)	
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	
3.00	Hospital and Hospital-Based Componen Hospital	t Identification: SCHNECK MEDICAL		150065	99915	1	07/16/1966	N	Р	0	3.00
4.00 5.00 6.00	Subprovi der – IPF Subprovi der – IRF Subprovi der – (Other)										4.00 5.00 6.00
7.00 8.00 9.00 10.00	Swing Beds - SNF Swing Beds - NF Hospital-Based SNF Hospital-Based NF	SCHNECK MEDI CAL		15U065 15U065	99915 99915		03/04/1999 03/04/1999		P	N O	7.00 8.00 9.00 10.00
11.00 12.00 13.00	Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC	JACKSON COUNTY H HEALTH	OME	157155	99915		07/01/1985	N	Р	0	11.00 12.00 13.00
	Hospi tal -Based Hospi ce	HOSPICE OF MEMOR HOSPITAL	IAL	151529	99915		12/09/1994				14.00
17. 00 18. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis										15.00 16.00 17.00 18.00
19.00	Other						From:		To		19.00
	1						1.00	1	2.0	00	
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information						01/01/2	014 8	12/31/	/2014	20.00 21.00
22.00	Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil	ance with 42 CFR ity subject to 42	§412.106? 2 CFR Sect	' In co ion §41	lumn 1,	enter "Y"			N		22.00
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	compensated care es or "N" for no October 1. Enter	payments for the p in column	for thi ortion 2, "Y"	of the of for yes	cost s or "N"	Y		Y		22. 01
22. 02	Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ons) Enter period pr	in col ior to	umn 1, ' October	'Y" for ye 1. Enter			N		22. 02
22. 03	Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	statistical area no for the portic 2, "Y" for yes or r after October 1 t more than 499 b	as adopted on of the ⁻ "N" for L. (see in peds (as c	by CMS cost re no for structi	in FY20 porting the port ons) Doe	D15? Enter period tion of th es this	е		N		22. 03
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	dicaid days on li f census days, or is cost reporting	nes 24 an 3 if dat period d	e of di ifferen	scharge. t from t	ls the the method		3	N		23. 00
			In-State Medicaid paid days	Medio	caid ble Mo aid pa			Medicai ∙MO day	's Med	ther li cai d lays	
24.00	If this provides is as 1000 be it is	optop the	1.00	2. (3.00	4.00	5.00		. 00	24.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	1, 15		276	0	0	1, 6		0	
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	in-state umn 2, 3, out-of-state umn 4, Medicaid		0	0	0	0		0		25.00

Heal th	Financial Systems SCHN	ECK MEDI	CAL CENTER		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	ΔΤΑ	Provi der	F	eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/20/20	me Pre	pared:
					Urban/Rur 1.00		Date of 2.0		
26.00	Enter your standard geographic classification (not			ginning of the	1.00	2	2.0	.0	26.00
27.00	cost reporting period. Enter "1" for urban or "2" f Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban	wage) st or "2" f	atus at the end 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 t effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00	0	Endi 2. (0	
36.00	Enter applicable beginning and ending dates of SCH		Subscript line	36 for number	1.00		2.0	10	36.00
37.00	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), ent in effect in the cost reporting period.		number of period	ds MDH status		О			37.00
38.00	Enter applicable beginning and ending dates of MDH		Subscript line	38 for number					38. 00
	of periods in excess of one and enter subsequent da	tes.			Y/N		Y/	N	
20.00	Does this facility qualify for the inpatient hospit		nt adjustmont f	For Low volume	1.00 Y		2.0 Y		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(or "N" for no. Does the facility meet the mileage r CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for ye Is this hospital subject to the HAC program reducti	ii)? Ent equireme s or "N"	er in column 1 ents in accordar for no. (see i	"Y" for yes nce with 42 nstructions)	N		N		40.00
	"N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October			yes or "N" for					
		1. (300			1	V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital paym	ent for	di sproporti onat	te share in acc	cordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment ex pursuant to 42 CFR §412.348(f)? If yes, complete Wk					N	N	N	46.00
	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS ca Is the facility electing full federal capital payme					N N	N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents i	n approv	ed GME programs	s? Enter "Y" 1	for yes	N			56.00
57 00	or "N" for no. If line 56 is yes, is this the first cost reporting	noriad	during which re	sidonts in an	round				57.00
	GME programs trained at this facility? Enter "Y" f is "Y" did residents start training in the first mo for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt.	or yes o nth of t "Y", com II, if a	or "N" for no ir his cost report pplete Worksheet pplicable.	n column 1. If ting period? I t E-4. If colur	column 1 Enter "Y" nn 2 is				
58.00	If line 56 is yes, did this facility elect cost rei defined in CMS Pub. 15–1, § 2148? If yes, complete	mburseme Wkst. D-	ent for physicia 5.	ans' services a	as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If y Are you claiming nursing school and/or allied healt	es, comp	olete Wkst. D-2,			N N			59.00 60.00
00.00	provider-operated criteria under §413.85? Enter "Y				ctions)				00.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00		5.0		(1.00
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		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	0.0					61.01
61. 02	instructions) Enter the current year total unweighted primary car FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	e	0.00	0.0					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 determining compliance with the 75% test. (see		0.00	0.0					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0					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 (lin	e	0.00	0.0	þ				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	0.0					61.06

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	I CAL CENTER Provi der	CCN: 150065 Pe	eri od:	u of Form CMS-2 Worksheet S-2	
				rom 01/01/2014	Part I	pared
	P	rogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 10 Of the FTEs in line 61.05, specify each new special ty, if any, and the number of FTE rest for each new program. (see instructions) Entrolumn 1, the program name, enter in column program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expaprogram special ty, if any, and the number of residents for each expanded program. (see instructions) Enter in column 1, the program enter in column 2, the program code, enter in 3, the IME FTE unweighted count and enter in 4, direct GME FTE unweighted count. 	sidents ter in 2, the E exct GME anded FTE n name, n column			0.00		61
	· · · · · · · · · · · · · · · · · · ·					
ACA Droviciona Affacting the Health Decourse	and Carviaca	Administration			1.00	
ACA Provisions Affecting the Health Resource 2.00 Enter the number of FTE residents that your				od for which	0.00	62.0
your hospital received HRSA PCRE funding (se	e instructions))				
2.01 Enter the number of FTE residents that rotation during in this cost reporting period of HRS/ Teaching Hospitals that Claim Residents in I	A THC program.	(see instructio		your hospital	0.00	62.0
3.00 Has your facility trained residents in nonpu "Y" for yes or "N" for no in column 1. If ye	rovider settings	s during this c	instructions)		N	63. (
			Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Reside period that begins on or after July 1, 2009			This base year	is your cost r	reporting	
4.00 Enter in column 1, if line 63 is yes, or you in the base year period, the number of unwei resident FTEs attributable to rotations occu settings. Enter in column 2 the number of u resident FTEs that trained in your hospital. of (column 1 divided by (column 1 + column 2	ur facility trai ghted non-prima urring in all no unweighted non-p Enter in colur 2)). (see_instru	ined residents ary care onprovider primary care mn 3 the ratio uctions)	0.00			
Program	Name P	rogram Code	Unwei ghted FTEs Nonprovi der Si te	5	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	0	2.00	3.00	4.00	5.00 0.000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						

Heal th	Financial Systems	SCHNE	CK MEDICAL (CENTER		I	n Lie	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TΑ	Provi der	CCN: 150065	Period: From 01/01 To 12/31		Workshe Part I Date/Ti		
								5/20/20	15 3:4	
					Unweighted FTEs	Unwei gh FTEs		Ratio (c (col. 1		
					Nonprovi der			2)		
					Si te 1.00	2.00)	3.0	0	
	Section 5504 of the ACA Current		n Nonprovid	er Setting						
66.00	beginning on or after July 1, 20 Enter in column 1 the number of		cy care resi	dent	0.	00	0.00	0	000000	66.00
00.00	FTEs attributable to rotations o	ccurring in all nonpr	rovider sett	tings.	0.	00	0.00	0.	000000	00.00
	Enter in column 2 the number of FTEs that trained in your hospit									
	(column 1 divided by (column 1 +	column 2)). (see ins	structions)							
		Program Name	Progra	m Code	Unweighted FTEs	Unwei gh FTEs		Ratio (c (col. 3		
					Nonprovi der			(2011 3		
		1 00	2.0	00	Si te 3.00	1.00	<u> </u>	5.0	0	
67.00	Enter in column 1, the program	1.00	2.0	00	3.00	4.00	0.00			67.00
	name associated with each of									
	your primary care programs in which you trained residents.									
	Enter in column 2, the program									
	code. Enter in column 3, the number of unweighted primary									
	care FTE residents attributable									
	to rotations occurring in all									
	non-provider settings. Enter in column 4. the number of									
	unweighted primary care									
	resident FTEs that trained in your hospital. Enter in column									
	5, the ratio of (column 3									
	divided by (column 3 + column 4)). (see instructions)									
					.1					
	Inpatient Psychiatric Facility F	PPS					1.00	2.00	3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or doe	es it cont	ain an IPF su	bprovi der?	N			70.00
71 00	Enter "Y" for yes or "N" for no		approved CME	tooching	program in th	a most			0	71.00
71.00	00 f line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see								0	/1.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching									
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost									
	reporting period covers the begi	nning of the fourth y	year, enter	4 in colu	mn 3, or if t					
	or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost									
	instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new									
	teaching program in existence, e Inpatient Rehabilitation Facilit		(see instruc	ctions)						
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it c	ontain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes		aproved CME	toachi na	program in th	o most			0	76.00
78.00	If line 75 yes: Column 1: Did th recent cost reporting period end								0	78.00
	no. Column 2: Did this facility	train residents in a	new teachir	ng program	in accordanc	e with 42				
	CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in									
	of the fourth year, enter 4 in c	olumn 3, or if the fi	fth or subs	sequent ac	ademic years	of the new				
	teaching program in existence, e on or after October 1, 2012, if									
	any subsequent academic year of									
	instructions)									
	1							1.0	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospita	U (LTCH)2 Enter "V"	for yes and	1 "N" for	no			N		80.00
	Is this a LTCH co-located within					g period? E	nter	N		81.00
	"Y" for yes and "N" for no.				-					
85.00	TEFRA Providers Is this a new hospital under 42	CFR Section §413.40(1	f)(1)(i) TEF	RA? Ente	r "Y" for ves	or "N" for	no.	N		85.00
86.00	Did this facility establish a ne	w Other subprovider ((excluded ur							86.00
	§413.40(f)(1)(ii)? Enter "Y" fo	or yes and "N" for no.								

^{5/20/2015 3:48} pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

Health Financial Systems SCHNECK MEDICAL	L CENTER		In Lie	eu of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/2014	Worksheet S-2 Part I	
			o 12/31/2014		
			V	XI X	
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applic			Ν	Ν	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicabl	certi fi cati	on)? (see		N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.			N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an applicable column.			N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of			0.0 N	0 0.00 N	95.00 96.00
 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appli 	cable column	۱.	0.0	0 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-ir		nod of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligible			N		107.00
for I &R training programs? Enter "Y" for yes or "N" for no i instructions) If yes, the GME elimination would not be on Wkst the program would be cost reimbursed. If yes complete Wkst. D- this facility is a CAH, do I&Rs in an approved medical educati CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" instructions)	t. B, Pt. I, -2, Pt. II. (ion program 1	col. 25 and Column 2: If train in the			
108.00 Is this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee scheo	dul e? See 42	Ν		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
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	-	1.00	
110.00 Did this hospital participate in the Rural Community Hospital		on project (41	OA Demo)for	1.00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N" fo	or no.				
Miscellaneous Cost Reporting Information			1.0	00 2.00 3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, §2208.1.	lf column 2 i for long ter	s "E", enter rm care (inclu	in column des	0	115.00
116.00 is this facility classified as a referral center? Enter "Y" for 117.00 is this facility legally-required to carry malpractice insurar no.			"N" for N	1 1	116. 00 117. 00
 118.00 Is the malpractice insurance a claims-made or occurrence policical claim-made. Enter 2 if the policy is occurrence. 	cy? Enter 1 i	f the policy	is 0		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		(0	0 0	118.01
				2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost ce			1.00	2.00	
Administrative and General? If yes, submit supporting schedul and amounts contained therein.			1.00 N	2.00	118.02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	le listing co Harmless prov column 1, "Y' lifies for th	ost centers vision in ACA ' for yes or ne Outpatient		Y	118. 02 119. 00 120. 00
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	le listing co Harmless prov column 1, "Y Lifies for th s? (see instr	vision in ACA ' for yes or ne Outpatient -uctions)	N		119. 00
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	le listing co Harmless prov column 1, "Y" lifies for th s? (see instr table devices	vision in ACA for yes or ne Outpatient ructions) s charged to	N		119. 00 120. 00
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. Transplant Center Information	He listing co Harmless prov column 1, "Y" lifies for th s? (see instr table devices yes and "N"	vision in ACA (for yes or ne Outpatient ructions) (s charged to	N N Y		119. 00 120. 00 121. 00

	X IDENTIFICATION DATA	Provi der	CCN: 150065	Peri od:		Worksheet S-2	2
				From 01	/01/2014 /31/2014	Part I	epared
				1	. 00	2.00	_
8.00 f this is a Medicare certified	ver transplant center, er	nter the certifi	cation date		. 00	2.00	128. (
in column 1 and termination date, 9.00 If this is a Medicare certified Lu			cation date	in			129. 0
column 1 and termination date, if 0.001f this is a Medicare certified pa	applicable, in column 2.						130. 0
date in column 1 and termination o	late, if applicable, in co	olumn 2.					
1.00 If this is a Medicare certified in date in column 1 and termination c			erti fi cati on				131. (
2.00 If this is a Medicare certified is in column 1 and termination date,			cation date				132. (
3.00 If this is a Medicare certified of in column 1 and termination date,	her transplant center, er	nter the certifi	cation date				133. (
4.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter 1		n column 1				134. (
All Providers 0.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-1.		N		140. (
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If	yes, and home	office cost	s			
1.00	2.	00			3.00		
If this facility is part of a chai home office and enter the home off				name and	address	of the	
1.00Name:	Contractor's Name:			tor's Num	ber:		141. (
2.00 Street:	PO Box:		7. 0.1				142. (
3. 00 Ci ty:	State:		Zip Cod	e:			143. (
4.00 Are provider based physicians' cos	ts included in Workshoot	12				1.00 Y	144.0
5.00 If costs for renal services are cl only? Enter "Y" for yes or "N" for	aimed on Worksheet A, lir		costs for in	patient s	ervi ces	N	145.
				1	. 00	2.00	-
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in	column 1. (See CMS Pub.			r	N		146. (
7. OUWas there a change in the statisti		yes or "N" for	no.		N		147.
7.00Was there a change in the statisti 8.00Was there a change in the order of 9.00Was there a change to the simplifi	cal basis? Enter "Y" for fallocation? Enter "Y" fo	or yes or "N" fo	or no.	r	N N N		148.
8.00 Was there a change in the order of	cal basis? Enter "Y" for fallocation? Enter "Y" fo	or yes or "N" fo Enter "Y" for ye	or no. es or "N" fo		N N	Ti the VIV	148. (
8.00Was there a change in the order of 9.00Was there a change to the simplifi	cal basis? Enter "Y" for fallocation? Enter "Y" fo	or yes or "N" fo	or no.	Ti	Ν	Title XIX 4.00	148. (
8.00 Was there a change in the order of 9.00 Was there a change to the simplifino.	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an	or yes or "N" for Enter "Y" for ye Part A 1.00 n exemption from	or no. es or "N" fo Part B 2.00 m the applic	Ti 3 cation of	N N tle V 3.00 the lowe	4.00 er of costs	148. (
8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an	or yes or "N" for Enter "Y" for ye Part A 1.00 n exemption from	or no. es or "N" fo Part B 2.00 m the applic	Ti 3 cation of	N N tle V 3.00 the lowe	4.00 er of costs	148. (149. (
8.00 Was there a change in the order of 9.00 Was there a change to the simplifind no. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an	Part A Part A 1.00 n exemption from N N	or no. es or "N" fo <u>Part B</u> 2.00 m the applic and Part B. N N	Ti 3 cation of	N N tle V 3.00 the lowe CFR §413 N N	4.00 er of costs 3.13) N N	148. (149. (155. (156. (
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 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an	Part A Part A 1.00 n exemption from nent for Part A N N	pr no. es or "N" fo 2.00 m the applic and Part B. N N N	Ti 3 cation of	N N 3.00 the lowe <u>CFR §413</u> N N N	4.00 er of costs 3.13) N N N	148. (149. (155. (156. (157. (158. (
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 B. 00 Was there a change in the order of 9. 00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an N" for no for each compon	r yes or "N" for nter "Y" for yes Part A 1.00 n exemption from nent for Part A N N N N N	or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N	Ti 3 Cation of (See 42	N N tle V 3.00 the lowe CFR §413 N N N N N N N N	4.00 er of costs 5.13) N N N N N N N 1.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each compon impus hospital that has or Name	Part A 1.00 n exemption from nent for Part A N N N N N N N N N N N N N	or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N State Z	Ti 3 cati on of (See 42 erent CBS	N N S. 00 CFR §413 N N N N N N As? CBSA	4.00 er of costs 5.13) N N N N N N N 1.00 FTE/Campus 5.00	148. (149. (149. (155. (156. (157. (158. (157. (158. (161. (161. (161. (165. (165. (
 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicate Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each compon impus hospital that has or Name	Part A 1.00 n exemption from nent for Part A N N N N N N N N N N N N N	or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N State Z	Ti 3 cati on of (See 42 erent CBS	N N S. 00 CFR §413 N N N N N N As? CBSA	4.00 er of costs .13) N N N N 1.00 FTE/Campus 5.00 0.00	148. (149. (149. (155. (156. (157. (158. (157. (158. (161. (161. (161. (165. (165. (
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 18.00 Was there a change in the order of 19.00 Was there a change to the simplifino. Does this facility contain a provior charges? Enter "Y" for yes or 55.00 Hospital 16.00 Subprovider - IPF 17.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 10.00 CMHC Multicampus 10.00 CMHC Multicampus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each component impus hospital that has or Name 0 () incentive in the America ' under Section \$1886(n)?	Part A 1.00 n exemption from nent for Part A N N N N N N N N N N N N N	pr no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N State 2.00 d Reinvestme yes or "N"	Ti 3 cation of (See 42 Gerent CBS ip Code 3.00 ent Act for no.	N N N 2.00 The lowe <u>CFR §413</u> N N N N N N As? <u>CBSA</u> 4.00	4.00 er of costs 5.13) N N N N N 1.00 FTE/Campus 5.00 0.00 1.00	148. (149. (149. (155. (155. (157. (157. (160. (161. (165. (165. (165. (165. (165. (166. (167. (167. (
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Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Provider CCN: 150065	Period: From 01/01/2014 To 12/31/2014		
			10 12/31/2014	Date/Time Pre 5/20/2015 3:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	09/30/2014	170.00			
				1.00	
171.00 If line 167 is "Y", does this provider have Medicare cost plans reported on Wkst. S-3, (see instructions)		N	171.00		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi de	r CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Date/Time Pr	repared
				Y/N	5/20/2015 3: Date	48 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO m	responses. Ente	er all dates in [.]	the	
00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the beginning of	E the cost	N	1	1.
00	reporting period? If yes, enter the date of t					'.
			Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Drearem? If	1.00 N	2.00	3.00	2.
50	yes, enter in column 2 the date of terminatio		IN IN			2.
00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)	tions, including management , chain home offices, drug d to the provider or its , or members of the board	N			3.
			Y/N	Туре	Date	
	Financial Data and Dan		1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	A		4.
0	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If y					
				Y/N 1.00	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	-
00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is	the provider is	s N		6.
0	the legal operator of the program?	2 If "V" coo instructions		N		7
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health proc		ed during the	N		7.
	cost reporting period? If yes, see instruction	ons.	0			
0	Are costs claimed for Intern-Resident program yes, see instructions.	ns claimed on the current co	ost report? If	N		9
00	Was an Intern-Resident program been initiated	d or renewed in the current	cost reporting	N N		10.
	period? If yes, see instructions.					
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		oproved	N		11.
	Treaching Program on worksheet A: Tri yes, see				Y/N	
					1.00	
00	Bad Debts	dehts? If wes see instru	ctions		1	12
	Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb			ost reporting	1.00 Y N	
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.	ot collection policy change	during this co		Y N	13
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a	ot collection policy change	during this co		Y	13
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection policy change and/or co-payments waived?	during this co If yes, see ins	structions.	Y N	13. 14.
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection policy change and/or co-payments waived? I pr cost reporting period? I	during this co If yes, see ins f yes, see inst	ructions.	Y N N Part B	13. 14.
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection policy change and/or co-payments waived?	during this co If yes, see inst f yes, see inst Y/N	art A Date	Y N N Part B Y/N	13
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric	ot collection policy change and/or co-payments waived? I or cost reporting period? If Description	during this co f yes, see inst f yes, see inst Pa Y/N 1.00	ructions.	Y N N Part B Y/N 3.00	13. 14. 15.
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio	ot collection policy change and/or co-payments waived? I or cost reporting period? If Description	during this co If yes, see inst f yes, see inst Y/N	art A Date	Y N N Part B Y/N	13. 14. 15.
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric	ot collection policy change and/or co-payments waived? I or cost reporting period? If Description	during this co f yes, see inst f yes, see inst Pa Y/N 1.00	art A Date	Y N N Part B Y/N 3.00	13 14 15
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26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 26.00 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 29.00 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
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27. 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27. 0 Interest Expense 28. 00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28. 00 29. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 29. 0 30. 00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30. 0 31. 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31. 0 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32. 0 33. 00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33. 0
copy.Interest Expense28.00Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.28.0029.00Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions29.0030.00Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.30.0031.00Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.31.0032.00Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.32.0033.00If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.33.00
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 29.00 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 11.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 29.0 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30.0 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 22.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.0 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
treated as a funded depreciation account? If yes, see instructions 30.00 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 30.00 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
instructions. instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00
instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.0 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.0
 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.
arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.0 no, see instructions.
no, see instructions.
,
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.0
physicians during the cost reporting period? If yes, see instructions.
Y/N Date
1.00 2.00
Home Office Costs
36.00Were home office costs claimed on the cost report?36.037.00If line 36 is yes, has a home office cost statement been prepared by the home office?37.0
If yes, see instructions.
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of 38.0
the provider? If yes, enter in column 2 the fiscal year end of the home office.
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.0
i nstructi ons.
1.00
1.00 2.00 Cost Report Preparer Contact Information 1.00 2.00
I. 00 I. 00 I. 00 I. 00 I. 00 Cost Report Preparer Contact Information 41. 00 Enter the first name, I ast name and the title/position LUCIA GERBER 41.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, LUCIA GERBER 41.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. LUCIA GERBER 41.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. LUCIA GERBER 41.00 42.00 Enter the employer/company name of the cost report BLUE AND CO., LLC 42.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. LUCIA GERBER 41.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/20/2015 3:4	pared:
		Part B					
		Date					
	DC*D Data	4.00					
16.00	PS&R Data Was the cost report prepared using the PS&R						16.00
18.00	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 instructions)						18.00
17.00	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)	04/12/2015					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
			2	. 00	_		
	Cost Report Preparer Contact Information		5				
41.00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		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	SCHNECK MEDI		CON 1500/5		eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider	CCN: 150065	Period: From 01/01/2014 To 12/31/2014		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
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)	30. 00	86				1. 00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						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		86	31, 3	90 0.00	0 0 0	5.00 6.00 7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	7	2, 5	55 0.00	0	8.00
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	43.00	93	33, 94	45 0.00	0 0 0	13.00 14.00 15.00 16.00 17.00
18.00 19.00 20.00 21.00	SUBPROVIDER SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						17.00 18.00 19.00 20.00 21.00
22. 00 23. 00 24. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	101. 00 116. 00	С		0	0	22. 00 23. 00 24. 00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24.10 25.00 26.00
26.25 27.00 28.00 29.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips		93			о	26.25 27.00 28.00 29.00
30.00 31.00 32.00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)		C		0		30.00 31.00 32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32. 01 33. 00

HOSPI 1	IFINANCIAL SYSTEMS TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/20/2015 3:4	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	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, 888	911	11, 271	7.00	10.00	1.00
2.00	HMO and other (see instructions)	74	1, 965				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	269	0	269			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	209			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 157	911	11, 749			7.00
8.00	INTENSIVE CARE UNIT	553	107	1, 322			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		141	1, 746			13.00
14.00	Total (see instructions)	5, 710	1, 159	14, 817	0.00	668.14	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER – IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5, 083	418	8, 532	0.00	23.63	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE	0	0	-		0.00	
24.10	HOSPICE (non-distinct part)	8, 474	306	9, 274			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				0.00	(04 77	26.25
27.00	Total (sum of lines 14-26)		225	1 / 17	0.00	691.77	
28.00 29.00	Observation Bed Days	0	235	1, 617			28.00 29.00
	Ambulance Trips	0		144			30.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF			146 0			30.00
		0	А	10			31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	4	10			32.00
JZ. UI	outpatient days (see instructions)						32.01
22.00	LTCH non-covered days	0					33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Prep 5/20/2015 3:48	
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid 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, 24	41 368	3, 416	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				20 0		2.00 3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						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, 24	41 368	3, 416	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

	Financial Systems AL WAGE INDEX INFORMATION		SCHNECK MEDI		F	eriod: rom 01/01/2014 o 12/31/2014	worksheet S-3 Worksheet S-3 Part II Date/Time Prep 5/20/2015 3:48	pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200.00	48, 302, 765	0	48, 302, 765	1, 513, 469. 54	31. 92	1.00
2.00	instructions) Non-physician anesthetist Part		O	0	0	0.00	0. 00	2.00
	A			_				
3.00	Non-physician anesthetist Part B		0	696, 001	696, 001	8, 817. 00	78. 94	3.00
4.00	Physician-Part A -		202, 412	0	202, 412	1, 230. 00	164. 56	4.00
4.01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		6, 151, 498	0	6, 151, 498			
5.00 7.00	Non-physician-Part B Interns & residents (in an	21.00	0	0	0	0.00 0.00		
7.00	approved program)	21.00	0			0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
B. 00	programs) Home office personnel		0	_	_	0.00	0. 00	8.00
9.00	SNF	44.00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		5, 862, 944	937	5, 863, 881	140, 669. 51	41.69	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient		345, 207	0	345, 207	5, 764. 98	59.88	11.00
12.00	Care Contract Labor: Top Level		0	о	0	0.00	0.00	12.00
	management and other management and administrative services							
13.00	Contract Labor: Physician-Part		393, 270	0	393, 270	2, 456. 98	160. 06	13.00
14.00	A - Administrative Home office salaries &		O	о	0	0.00	0.00	14.00
15 00	wage-related costs				0		0.00	45 00
15.00	Home office: Physician Part A - Administrative		U	0	0	0.00	0.00	15.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS		11 0// 005		11 0// 005			
17.00	Wage-related costs (core) (see instructions)		11, 066, 335	0	11, 066, 335			17.00
18.00	Wage-related costs (other)		C	0	0			18.00
19.00	(see instructions) Excluded areas		1, 620, 996	0	1, 620, 996			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21.00	A Non-physician anesthetist Part		115, 929	о	115, 929			21.00
22.00	B Physician Part A -		9, 336	0	9, 336			22.00
	Admi ni strati ve		.,		.,			
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 542, 228	0	0 542, 228			22.01 23.00
24.00	Wage-related costs (RHC/FQHC)		012, 220	0	0 12, 220			24.00
25.00	Interns & residents (in an		0	0	0			25.00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	S		I	I			
26.00	Employee Benefits Department	4.00	480, 016					26.00
27.00 28.00	Administrative & General Administrative & General under	5.00	6, 716, 374 615, 668		6, 716, 374 615, 668			27.00 28.00
20.00	contract (see inst.)		015,000		015,000	2, 520. 77	243.47	28.00
29.00	Maintenance & Repairs	6.00	0	0	1 020 (05			29.00
30.00 31.00	Operation of Plant Laundry & Linen Service	7.00 8.00	1, 028, 685 49, 001		1, 028, 685 49, 001			30.00 31.00
	Housekeepi ng	9.00	800, 676		800, 676			32.00
33.00	Housekeeping under contract		C	0	0	0.00		33.00
34.00	(see instructions) Dietary	10.00	661, 980	-406, 559	255, 421	16, 133. 79	15. 83	34.00
	Dietary under contract (see		0	0	0	0.00		35.00
36. 00	i nstructi ons) Cafeteri a	11.00	0	406, 559	406, 559	25, 749. 00	15. 79	36.00
	Maintenance of Personnel	12.00	0	400, 559	400, 559	25, 749.00		37.00
57.00 j								
	Nursing Administration Central Services and Supply	13.00 14.00	2, 608, 792 419, 512		2, 607, 855 419, 512			38.00 39.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2014		
					o 12/31/2014	Date/Time Pre 5/20/2015 3:48	
	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	$(col.2 \pm col.)$	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	16.00	916, 230	0	916, 230	44, 573. 84	20. 56	41.00
Records Library							
42.00 Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00 Other General Service	18.00	212, 570	0	212, 570	5, 536. 00	38.40	43.00

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Li€	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3	
						To 12/31/2014		oared:
							5/20/2015 3:4	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col	Salaries in	col. 5)	
				Worksheet A-6)	,	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		42, 766, 935	-696, 001	42, 070, 93	4 1, 471, 668. 31	28. 59	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 862, 944	937	5, 863, 88	1 140, 669. 51	41.69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		36, 903, 991	-696, 938	36, 207, 05	3 1, 330, 998. 80	27.20	3.00
	minus line 2)							
4.00	Subtotal other wages & related		738, 477	0	738, 47	7 8, 221. 96	89.82	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 075, 671	0	11, 075, 67	1 0.00	30. 59	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		48, 718, 139	-696, 938	48, 021, 20	1 1, 339, 220. 76	35.86	6.00
7.00	Total overhead cost (see		15, 581, 703	-937	15, 580, 76	6 551, 006. 66	28. 28	7.00
	instructions)							

Heal th	Financial Systems	SCHNECK MEDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN: 1	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-3 Part IV Date/Time Pre 5/20/2015 3:43	pared:
						Amount Reported	
						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 Contrib					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	tructions)				1, 207, 748	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	n				0	6.00
7.00	Employee Managed Care Program Administration	Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					7, 954, 930	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or bene	fi ci ary)				77, 730	11.00
12.00	Accident Insurance (If employee is owner or					0	12.00
13.00	Disability Insurance (If employee is owner c					404, 479	
14.00	Long-Term Care Insurance (If employee is own	er or beneficiary))			10, 937	
15.00	'Workers' Compensation Insurance					343, 483	
16.00	Retirement Health Care Cost (Only current ye	ar, not the extra	ordinary accrual r	requi red	by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					3, 021, 775	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
	Unemployment Insurance					0	19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost Re	eported on lines 1	through	4 above. (see	0	21.00
	Day Care Cost and Allowances					0	
23.00	Tuition Reimbursement					333, 742	
24.00	Total Wage Related cost (Sum of lines 1 -23)					13, 354, 824	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150065	Peri od:	Worksheet S-3	
		From 01/01/2014		
		To 12/31/2014		
Cost Center Description		Contract Labor	5/20/2015 3:4 Benefit Cost	8 pili I
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Ider	nti fi cati on:			1
1.00 Total facility's contract labor and benef	it cost	0	0	1.00
2.00 Hospital		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			1	8.00
9.00 Hospital-Based NF				9.00
10.00 Hospi tal -Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 Separately Certified ASC				12.00
13.00 Hospi tal -Based Hospi ce		0	0	13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospi tal -Based-CMHC				16.00
17.00 Renal Dialysis				17.00
18.00 Other		0	0	18.00

	Financial Systems IEALTH AGENCY STATISTICAL DATA	SCHNECK MEDI			Period:	eu of Form CMS-: Worksheet S-4	
			Componen		rom 01/01/2014 o 12/31/2014 Home Health		
					Agency I		
0.00	Country				1.	00	0.00
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	0	C		0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		0.00	0.00	0.00	
				Number of Empl	loyees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
				1.00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		0	1.00	2.00	3.00	-
3.00	Administrator and Assistant Administrator(s)		0.00				
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00			
6.00	Direct Nursing Service			0.00			
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.00			
9.00	Physical Therapy Supervisor			0.00			
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0.00			1
12.00	Speech Pathol ogy Servi ce			0.00			
13.00	Speech Pathology Supervisor			0.00			
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0.00			1
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.00			1
16.00	HOME HEALTH AGENCY CBSA CODES			0.00	0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost			3	8		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			18020			20.00
	contains the first code).						
20.01				99915			20.01
20. 02		Full Ep	oi sodes	31140			20.02
		Without	With Outliers	LUPA Epi sodes		Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4.00	1-4) 5.00	
21 00	PPS ACTIVITY DATA Skilled Nursing Visits	1 / 0/	4	126		1, 794	21 00
21. 00 22. 00	Skilled Nursing Visit Charges	1, 626 351, 978					
23.00	Physical Therapy Visits	1, 407	12	35	5 18	1, 472	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	376, 482				392, 671 1, 156	1
26.00	Occupational Therapy Visit Charges	313, 445					
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	70 19, 950			2 5 1, 383	91	
28.00 29.00	Medical Social Service Visits	19,950		570 0		25, 893 14	1
30.00	Medical Social Service Visit Charges	4, 559			, j	4, 911	
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	552 72, 399				556 72, 939	
33.00	Total visits (sum of lines 21, 23, 25, 27,	4, 775					
34.00	29, and 31) Other Charges	0	c		0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	1, 138, 813		-	-		
	30, 32, and 34) Total Number of Episodes (standard/non	285		45	5	335	36.00
36.00							
36.00 37.00	outlier) Total Number of Outlier Episodes		1		0	1	37.00

	Financial Systems SCHNECK MEDI		CCN: 150065		ri od:	u of Form CMS-2 Worksheet S-7	
				Fro To	om 01/01/2014 12/31/2014	Date/Time Pre 5/20/2015 3:4	pared: 8 pm
					1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all pa or was there no Medicare utilization? Enter "Y" for yes in complete the rest of this worksheet. Does this hospital have an agreement under either section 1 swing beds? Enter "Y" for yes or "N" for no in column 1. I	column 1 and d 883 or section	o not 1913 for			2.00	1.00 2.00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days		Swing Bed SNF	Total (sum of	
		1.00	2.00		Days 3. 00	<u>col. 2 + 3)</u> 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	0	6.00
7.00 8.00		RHX RHL		0	0	0	7.00 8.00
9.00		RMX		0	0	0	1
10.00 11.00		RML RLX		0 0	0	0	10.00
12.00		RUC		0	0	0	12.00
13.00 14.00		RUB RUA		0 0	0	0	13.00 14.00
15.00		RVC		0	0	0	14.00
16. 00 17. 00		RVB RVA		0 0	0 0	0	16.00 17.00
17.00		RHC		0	0	0	17.00
19.00		RHB		0	0	0	
20.00 21.00		RHA RMC		0 0	0	0	20.00
22.00		RMB		0	0	0	22.00
23.00 24.00		RMA RLB		0 0	0	0	23.00 24.00
25.00		RLA		0	0	0	25.00
26.00		ES3		0 0	0	0	26.00
27.00 28.00		ES2 ES1		0	0	0	27.00 28.00
29.00		HE2		0	0	0	29.00
30.00 31.00		HE1 HD2		0 0	0	0	30.00
32.00		HD1		0	0	0	32.00
33.00 34.00		HC2 HC1		0 0	0	0	33.00 34.00
35.00		HB2		0	0	0	35.00
36.00 37.00		HB1 LE2		0 0	0 0	0	36.00 37.00
38.00		LE1		0	0	0	
39.00		LD2		0	0	0	39.00
40.00 41.00		LD1 LC2		0 0	0 0	0	40.00
42.00		LC1		0	0	0	1
43.00 44.00		LB2 LB1		0 0	0 0	0	43.00 44.00
45.00		CE2		0	0	0	45.00
46.00 47.00		CE1 CD2		0 0	0 0	0	46.00 47.00
48.00		CD1		0	0	0	48.00
49.00 50.00		CC2 CC1		0 0	0 0	0	49.00 50.00
51.00		CB2		0	0	0	51.00
52.00		CB1		0	0	0	52.00
53.00 54.00		CA2 CA1		0 0	0 0	0	53.00 54.00
55.00		SE3		0	0	0	55.00
56.00 57.00		SE2 SE1		0 0	0	0	56.00 57.00
58.00		SSC		0	0	0	58.00
59.00 60.00		SSB SSA		0 0	0 0	0	59.00 60.00
61.00		I B2		0	0	0	61.00
62.00		IB1		0 0	0	0	62.00
63.00 64.00		I A2 I A1		0	0 0	0	63.00 64.00
65.00		BB2		0	0	0	65.00
66.00		BB1		0	0	0	66.00
67.00		BA2		0	0	0	67.00

Health Financial Systems SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Worksheet S-7	,
			10 12/31/2014	5/20/2015 3:4	
	Group	SNF Days		Total (sum of	
			Days	col. 2 + 3)	
	1.00	2.00	3.00	4.00	
69.00	PE2		0 0	-	
70.00	PE1		0 0	-	
71.00	PD2		0 0	0	
72.00	PD1		0 0	0	
73.00	PC2		0 0	0	
74.00	PC1 PB2		0 0	0	
75.00	PB2 PB1		0 0	0	
76.00	PBT PA2		0 0	0	
77. 00 78. 00	PA2 PA1		0 0	0	
199.00	AAA		0 269	-	199.00
200. 00 TOTAL	AAA		0 269		200.00
			CBSA at	CBSA on/after	200.00
			Begi nni ng of	October 1 of	
			Cost Reporting		
			Peri od	Reporting	
				Period (if	
				applicable)	
			1.00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBS			99915	99915	201.00
in effect at the beginning of the cost reporting period. E					
in effect on or after October 1 of the cost reporting perio	od (if applicat				
		Expenses	Percentage	Associated	
				with Direct	
				Patient Care and Related	
				Expenses?	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No.	149 August 4 - 2				
payments beginning 10/01/2003. Congress expected this incre					
expenses. For lines 202 through 207: Enter in column 1 the					
column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" for	no if the spe	nding reflec	ts increases asso	oci ated	
with direct patient care and related expenses for each cate	egory. (see ins	tructions)			
202.00 Staffing			0 0.00		202.00
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
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0	I	207.00

Heal th	n Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI	TAL IDENTIFICATION DATA			Provi der	CCN: 150065	Period:	Worksheet S-9	
						From 01/01/2014		
				Component	CCN: 151529	To 12/31/2014		
						Hospi ce I	5/20/2015 3:48	s pm
		Unduplicated				HUSPICE I		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
			II LIE AIA	Skilled	Nursing	All other	col s. 1, 2 &	
				Nursing	Facility		5)	
				Facility	l		0)	
		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, 410	289	641	1!	54 161	8, 860	2.00
3.00	Inpatient Respite Care	21	3	0		3 8	32	3.00
4.00	General Inpatient Care	67	14	0		0 5	86	4.00
5.00	Total Hospice Days	8, 498	306	641	1!	57 174	8, 978	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	193	6	18		2 20	219	6.00
	Hospice Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	44.03	51.00	35.61	78. !	50 8.70	41.00	8.00
	5/line 6)	100						
9.00	Unduplicated Census Count	180	6	16		2 20	206	9.00

Heal th	Financial Systems SCHNECK MEDICAL	L CENTER		In Lie	u of Form CMS-:	2552-10
HOSPI TA	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider (Peri od:	Worksheet S-1	0
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre	narod
				10 12/31/2014	5/20/2015 3:4	
					4.00	
	Uncompensated and indigent care cost computation				1.00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	e 202 column	8)	0. 344259	1.00
	Medicaid (see instructions for each line)	I vided by III		0)	0. 344239	1.00
	Net revenue from Medicaid				11, 165, 081	2.00
	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
	If line 3 is "yes", does line 2 include all DSH or supplement.	al payments f	rom Medicaid	2	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fr	om Medicaid			2, 158, 643	5.00
6.00	Medi cai d charges				37, 478, 815	6.00
	Medicaid cost (line 1 times line 6)				12, 902, 419	
	Difference between net revenue and costs for Medicaid program	(line 7 minu	s sum of line	es 2 and 5; if	0	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruc	ctions for ea	ch line)			
	Net revenue from stand-al one SCHIP				0	
	Stand-alone SCHIP charges				0	
	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHI	D (line 11 mi		f . Tono thon	0	
	enter zero)		nus inte 9, i	I < Zel O then	0	12.00
	Other state or local government indigent care program (see in:	structions fo	r each line)			
	Net revenue from state or local indigent care program (Not in			1	0	13.00
	Charges for patients covered under state or local indigent ca				0	14.00
	10)					
	State or local indigent care program cost (line 1 times line				0	•
	Difference between net revenue and costs for state or local i	ndigent care	program (line	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)	Currell and the set	+		25.000	1 17 00
	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of				35, 203 28, 500	•
	Total unreimbursed cost for Medicaid , SCHIP and state and Io			(sum of lines	28, 500	•
	8, 12 and 16)	car murgent		s (sum of filles	0	19.00
			Uni nsured	Insured	Total (col. 1	
		Ļ	patients	pati ents	+ col. 2)	
00.00			1.00	2.00	3.00	00.00
20.00	Total initial obligation of patients approved for charity can charges excluding non-reimbursable cost centers) for the enti		2, 549, 76	1, 694, 603	4, 244, 367	20.00
21.00	Cost of initial obligation of patients approved for charity c		877, 77	583, 382	1, 461, 161	21.00
	times line 20)		077,77	505, 502	1, 401, 101	21.00
	Partial payment by patients approved for charity care		16, 51	150, 005	166, 521	22.00
	Cost of charity care (line 21 minus line 22)		861, 26		1, 294, 640	23.00
					1.00	
	Does the amount in line 20 column 2 include charges for patie		d a length of	°stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent car			с. н. н. н.		05 00
	If line 24 is "yes," charges for patient days beyond an indi-		gram's length	i or stay limit	0	
	Total bad debt expense for the entire hospital complex (see i Medicare bad debts for the entire hospital complex (see instr				53, 794	
	Non-Medicare and non-reimbursable Medicare bad debt expense (,	line 27)		-53, 794	
						•
27.00	Cost of non-Medicare and non-reimbursable Medicare had debt e	xnense (line	1 times line	28)	_18 510	29 00
	Cost of non-Medicare and non-reimbursable Medicare bad debt e Cost of uncompensated care (line 23 column 3 plus line 29)	xpense (line	1 times line	28)	-18, 519 1, 276, 121	•

02/10	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provi der		Period: From 01/01/2014	Worksheet A	
					Го 12/31/2014	Date/Time Pre 5/20/2015 3:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
~ ~	GENERAL SERVICE COST CENTERS	T T	0.400.005			5 (50 (70	
00 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP		8, 432, 995 0	8, 432, 995 (
00	00300 OTHER CAPITAL RELATED COSTS		0	(
00	00400 EMPLOYEE BENEFITS DEPARTMENT	480, 016	13, 599, 885	14, 079, 901	-77	14, 079, 824	
00	00500 ADMINI STRATI VE & GENERAL	6, 716, 374	12, 963, 031	19, 679, 405			
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 028, 685 49, 001	1, 998, 982 262, 865	3, 027, 667 311, 866			
00	00900 HOUSEKEEPING	800, 676	258, 929	1, 059, 605			
. 00	01000 DI ETARY	661, 980	568, 336	1, 230, 316			
. 00	01100 CAFETERI A	0	0	(,		
. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 608, 792 419, 512	572, 988 5, 428, 121	3, 181, 780 5, 847, 633			
. 00	01500 PHARMACY	1, 072, 199	7, 610, 438	8, 682, 637			
. 00	01600 MEDICAL RECORDS & LIBRARY	916, 230	226, 582	1, 142, 812			
	01850 PHYSICIAN PRIVATE PRACTICE	212, 570	531	213, 101		213, 101	
. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	(696, 001	696, 001	19.
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	5, 948, 514	1, 441, 136	7, 389, 650	- 1, 866, 755	5, 522, 895	30. (
. 00	03100 I NTENSI VE CARE UNI T	885, 130	166, 665	1, 051, 795			
. 00	04300 NURSERY	0	331	331			
	ANCI LLARY SERVI CE COST CENTERS						
0. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2, 488, 162	2, 706, 755	5, 194, 917			
. 00	05200 DELIVERY ROOM & LABOR ROOM	408, 330	23, 501 0	431, 831		427, 690 1, 123, 556	
. 00	05300 ANESTHESI OLOGY	2, 777, 777	181, 105	2, 958, 882			
. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 162, 948	1, 317, 017	3, 479, 965		3, 418, 810	54.
. 01	03630 ULTRA SOUND	247, 253	42, 912	290, 165			
. 02 . 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	95, 528 231, 670	170, 936 440, 173	266, 464 671, 843			
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	114, 679	199, 772	314, 451			
. 00	06000 LABORATORY	1, 414, 192	2, 855, 880	4, 270, 072			
. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	378, 653	378, 653		378, 653	
. 00	06400 I NTRAVENOUS THERAPY	211, 799	18, 762	230, 561			
. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	788, 320 935, 250	209, 277 32, 922	997, 597 968, 172		847, 032 959, 031	
. 00	06700 OCCUPATI ONAL THERAPY	269, 870	6, 723	276, 593			
. 00	06800 SPEECH PATHOLOGY	193, 370	3, 978	197, 348			
. 00	06900 ELECTROCARDI OLOGY	90, 452	153, 247	243, 699			
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0 0	(
	07300 DRUGS CHARGED TO PATIENTS	0	0		6, 183, 104		
	03952 WOUND CARE	157, 177	50, 006	207, 183			
. 02	03951 CASE MANAGEMENT	366, 676	9, 158	375, 834			
	03950 PALN MANAGEMENT 07697 CARDI AC REHABI LI TATI ON	1, 120, 083 381, 250	113, 000 13, 240	1, 233, 083			
0. 97	OUTPATIENT SERVICE COST CENTERS	301,230	13, 240	394, 490	J -1, 994	392, 490	76.
. 00	04953 OTHER OUTPATIENT SERVICE COST CENTER	41, 758	3, 676	45, 434	4 -514	44, 920	90.
. 01	04951 PALLI ATI VE HEALTH	96, 382	3, 584	99, 966			
	09000 VEIN CENTER	273, 781	55, 236	329, 017			
0. 03 . 00	09001 OB GYN 09100 EMERGENCY	2, 131, 404 3, 484, 208	350, 200 525, 214	2, 481, 604 4, 009, 422			
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,404,200	525, 214	4,007,422	-/4,23/	3, 733, 103	92.
. 00	04952 BEHAVOURAL HEALTH	157, 823	11, 378	169, 201	3, 635	172, 836	
	OTHER REIMBURSABLE COST CENTERS						
01. OC	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	919, 312	149, 709	1, 069, 021	1 3, 034	1, 072, 055	101.
3.00	11300 INTEREST EXPENSE		1, 564, 137	1, 564, 137	7 -1, 564, 137	0	113.
	11600 HOSPI CE	576, 596	212, 281	788, 877			
8.00		43, 935, 729	65, 334, 247	109, 269, 976	5 286, 968	109, 556, 944	118.
	NONREI MBURSABLE COST CENTERS		0				100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 2, 814, 776	0 271, 936	(3, 086, 712			190. 192
	07950 WELLNESS	2, 814, 778	271, 938 20, 574	3,086,712 61,582			
	07951 PALN MANAGEMENT	0	20, 374	01, 302			194.
4. 02	07952 EXTERNAL SVCS MARKETING	164, 918	675, 918	840, 836		840, 836	194.
	07953 WASHINGTON CLINIC	170, 743	1, 394	172, 137		172, 137	
	07954 PHYSICIAN OFFICES	697, 540	160, 359 165, 076	857, 899			
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	285, 613 192, 438	165, 076 47, 860	450, 689 240, 298			
	TOTAL (SUM OF LINES 118-199)		. , , 000	210,270	1,200	114, 980, 129	

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (SCHNECK MEDI	CAL CENTER Provider CCN:	150065 Period: Wo	f Form CMS-2552-10 vrksheet A
				te/Time Prepared:
Cost Center Description	Adjustments	Net Expenses	57	20/2015 3:48 pm
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-527, 644			1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 3.00 00300 OTHER CAPITAL RELATED COSTS	0			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-547			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-2, 010, 392			5.00
7.00 00700 OPERATION OF PLANT	0			7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0			8.00 9.00
10. 00 01000 DI ETARY	-394	472, 297		10.00
11. 00 01100 CAFETERIA	-398, 180			11.00
13.00 01300 NURSING ADMINISTRATION	0	3, 180, 843		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	-38, 198			15.00 16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	-30, 198	213, 101		18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	-696, 001	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS	1			
30. 00 03000 ADULTS & PEDIATRICS	-1, 022			30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0			31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	0	230, 330		43.00
50. 00 05000 OPERATING ROOM	-649, 100	3, 519, 885		50.00
51.00 05100 RECOVERY ROOM	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	., .==, ===		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	-2, 081, 776			53.00 54.00
54. 01 03630 ULTRA SOUND	-377, 353			54.00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	148, 174		54.02
57.00 05700 CT SCAN	0			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
60.00 06000 LABORATORY	-69, 700			60.00 63.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY	0	378, 653 221, 837		64.00
65. 00 06500 RESPI RATORY THERAPY	-119			65.00
66. 00 06600 PHYSI CAL THERAPY	0	959, 031		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0			67.00
	0			68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-3, 469			69.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 183, 104		73.00
76.00 03952 WOUND CARE	0			76.00
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	-366, 435			76.02
76. 97 07697 CARDIAC REHABILITATION	-483, 269			76. 03 76. 97
OUTPATIENT SERVICE COST CENTERS		0,2,1,0		/ / / / /
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0			90.00
90. 01 04951 PALLI ATI VE HEALTH	-1, 938			90.01
90. 02 09000 VELN CENTER 90. 03 09001 0B GYN	-154, 443 -1, 612, 745			90. 02 90. 03
91. 00 09100 EMERGENCY	-1, 621, 526			90.03
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 021, 020	2,010,007		92.00
93. 00 04952 BEHAVOURAL HEALTH	0	172, 836		93.00
OTHER REIMBURSABLE COST CENTERS		4 074 055		
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	-200	1, 071, 855		101.00
113. 00 11300 INTEREST EXPENSE	0	0		113.00
116. 00 11600 HOSPI CE	-140			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-11, 094, 591	98, 462, 353		118.00
NONREI MBURSABLE COST CENTERS	-			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES		2, 955, 591		192.00
194. 01 07951 PALN MANAGEMENT	0	0		194.01
194. 02 07952 EXTERNAL SVCS MARKETING	0	840, 836		194.02
194. 03 07953 WASHI NGTON CLI NI C	0	172, 137		194.03
194. 04 07954 PHYSI CLAN OFFI CES	0	828, 702		194. 04 194. 05
194. 05 07955 I NTEGRATED MEDI CI NE 194. 06 07956 SURGI CAL PROFESSI ONAL		331, 260 236, 035		194.05
200.00 TOTAL (SUM OF LINES 118-199)	-11, 094, 591			200.00
				1

Financial Systems SIFICATIONS		SCHNECK MEDIC		CCN: 150065	Period: From 01/01/2014 To 12/31/2014	u of Form CMS-255 Worksheet A-6 Date/Time Prepar 5/20/2015 3:48 p
Cost Center	Increases	Colony	Other		- I	372072013 3.40
2. 00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
A - CAFETERIA CAFETERIA	11.00	406, 559	349, 047			
	<u></u>	406, 559	<u>349,047</u> 349,047			
B - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	E 240 260			
PATIENTS			5, 349, 260			
O O		0	5, 349, 260			
MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	4, 454, 439			
	0.00 0.00	0	0 0			
	0.00	0	0			
	0.00 0.00	0	0 0			
	0.00	0	0			
	0.00	0	0			
	0.00 0.00	0	0 0			1
	0.00	0	0			1
	0.00 0.00	0	0			1
	0.00	0	0			1
	0.00 0.00	0	0			1
	0.00	0	0			1
	0.00 0.00	0	0 0			1
	0.00	0	0			2
	0.00 0.00	0	0 0			2
	0.00	0	0			2
	0.00 0.00	0	0 0			2
	0.00	0	0			2
	0.00	0	0			2
	0.00 0.00	0	0 0			2
	0.00	0	0			3
	0.00 0.00	0	0			3
	0.00	0	0			3
	0.00 0.00	0	0			3
$\square _ _ _ _ _ _$	0.00	0	0			3
O E - DRUGS CHG PATIENTS DRUGS CHARGED TO PATIENTS	73.00	0	4, 454, 439 6, 183, 104			
DRUGS CHARGED TO PATTENTS	0.00	0	0, 183, 104			
	0.00 0.00	0	0 0			
	0.00	0	0			
	0.00	0	0			
	0.00 0.00	0	0 0			
	0.00	0	0			
	0.00 0.00	0	0			1
	0.00	0	0			1
	0.00 0.00	0	0 0			1
0		0	6, 183, 104			
NEW CAP REL COSTS-BLDG &	1.00	0	2, 036			
0 H - PROPERTY INSURANCE		0	2,036			
NEW CAP REL COSTS-BLDG &	1.00	0	110, 622			
NEW CAP REL COSTS-MVBLE	2.00	О	58, 292			
EQUI P	+					

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

SCHNECK MEDICAL CENTER

Provider CCN: 150065

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/20/2015 3:48 pm

					10	12/ 31/ 2014	5/20/2015 3:48 pm
		Increases					
	Cost Center	Line #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
1.00	I - BIO-MED EMPLOYEE BENEFITS DEPARTMENT	4.00	0	122			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	825			2.00
3.00	HOUSEKEEPING	9.00	0	68			3.00
4.00	DI ETARY	10.00	Ö	662			4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	8, 896			5.00
6.00	PHARMACY	15.00	О	1, 352			6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	203			7.00
8.00	ADULTS & PEDIATRICS	30.00	0	108, 707			8.00
9.00	INTENSIVE CARE UNIT	31.00	0	22, 154			9.00
10.00	NURSERY	43.00	0	8, 304			10.00
11.00	OPERATING ROOM	50.00	0	97, 123			11.00
12.00	ANESTHESI OLOGY	53.00	0	16, 763			12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	11, 425			13.00
14.00 15.00	ULTRA SOUND NUCLEAR MEDICINE -	54.01 54.02	0	1, 324 404			14.00 15.00
15.00	DI AGNOSTI C	54.02	0	404			15.00
16.00	CT SCAN	57.00	0	662			16.00
17.00	MAGNETIC RESONANCE IMAGING	58.00	o	1, 646			17.00
	(MRI)			.,			
18.00	LABORATORY	60.00	0	11, 550			18.00
19.00	INTRAVENOUS THERAPY	64.00	0	4, 655			19.00
20.00	RESPI RATORY THERAPY	65.00	0	25, 676			20.00
21.00	PHYSI CAL THERAPY	66.00	0	10, 435			21.00
22.00	OCCUPATI ONAL THERAPY	67.00	0	1, 352			22.00
23.00	ELECTROCARDI OLOGY	69.00	0	2, 177			23.00
24.00	WOUND CARE	76.00	0	297			24.00
25.00	CASE MANAGEMENT	76.02	0	8, 747			25.00
26.00	CARDI AC REHABI LI TATI ON	76.97	0	2, 987			26.00
27.00 28.00	VEIN CENTER OB GYN	90. 02 90. 03	0	6, 384 25, 973			27.00 28.00
28.00	BEHAVOURAL HEALTH	90. 03 93. 00	0	23, 973			28.00
30.00	HOME HEALTH AGENCY	101.00	0	2, 097			30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	487			31.00
32.00	WELLNESS	194.00	o	1, 428			32.00
33.00	PHYSICIAN OFFICES	194.04	0	136			33.00
34.00	INTEGRATED MEDICINE	194.05	0	584			34.00
	0			389, 250			
	J - DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	4, 459, 318			1.00
	EQUI P		+				
			0	4, 459, 318			
1 00	K - BOND INTEREST EXP	1.00		4 5 (4 4 9 7			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 564, 137			1.00
	FIXT	+	— — — ₀	1, 564, 137			
	N - NURSERY		U	1, 304, 137			
1.00	NURSERY	43.00	249, 723	0			1.00
			249, 723	— — <u> </u>			
	0 - LABOR AND DELIVERY	I					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 123, 556	0			1.00
	0	T	1, 123, 556	ī			
	P - CRNA						
1.00	NONPHYSI CLAN ANESTHETI STS		<u> </u>	0			1.00
	0		696, 001	0			
	Q - HHA MSW	1		1			
1.00	HOME HEALTH AGENCY	<u> </u>	937	0			1.00
			937	0			
1 00	R - IMPLANTABLE DEVICES	70.00		0 (74 000			
1.00	IMPL. DEV. CHARGED TO	72.00	0	2, 671, 823			1.00
	PATI ENT	+		2,671,823			
500 00	Grand Total: Increases		2, 476, 776	25, 591, 328			500.00
000.00		1	2, 110, 110	20, 071, 020			1 300.00

	Financial Systems		SCHNECK MEDIC		CON- 1500/F		u of Form CMS	
REULAS	SI FI CATI ONS			Provi der	- CCN: 150065	Period: From 01/01/2014	Worksheet A-	
						To 12/31/2014	Date/Time Pr 5/20/2015 3:	
	Cont Conton	Decreases	Cal arriv			1		
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00			
	A - CAFETERIA	7.00	0.00	7.00	10.00			
1.00	DI ETARY		406, 559	349, 047		0		1.00
			406, 559	349, 047				_
1.00	B - MEDI CAL SUPPLI ES CENTRAL SERVI CES & SUPPLY	14.00	0	5, 349, 260		0		1.00
1.00			0	5, 349, 260	<u> </u>			1.00
	C - BILLIABLE SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	199		0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	275		0		2.00
3.00 4.00	DI ETARY PHARMACY	10. 00 15. 00	0	2, 681 141, 628		0		3.00
5.00	ADULTS & PEDIATRICS	30.00	0	602, 183		0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	122, 477		o		6.00
7.00	OPERATING ROOM	50.00	0	1, 123, 055		0		7.00
8.00 9.00	RECOVERY ROOM	51.00 53.00	0	4, 141 402		0		8.00 9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	61, 497		0		10.00
11.00	ULTRA SOUND	54.01	0	19, 149		0		11.00
12.00	NUCLEAR MEDICINE -	54.02	О	186		0		12.00
12 00	DI AGNOSTI C	57.00	0	70 (51				12.00
13.00 14.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00	0	78, 651 3, 879		0		13.00
14.00	(MRI)	50.00	0	5, 677				14.00
15.00	LABORATORY	60.00	0	1, 427, 783		o		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	13, 379		0		16.00
17.00		65.00	0	165, 908		0		17.00
18.00 19.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00	0	19, 576 5, 864		0		18.00 19.00
20.00	SPEECH PATHOLOGY	68.00	0	1, 634		0		20.00
21.00	ELECTROCARDI OLOGY	69.00	0	19, 732		o		21.00
22.00	WOUND CARE	76.00	0	2, 317		0		22.00
23.00		76.02	0	1,649		0		23.00
24.00 25.00	PAIN MANAGEMENT CARDIAC REHABILITATION	76. 03 76. 97	0	4, 956 4, 981		ol		24.00 25.00
26.00	OTHER OUTPATIENT SERVICE	90.00	0	514		0		26.00
	COST CENTER							
27.00	VEIN CENTER	90.02	0	3, 011		0		27.00
28.00 29.00	OB GYN EMERGENCY	90. 03 91. 00	0	265, 409 74, 257		0		28.00 29.00
30.00	BEHAVOURAL HEALTH	93.00	0	10		0		30.00
31.00	HOSPICE	116.00	0	9, 382		0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	121, 679		0		32.00
33.00	WELLNESS PHYSICIAN OFFICES	194.00	0	637		0		33.00
34.00 35.00	INTEGRATED MEDICINE	194.04 194.05	0	29, 309 118, 050		0		34.00 35.00
36.00	SURGI CAL PROFESSI ONAL	194.06	0	3, 999		0		36.00
	0		0	4, 454, 439				
1 00	E - DRUGS CHG PATIENTS	15.00		E 070 004	1			1 00
1.00 2.00	PHARMACY RADI OLOGY-DI AGNOSTI C	15.00 54.00	0	5, 878, 924 11, 083		0		1.00
3.00	NUCLEAR MEDICINE -	54.02	0	118, 508		o		3.00
	DI AGNOSTI C							
4.00	CT SCAN	57.00	0	47, 230		0		4.00
5.00	MAGNETIC RESONANCE IMAGING	58.00	0	27, 933		0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	10, 333		o		6.00
7.00	ELECTROCARDI OLOGY	69.00	0	35, 108		0		7.00
8.00	OB GYN	90. 03	0	20, 132		0		8.00
9.00		116.00	0	17, 924		0		9.00
10. 00 11. 00	PHYSICIANS' PRIVATE OFFICES WELLNESS	192.00 194.00		9, 929 3, 749		0		10.00
12.00	PHYSICIAN OFFICES	194.00	0	3, 749		0		12.00
13.00	INTEGRATED MEDICINE	194.05	0	1, 963		0		13.00
14.00	SURGICAL PROFESSIONAL	1 <u>94.</u> 06	0	264		<u>o</u>		14.00
	O F - CAP LEASE - INTEREST		0	6, 183, 104	·			-
1.00	CT SCAN	57.00	0	2, 036	1	1		1.00
	0		— — — <u>o</u>	2,036		1		
	H - PROPERTY INSURANCE				1			
1.00 2.00	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	168, 914	1			1.00
		0.00	U	0	· · · · · · · · · · · · · · · · · · ·	실		∠.00

RECLASSIFICATIONS Provider CCN: 150065 Period: From 01/01/ To 12/31/ - <th></th>	
Decreases Network	
$\begin{tabular}{ c c c c c c } \hline Cost Center & Line # Sal ary & Other Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 \\ \hline 6.00 7.00 8.00 9.00 0 0.00 \\ \hline 0.00 0 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 0 0 \\ \hline 0.00 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 0 \\ \hline 1.00 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 \\ \hline 1.00 0 0 0 0 0 \\ \hline 1.00 0$	
6.00 7.00 8.00 9.00 10.00 1 - BIO-MED 0 389,250 0 2.00 0.00 0 0 0 3.00 0.00 0 0 0 4.00 0.00 0 0 0 5.00 0.00 0 0 0 6.00 0.00 0 0 0 7.00 0.00 0 0 0 7.00 0.00 0 0 0 7.00 0.00 0 0 0 8.00 0.00 0 0 0 9.00 0.00 0 0 0 11.00 0.00 0 0 0 12.00 0.00 0 0 0 13.00 0.00 0 0 0 14.00 0.00 0 0 0 19.00 0.00 0 0 0 <td></td>	
I - BIO-MED 0PERATION OF PLANT 7.00 389,250 0 3.00 0.00 0 0 0 4.00 0.00 0 0 0 5.00 0.00 0 0 0 6.00 0.00 0 0 0 7.00 0.00 0 0 0 8.00 0.00 0 0 0 9.00 0.00 0 0 0 9.00 0.00 0 0 0 11.00 0.00 0 0 0 9.00 0.00 0 0 0 12.00 0.00 0 0 0 13.00 0.00 0 0 0 14.00 0.00 0 0 0 15.00 0.00 0 0 0 19.00 0.00 0 0 0 22.00 0.00 0 </td <td></td>	
1.00 OPERATION OF PLANT 7.00 0 389,250 0 2.00 0.00 0 0 0 0 3.00 0.00 0 0 0 0 4.00 0.00 0 0 0 0 5.00 0.00 0 0 0 0 6.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 11.00 0.00 0 0 0 0 12.00 0.00 0 0 0 0 14.00 0.00 0 0 0 0 19.00 0.00 0	
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32.00 0.00 0 0 0 33.00 0.00 0 0 0 0	30.00
33.00 0.00 0 0	31.00
	32.00
	33.00
	34.00
J - DEPRECIATION	
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 4,459,318 9	1.00
FIXT	
0 0 4,459,318	
K - BOND INTEREST EXP	
1. 00 $ INTEREST EXPENSE 113.00 0 1, 564, 137 11564, 137 11$	1.00
N - NURSERY	
1.00 ADULTS & PEDI ATRI CS 30.00 249, 723 0 0	1.00
	1.00
0 - LABOR AND DELIVERY	
1. 00 ADULTS & PEDIATRICS 30. 001, 123, 556 0 0	1.00
1. 00 <u>ANESTHESI OLOGY</u> <u></u> <u>53. 00</u> <u>696, 001</u> <u>0</u> <u>0</u>	1.00
Q - HHA MSW	
1.00 NURSI NG ADMI NI STRATI ON 13.00 937 0 0	1.00
R - I MPLANTABLE DEVICES	
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 2, 671, 823 0	1.00
0 2, 671, 823 500. 00 Grand Total : Decreases 2, 476, 776 25, 591, 328	500.00
500, 00 joi and 10 tail. Deci eases 2, 470, 770 23, 341, 328	ן 500.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552-			
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150065	Peri Fror To	iod: m 01/01/2014 12/31/2014		pared: 8 pm
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances 1.00	2.00	3.00		4,00	Retirements 5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00		4.00	5.00	
1.00	Land	6, 311, 797	8, 320		0	8, 320	0	1.00
2.00	Land Improvements	6, 311, 797 3, 988, 678	8, 320 30, 750		0	8, 320 30, 750	0	2.00
					0			
3.00	Buildings and Fixtures	78, 286, 932	1, 799, 856		0	1, 799, 856		3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	6, 326, 943	46, 725		0	46, 725	4,090	
6.00	Movable Equipment	48, 582, 255	4, 487, 958		0	4, 487, 958		6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143, 496, 605	6, 373, 609		0	6, 373, 609	2, 152, 918	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	143, 496, 605	6, 373, 609		0	6, 373, 609	2, 152, 918	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	6, 320, 117	0					1.00
2.00	Land Improvements	4, 019, 428	0					2.00
3.00	Buildings and Fixtures	80, 031, 280	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	6, 369, 578	0					5.00
6.00	Movable Equipment	50, 976, 893	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	147, 717, 296	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	147, 717, 296	0					10.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150065	Period: From 01/01/2014	Worksheet A-7 Part II		
					To 12/31/2014	Date/Time Pre	pared:	
						5/20/2015 3:4	8 pm	
			SL	JMMARY OF CAF				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9,00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	8, 432, 995			0 0	0	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	8, 432, 995	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	1				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	8, 432, 995				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	8, 432, 995				3.00	

Health Financial Systems	SCHNECK MEDI			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 01/01/2014 To 12/31/2014		
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	96, 740, 403 50, 976, 893 147, 717, 296	0	96, 740, 403 50, 976, 893 147, 717, 296	0. 345098	0 0 0	1.00 2.00 3.00
	ALLUCA	ITON OF OTHER (JAPTTAL	SUMMART	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols.5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS				0.050	
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0) 3, 973, 677 4, 459, 318 8, 432, 995		1.00 2.00 3.00
		SL	JMMARY OF CAPI		-0, 050	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 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 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	NTERS 1, 046, 579 0 1, 046, 579	58, 292	(0 0	5, 122, 828 4, 517, 610 9, 640, 438	1.00 2.00 3.00

	Financial Systems MENTS TO EXPENSES		SCHNECK MEDI	Provider CCN: 150065	Period:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2014 To 12/31/2014	Date/Time Prep 5/20/2015 3:48	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-354, 013	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	114 404	ADMI NI STRATI VE & GENERAL	5.00		
	expenses (chapter 8)						
6.00	Rental of provider space by suppliers (chapter 8)	В	-8, 050	NEW CAP REL COSTS-BLDG &	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5, 706	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8.00	Television and radio service		0		0.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7, 257, 923			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	C			0	
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -398, 180	CAFETERI A	0.00		
15.00	Rental of quarters to employee		0,00		0.00		
16.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16.00
17.00	patients Sale of drugs to other than		O		0.00	0	17.00
	patients	P					
18.00	Sale of medical records and abstracts	В	-38, 198	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
	Vending machines	В	-8, 379	ADMI NI STRATI VE & GENERAL	5.00		•
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		U		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		O	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist	А	-696, 001	EQUI P NONPHYSI CI AN ANESTHETI STS	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
30.00	therapy costs in excess of	n-0-3	U	USUULATIONAL THENAFT	07.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C		0.00	0	32.00

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 01/01/2014 To 12/31/2014	Date/Time Pre	narod
				10 12/31/2014	5/20/2015 3:48	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description Bas	sis/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		ADMI NI STRATI VE & GENERAL	5.00	0	33.00
34.00 MISC INCOME	В	-210, 329	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00		35.00
36.00 THA DUES	A		ADMI NI STRATI VE & GENERAL	5.00		36.00
36.01 PAIN LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	36.01
37.00 AHA DUES	A		ADMI NI STRATI VE & GENERAL	5.00		37.00
38.00 TELEPHONE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	38.00
39.00 NEROMODULATION LOBBYING	A	-43	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
EXPENSE						
		0		0.00		
41. OO DEVELOPMENT MARKETING	A		ADMINISTRATIVE & GENERAL	5.00		41.00
42.00 NURTITION MARKETING	A		DI ETARY	10.00		42.00
43.00		0		0.00		43.00
44.00 45.00 4N MEDICAL NRSG MARKETING	•	1 022	ADULTS & PEDIATRICS	0.00 30.00		44.00 45.00
45. 00 4N MEDICAL NRSG MARKETING 45. 01 OB/GYN MARKETING	A A	-1, 022		90.03		45.00 45.01
45. 02 HOSPICE MARKETING	A		HOSPICE	116.00		45.01
45. 03 HOME HEALTH MARKETING	A		HOME HEALTH AGENCY	101.00		45.02
45. 04 RESPIRATORY THERAPY MARKETING	A		RESPIRATORY THERAPY	65.00		45.03
45. 06 HOSPITALIST MARKETING	A		EMERGENCY	91.00		45.04
45. 07	~	-203		0.00		45.00
45. 08		0		0.00		45.08
45.09		0		0.00		45.09
45. 10		0		0.00		45.10
45. 11		0		0.00		45.11
45.12 UNNECESSARY BORROWING	А	-165, 581	NEW CAP REL COSTS-BLDG &	1.00		45.12
			FIXT			
45.13 BARI ATRI C NP	Α	-162, 066	CASE MANAGEMENT	76.02	0	45.13
50.00 TOTAL (sum of lines 1 thru 49)		-11, 094, 591				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	ICAL CENTER			eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period: From 01/01/2014		
						To 12/31/2014	Date/Time Pre 5/20/2015 3:4	epared: 18 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADI OLOGY-DI AGNOSTI C	506, 030	303, 618	202, 412	2 217,600	1, 230	1.00
2.00	60.00	LABORATORY	230, 000	0	230,000	208,000	1, 603	2.00
3.00		ELECTROCARDI OLOGY	9,000		9,000		72	
4.00		OB GYN	1, 611, 245				0	
5.00		CASE MANAGEMENT	204, 369		(0	
6.00		PAIN MANAGEMENT	483, 269		(0	6.00
7.00		PALLI ATI VE HEALTH	1, 938			159, 800	0	
8.00		VEIN CENTER	154, 443		(0	8.00
9.00		EMERGENCY	310, 421	310, 421	(107/000	0	9.00
10.00		EMERGENCY	1, 310, 840		(0	101.00
11.00		OPERATI NG ROOM	649, 100		(0	11.00
12.00	53.00	ANESTHESI OLOGY	2, 081, 776		(.02,,000		12.00
200.00	What Alipa #	Cast Canton (Dhusi si an	7, 552, 431		441, 412	Provi der	2,905	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE	Cost of		Physician Cost of Malpractice	
		rdentirrei		Limit	Continuing	Share of col.	Insurance	
					Educati on	12	mourance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		RADI OLOGY-DI AGNOSTI C	128, 677	6, 434	(0	1.00
2.00		LABORATORY	160, 300		(0	
3.00	69.00	ELECTROCARDI OLOGY	5, 531	277	(o o	0	3.00
4.00	90. 03	OB GYN	0	0	(o o	0	4.00
5.00	76. 02	CASE MANAGEMENT	0	0	(0 0	0	5.00
6.00	76.03	PAIN MANAGEMENT	0	0	(0 0	0	6.00
7.00	90. 01	PALLIATIVE HEALTH	0	0	(0 0	0	7.00
8.00		VEIN CENTER	0	0	(0 0	0	8.00
9.00		EMERGENCY	0	0	(· · · · ·	0	9.00
10.00		EMERGENCY	0	0	(-	0	10.00
11.00		OPERATING ROOM	0	0	(0	
12.00	53.00	ANESTHESI OLOGY	0	0	(0	
200.00			294, 508		(-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		RADI OLOGY-DI AGNOSTI C	0		73, 73			1.00
2.00		LABORATORY	0		69, 700			2.00
3.00		ELECTROCARDI OLOGY	0		3, 469			3.00
4.00		OB GYN	0		(4.00
5.00		CASE MANAGEMENT	0	0	(5.00
6.00		PAIN MANAGEMENT	0	0	(6.00
7.00	90.01	PALLIATIVE HEALTH	0	0	(1, 938		7.00
8.00	90. 02	VEIN CENTER	0	0	(154, 443		8.00
9.00		EMERGENCY	0	0	(310, 421		9.00
10.00		EMERGENCY	0	0	(.,		10.00
11.00		OPERATING ROOM	0	Ŭ Ŭ	(11.00
12.00	53.00	ANESTHESI OLOGY	0	0	(2, 081, 776		12.00
200.00			0	294, 508	146, 904	1 7, 257, 923		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI			eriod: rom 01/01/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/20/2015 3:4	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	5 400 000	E 100 000				1 4 44
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	5, 122, 828 4, 517, 610	5, 122, 828	4, 517, 610			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	14, 079, 277	19, 588	2, 803	14, 101, 668		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	17, 500, 649	427, 675	566, 402	1, 980, 456	20, 475, 182	5.00
7.00	00700 OPERATION OF PLANT	2, 638, 417	758, 135	1, 653, 812	303, 327	5, 353, 691	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	311, 866 1, 059, 673	27, 025 39, 160	1, 050 6, 042	14, 449 236, 095	354, 390 1, 340, 970	
	01000 DI ETARY	472, 297	104, 909	22, 338	75, 485	675, 029	
11.00	01100 CAFETERI A	357, 426	0	0	119, 882	477, 308	
	01300 NURSING ADMINISTRATION	3, 180, 843	123, 443	98, 792	769, 025	4, 172, 103	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	507, 269 2, 663, 437	80, 609 45, 694	40, 584 147, 895	123, 701 316, 158	752, 163 3, 173, 184	
	01600 MEDICAL RECORDS & LIBRARY	1, 104, 817	35, 938	2, 527	270, 168	1, 413, 450	
	01850 PHYSICIAN PRIVATE PRACTICE	213, 101	5, 435	0	62, 680	281, 216	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	205, 229	205, 229	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	E E 21 072	1 105 400	252 154	1, 349, 095	0.040.007	1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 521, 873 951, 472	1, 125, 483 87, 354	252, 156 107, 977	1, 349, 095 260, 997	8, 248, 607 1, 407, 800	
	04300 NURSERY	258, 358	0/,001	0	73, 636	331, 994	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	3, 519, 885	627, 451	562, 380	528, 453	5, 238, 169	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	427, 690 1, 123, 556	0	6, 768 0	120, 404 331, 302	554, 862 1, 454, 858	
	05300 ANESTHESI OLOGY	197, 466	0	27,677	819, 080	1, 044, 223	
	05400 RADI OLOGY-DI AGNOSTI C	3, 041, 457	437, 702	489, 802	637, 786	4, 606, 747	
	03630 ULTRA SOUND	272, 340	0	13, 946	72, 907	359, 193	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	148, 174	0	860 46, 934	28, 168	177, 202	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	544, 588 284, 285	0	46, 934 4, 851	68, 312 33, 815	659, 834 322, 951	
	06000 LABORATORY	2, 784, 139	85, 562	48, 183	417,001	3, 334, 885	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	378, 653	0	0	0	378, 653	63.00
	06400 I NTRAVENOUS THERAPY	221,837	67, 841	51, 680	62, 453	403, 811	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	846, 913 959, 031	39, 190 109, 200	33, 406 19, 892	232, 451 275, 776	1, 151, 960 1, 363, 899	
67.00	06700 OCCUPATIONAL THERAPY	272, 081	7, 483	1,046	79, 576	360, 186	
68.00	06800 SPEECH PATHOLOGY	195, 714	0	0	57, 019	252, 733	
	06900 ELECTROCARDI OLOGY	187, 567	75, 941	57, 144	26, 671	347, 323	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	7, 131, 876	0	0	0	7, 131, 876	
	07200 TMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	2, 671, 823 6, 183, 104	0	0	0	2, 671, 823 6, 183, 104	
	03952 WOUND CARE	205, 163	0	328	46, 347	251, 838	
	03951 CASE MANAGEMENT	16, 497	16, 727	455	108, 121	141, 800	76.02
	03950 PAIN MANAGEMENT	744,858	79, 570	6, 299	330, 278	1, 161, 005	
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	392, 496	0	370	112, 419	505, 285	76.97
90.00	04953 OTHER OUTPATIENT SERVICE COST CENTER	44, 920	0	1, 470	12, 313	58, 703	90.00
	04951 PALLI ATI VE HEALTH	98, 028	0	0	28, 420	126, 448	
	09000 VEIN CENTER	177, 947	0	1, 475	80, 730	260, 152	
	09001 OB GYN 09100 EMERGENCY	609, 291	147 150	94, 620	628, 485	1, 332, 396	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 313, 639	167, 150	34, 747	1, 027, 385	3, 542, 921 0	
	04952 BEHAVOURAL HEALTH	172, 836	17, 043	15, 249	46, 537	251, 665	1
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 071, 855	57, 965	9, 172	271, 353	1, 410, 345	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1					113.00
	11600 HOSPI CE	761, 431	2, 258	8, 639	170, 020	942, 348	
118.00		98, 462, 353	4, 671, 531	4, 439, 771	12, 813, 965	96, 645, 514	
	NONREI MBURSABLE COST CENTERS	-1					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	2 955 591	17,886	0 67 090	0 820_000		190.00
	07950 WELLNESS	2, 955, 591 58, 624	345, 320 0	67, 980 0	829, 990 12, 092	4, 198, 881 70, 716	192.00
	07950 WELENESS 07951 PALN MANAGEMENT	0	0	222	48, 629		194.00
194.02	07952 EXTERNAL SVCS MARKETING	840, 836	3, 312	572	0	844, 720	194.02
	07953 WASHINGTON CLINIC	172, 137	75, 294	0	50, 347	297, 778	
194.04	07954 PHYSI CI AN OFFI CES 07955 I NTEGRATED MEDI CI NE	828, 702 331, 260	0 9, 485	6, 429 1, 951	205, 683 84, 218	1, 040, 814 426, 914	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2014 To 12/31/2014		pared.	
				10 12/01/2011	5/20/2015 3:4		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal		
cost center bescription	for Cost	FIXT		BENEFITS	Subtotal		
	Allocation	11/11	Laon	DEPARTMENT			
	(from Wkst A						
	col. 7)						
	0	1.00	2.00	4.00	4A		
200.00 Cross Foot Adjustments					0	200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	103, 885, 538	5, 122, 828	4, 517, 61	0 14, 101, 668	103, 885, 538	202.00	

^{5/20/2015 3:48} pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

Health Fina COST ALLOCA	ncial Systems TION - GENERAL SERVICE COSTS	SCHNECK MEDI		1	In Lie Period: From 01/01/2014 To 12/31/2014		pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	5/20/2015 3: 4 DI ETARY	8 pm
	·	& GENERAL 5.00	PLANT	LINEN SERVICE	9.00	10.00	
GENE	RAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
	D NEW CAP REL COSTS-BLDG & FIXT						1.00
	D NEW CAP REL COSTS-MVBLE EQUIP						2.00
	D EMPLOYEE BENEFITS DEPARTMENT D ADMINISTRATIVE & GENERAL	20, 475, 182					4.00 5.00
	O OPERATION OF PLANT	1, 314, 197	6, 667, 888	3			7.00
	D LAUNDRY & LINEN SERVICE	86, 994	46, 000		4		8.00
	D HOUSEKEEPI NG	329, 175	66, 655				9.00
	D DI ETARY D CAFETERI A	165, 703 117, 167	178, 566 0		0 47,385 0 0	1, 066, 683 0	10.00 11.00
	D NURSI NG ADMI NI STRATI ON	1, 024, 147	210, 113		0 55, 756	0	13.00
	D CENTRAL SERVICES & SUPPLY	184, 637	137, 205		0 36, 409	0	14.00
	D PHARMACY	778, 937	77, 777		0 20, 639	0	15.00
	D MEDICAL RECORDS & LIBRARY	346, 967	61, 171		0 16, 233	0	16.00
	D PHYSI CI AN PRI VATE PRACTI CE D NONPHYSI CI AN ANESTHETI STS	69, 031 50, 379	9, 251 0		0 2,455 0 0	0	18.00 19.00
	TI ENT ROUTI NE SERVI CE COST CENTERS	00,017		·	<u> </u>		
	D ADULTS & PEDIATRICS	2, 024, 849	1, 915, 688			954, 495	30.00
	DINTENSIVE CARE UNIT	345, 580	148, 686			112, 188	31.00
	D NURSERY _LARY_SERVICE_COST_CENTERS	81, 496	C	11, 08	5 0	0	43.00
	O OPERATING ROOM	1, 285, 840	1, 067, 989	50, 14	6 283, 406	0	50.00
	D RECOVERY ROOM	136, 205	C		0 0	0	51.00
	D DELIVERY ROOM & LABOR ROOM	357, 131	0	3, 96		0	52.00
	D ANESTHESI OLOGY D RADI OLOGY-DI AGNOSTI C	256, 331 1, 130, 841	745, 017	41, 52	0 0 2 197, 701	0	53.00 54.00
	ULTRA SOUND	88, 173	743,017) 41, 52	0 0	0	54.00
	NUCLEAR MEDICINE - DIAGNOSTIC	43, 499	C		0 0	0	54.02
	D CT SCAN	161, 973	0		0 0	0	57.00
	D MAGNETIC RESONANCE IMAGING (MRI) D LABORATORY	79, 276 818, 631	0 145, 636)	0 0 0 38,647	0	58.00 60.00
	D BLOOD STORING, PROCESSING, & TRANS.	92, 950	145, 050		0 38,047	0	63.00
	DINTRAVENOUS THERAPY	99, 126	115, 473		0 30, 643	0	64.00
	RESPI RATORY THERAPY	282, 777	66, 706		0 17, 701	0	65.00
	D PHYSI CAL THERAPY	334, 803	185, 870			0	66.00
	D OCCUPATI ONAL THERAPY D SPEECH PATHOLOGY	88, 417 62, 040	12, 736		0 3, 380 0 0	0	67.00 68.00
	D ELECTROCARDI OLOGY	85, 259	129, 261		-	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 750, 697	C		0 0	0	71.00
	DIMPL. DEV. CHARGED TO PATIENT	655, 866	0		0 0	0	72.00
	D DRUGS CHARGED TO PATIENTS 2 WOUND CARE	1, 517, 797 61, 820			0 0	0	73.00 76.00
	1 CASE MANAGEMENT	34, 808	28, 471		0 7, 555	0	76.02
	PAIN MANAGEMENT	284, 998	135, 437		0 35, 940	0	
	7 CARDI AC REHABI LI TATI ON	124, 035	0		0 0	0	76.97
	ATIENT SERVICE COST CENTERS 3 OTHER OUTPATIENT SERVICE COST CENTER	14, 410	0	ป	0 0	0	90.00
	1 PALLIATIVE HEALTH	31,040	C		0 0	0	90.01
90. 02 0900	VEIN CENTER	63, 861	C		0 0	0	90. 02
	1 OB GYN	327,070	0		0 0	0	90.03
	D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT PART)	869, 699	284, 507	43, 12	1 75, 498	0	91.00 92.00
	2 BEHAVOURAL HEALTH	61, 777	29, 009		0 7, 698	0	93.00
	R REIMBURSABLE COST CENTERS			T			
	D HOME HEALTH AGENCY	346, 204	98, 662	2	0 26, 181	0	101.00
	AL PURPOSE COST CENTERS						113.00
116.001160		231, 323	3, 844	L I	0 1, 020	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18, 697, 936	5, 899, 730			1, 066, 683	118.00
	EI MBURSABLE COST CENTERS			.1	al a azal		
190.001900	D GIFT, FLOWER, COFFEE SHOP & CANTEEN D PHYSICIANS' PRIVATE OFFICES	4, 391 1, 030, 720	30, 444 587, 772		0 8, 079 0 155, 974		190. 00 192. 00
194.0007950		17, 359	507,772)	0 0		192.00
	1 PALN MANAGEMENT	11, 992	C		0 0		194. 01
	2 EXTERNAL SVCS MARKETING	207, 358	5, 638		0 1, 496		194. 02
	3 WASHINGTON CLINIC	73, 097	128, 159		0 34,009		194.03
	4 PHYSICIAN OFFICES 5 INTEGRATED MEDICINE	255, 494 104, 797	16, 145	5	0 4, 284		194. 04 194. 05
	6 SURGI CAL PROFESSI ONAL	72, 038	0, 143		0 0		194.05
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	4 447 000	407 20			201.00
202.00	TOTAL (sum lines 118-201)	20, 475, 182	6, 667, 888	487, 38	4 1, 739, 526	1, 066, 683	∠UZ. UU

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI			In Lie Period: From 01/01/2014	u of Form CMS-2 Worksheet B Part I	2552-10
					To 12/31/2014	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/20/2015 3: 4 MEDI CAL	8 pm
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A	594, 475					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	37, 491	5, 499, 610				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	13, 497 15, 351	0 244, 867	1, 123, 91 1, 84			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	23, 320	244, 807	1, 84		1, 862, 714	16.00
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE	2,896	0		7 0	0	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	4,604	0		0 0	0	19.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	91, 282	1, 456, 019	10, 80	0 0	86, 678	30.00
30.00	03100 I NTENSI VE CARE UNI T	15, 915	253, 862	1, 01		11, 961	31.00
43.00	04300 NURSERY	5, 581	89, 029		6 0	9, 960	
50.00	ANCI LLARY SERVICE COST CENTERS	47.0(0)	750 (07	40.50		445.000	50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	47, 063 6, 826	750, 697 0	18, 53 1, 82		415, 322 37, 350	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	19, 759	315, 164		0 0	46, 333	52.00
53.00	05300 ANESTHESI OLOGY	10, 786	0	21		29, 371	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34,068	543, 410	4, 57		106, 433	
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	3, 640	0	38 22		25, 346 12, 884	54.01 54.02
57.00	05700 CT SCAN	3, 823	0	19		202, 098	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 703	0	17		69, 359	
60.00	06000 LABORATORY	34, 844	555, 784	3, 71		304, 601	60.00
63.00 64.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	4, 286	0	36	-	5, 643 8, 702	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	16, 959	0	59		31, 205	
66.00	06600 PHYSI CAL THERAPY	16, 262	259, 385	1, 07		29, 023	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	4, 194 3, 007	0	5	2 0 8 0	11, 218 3, 015	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	1, 617	25, 791	41		43, 395	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	769, 60		58, 248	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0			31, 895	
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE	2,608	0	1	0 4, 312, 596 8 0	109, 064 4, 098	
	03951 CASE MANAGEMENT	2,000	0	57			76.02
76.03	03950 PALN MANAGEMENT	13, 303	0	1, 23		13, 337	
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	6, 491	0	50	6 0	1, 068	76.97
90.00	04953 OTHER OUTPATIENT SERVICE COST CENTERS	624	0	33	8 0	921	90.00
	04951 PALLI ATI VE HEALTH	1, 124	0		1 0	1, 065	
90.02	09000 VEIN CENTER	3, 129	0	32		9,674	
90. 03 91. 00	09001 OB GYN 09100 EMERGENCY	19, 159 47, 800	0 762, 445	3, 18 3, 31		11, 517 102, 077	90.03 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	17,000	, 02, 110	0,01	,	102,077	92.00
93.00	04952 BEHAVOURAL HEALTH	2, 919	0	37	3 0	1, 441	93.00
101 00	OTHER REIMBURSABLE COST CENTERS	15 044	242 157	1 05		14.000	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	15, 244	243, 157	1, 35	0	14, 228	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	10, 467	0	87			116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	543, 109	5, 499, 610	1, 117, 72	4, 312, 596	1, 862, 714	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	28, 477	0	1, 55		0	192.00
194.00	07950 WELLNESS 07951 PAIN MANAGEMENT	794	0	21			194.00
104 01	07951 PALN MANAGEMENT 07952 EXTERNAL SVCS MARKETING	3, 042 819	0	81	0 0		194. 01 194. 02
	U/952 EXTERNAL SVUS MARKETTNG		0	14			194.02
194.02	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	6, 229	U				
194.02 194.03 194.04	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES	7, 411	0	84	4 0	0	
194.02 194.03 194.04 194.05	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE	7, 411 3, 211	0	84 48	4 0 5 0	0 0	194.04 194.05
194. 02 194. 03 194. 04 194. 05 194. 06	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE 07956 SURGICAL PROFESSIONAL	7, 411	0 0 0	84	4 0 5 0	0 0	194. 05 194. 06
194.02 194.03 194.04 194.05	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE 07956 SURGICAL PROFESSIONAL Cross Foot Adjustments	7, 411 3, 211	0 0 0 0	84 48 2, 12	4 0 5 0	0 0 0	194. 05 194. 06 200. 00 201. 00

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 01/01/2014	Worksheet B Part I	
					To 12/31/2014	Date/Time Pre	pared:
		OTHER GENERAL				5/20/2015 3:4	8 pm
		SERVI CE					
	Cost Center Description	PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total	
		PRI VATE PRACTI CE	ANESTHETI STS		Residents Cost & Post		
		THUROTTOL			Stepdown		
		10.00	10.00	0.1.00	Adjustments		
	GENERAL SERVICE COST CENTERS	18.00	19.00	24.00	25.00	26.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00							10.00
11. 00 13. 00	01100 CAFETERIA 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	2/4 00/					16.00
18. 00 19. 00	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	364, 906 0	260, 212				18.00 19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		200,212				17.00
30.00	03000 ADULTS & PEDIATRICS	0				15, 562, 200	•
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0				2, 360, 138 529, 181	•
43.00	ANCI LLARY SERVICE COST CENTERS	0	0	529, 18	1 0	529, 161	43.00
50.00	05000 OPERATI NG ROOM	0	0	9, 157, 16	4 0	9, 157, 164	50.00
51.00	05100 RECOVERY ROOM	0				737, 069	•
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 260, 212	2, 197, 20		2, 197, 209	
53.00 54.00	05400 RADI OLOGY – DI AGNOSTI C	0	200, 212	1, 601, 14 7, 410, 31	-	1, 601, 141 7, 410, 310	•
54.01	03630 ULTRA SOUND	0	0	476, 73		476, 736	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	235, 27		235, 278	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 027, 92 473, 46		1, 027, 921 473, 461	1
60.00	06000 LABORATORY	0	0	5, 236, 74		5, 236, 742	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	477, 24		477, 246	•
64.00	06400 I NTRAVENOUS THERAPY	0	0	662, 40		662, 408	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	1, 567, 90 2, 263, 59		1, 567, 902 2, 263, 590	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	480, 18		480, 183	•
68.00	06800 SPEECH PATHOLOGY	0	0	320, 83		320, 833	•
69.00	06900 ELECTROCARDI OLOGY	0	0			689, 131	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	9, 710, 42 3, 647, 90		9, 710, 429 3, 647, 903	
	07300 DRUGS CHARGED TO PATIENTS	0	0	12, 122, 56		12, 122, 561	•
76.00	03952 WOUND CARE	0	0	320, 38		320, 382	•
76.02	03951 CASE MANAGEMENT	0	0	214, 48		214, 489	•
	03950 PALN MANAGEMENT 07697 CARDLAC REHABLLITATION	0	0	1, 645, 25 637, 38		1, 645, 259 637, 385	•
	OUTPATIENT SERVICE COST CENTERS	-	-		-		
90.00	04953 OTHER OUTPATIENT SERVICE COST CENTER	3, 182		78, 17		78, 178	
90. 01 90. 02	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	5, 729 15, 956		165, 40 353, 09		165, 407 353, 098	
90.02 90.03	09001 0B GYN	97, 689		1, 791, 01		1, 791, 016	•
91.00	09100 EMERGENCY	0		5, 731, 38		5, 731, 385	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04952 BEHAVOURAL HEALTH OTHER REIMBURSABLE COST CENTERS	0	0	354, 88	2 0	354, 882	93.00
101.00	10100 HOME HEALTH AGENCY	0	0	2, 155, 37	2 0	2, 155, 372	101.00
	SPECIAL PURPOSE COST CENTERS		-			_,,	
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	122 554				1, 202, 781	•
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	122, 556	260, 212	93, 596, 37		93, 596, 370	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	60, 80	0 0	60, 800	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	145, 205	0	6, 148, 58		6, 148, 584	
	07950 WELLNESS 07951 PAIN MANAGEMENT	0		89, 07 64, 70		89, 079 64, 702	194.00 194.01
	07951 PATN MANAGEMENT 07952 EXTERNAL SVCS MARKETING	4, 174	0	1, 064, 20		1, 064, 205	•
194.03	07953 WASHINGTON CLINIC	31, 762	0	571, 18	0 0	571, 180	194.03
	07954 PHYSI CLAN OFFI CES	37, 787		1, 342, 35		1, 342, 350	
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	16, 372 7, 050		572, 20 376, 06		572, 208 376, 060	
- 74. UU		, 030		1 370,00		1 370,000	1174.00

Health Financial Systems	Health Financial Systems					In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERA		Provider CCN: 150065		Peri od:		Worksheet	В		
							/01/2014 2/31/2014	Date/Time	Prepared:
		OTHER GENERAL						5/20/2015	3:48 pm
		SERVI CE							
Cost Center	Description	PHYSI CI AN		HYSI CI AN	Subtotal		tern &	Total	
		PRI VATE	ANES	THETI STS			ents Cost		
		PRACTI CE					Post		
							epdown		
						Adj u	stments		
		18.00	1	9.00	24.00	2	5.00	26.00	
200.00 Cross Foot A	Adjustments			0		0	0		0 200. 00
201.00 Negative Cos	st Centers	0		0		0	0		0 201.00
202.00 TOTAL (sum I	ines 118-201)	364, 906		260, 212	103, 885, 5	38	0	103, 885, !	538 202. 00

^{5/20/2015 3:48} pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI			In Lie Period: From 01/01/2014 To 12/31/2014	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/20/2015 3:4	8 pm
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS			I	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 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 9, 456 11, 733 0 5, 144 3, 954 0 0	19, 588 427, 675 758, 135 27, 025 39, 160 104, 909 0 123, 443	566, 40: 1, 653, 81: 1, 05(6, 04: 22, 33(98, 79:	2 1, 003, 533 2 2, 423, 680 2 8, 075 2 50, 346 8 131, 201 0 0 2 222, 235	22, 391 3, 153 481 23 375 120 190 1, 221	1.00 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 19.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0 16, 870 0 0	80, 609 45, 694 35, 938 5, 435 0	147, 89 2, 52	5 210, 459	196 502 429 99 326	14.00 15.00 16.00 18.00 19.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	6, 659 1, 814 0	1, 125, 483 87, 354 0	107, 97		2, 141 414 117	30. 00 31. 00 43. 00
50.00	05000 OPERATING ROOM	146, 433	627, 451	562, 38	1, 336, 264	839	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 0 0 437, 702	6, 76	8 6, 768 0 0 7 27, 677	191 526 1, 300 1, 012	51.00 52.00 53.00 54.00
54.01 54.02 57.00	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE – DIAGNOSTIC 05700 CT SCAN	0 0 51,000	0 0 0	13, 94) 86(46, 93	6 13, 946 0 860 4 97, 934	116 45 108	54.01 54.02 57.00
58.00 60.00 63.00 64.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0 101, 189 0 0	0 85, 562 0 67, 841	51, 68	3 234, 934 0 0 0 119, 521	54 662 0 99	58.00 60.00 63.00 64.00
65.00 66.00 67.00 68.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 150 0 0 0	39, 190 109, 200 7, 483 0	19, 89: 1, 04	2 129, 092	369 438 126 90	65.00 66.00 67.00 68.00
72.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	7, 943 0 0 0	75, 941 0 0 0		4 141, 028 0 0 0 0 0 0 0 0	42 0 0 0	72.00
76. 00 76. 02 76. 03	03952 WOUND CARE 03951 CASE MANAGEMENT 03950 PALN MANAGEMENT 07697 CARDIAC REHABILITATION	41,069 0 0 0	0 16, 727 79, 570 0	323 455 6, 29	8 41, 397 5 17, 182 9 85, 869	74 172 524 178	76.00 76.02 76.03
	OUTPATIENT SERVICE COST CENTERS		0	4 47			
90. 01 90. 02 90. 03 91. 00	04953 OTHER OUTPATIENT SERVICE COST CENTER 04951 PALLIATIVE HEALTH 09000 VEIN CENTER 09001 OB GYN 09100 EMERGENCY		0 0 0 167, 150	1, 47 94, 62	0 0 5 1, 475 0 94, 620	20 45 128 997 1, 631	90. 01 90. 02 90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVOURAL HEALTH	0	17, 043	15, 24	0 9 32, 292	74	92.00 93.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	57, 965	9, 17:	2 67, 137	431	101.00
		88, 214 496, 628	2, 258 4, 671, 531				113.00 116.00 118.00
192.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 WELLNESS	0 150 878	17, 886 345, 320 0	67, 98	0 878	1, 317 19	190. 00 192. 00 194. 00
194. 02 194. 03	07951 PALN MANAGEMENT 07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES	0 0 0	0 3, 312 75, 294 0	22: 57: (6, 42)	2 3, 884 0 75, 294	0 80	194. 01 194. 02 194. 03 194. 04
194.05	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	0	9, 485 0		1 11, 436	134 90	194. 05 194. 06 200. 00

Health Fin	ancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION	N OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FLXT	EQUI P		BENEFI TS DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	497, 656	5, 122, 828	4, 517, 61	0 10, 138, 094	22, 391	202.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
				0 12/31/2014		pared:
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS					101.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	1, 006, 686					5.00
7.00 00700 OPERATION OF PLANT	64, 614					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	4, 277 16, 184					8.00 9.00
10. 00 01000 DI ETARY	8, 147				208, 625	
	5, 761				0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	50, 353 9, 078				0	13.00 14.00
15. 00 01500 PHARMACY	38, 297				0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	17, 059				0	16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	3, 394 2, 477				0	18.00 19.00
INPATIENT ROUTINE SERVICE COST CENTERS	2,477		<u></u>	<u> </u>	0	19.00
30. 00 03000 ADULTS & PEDI ATRI CS	99, 557				186, 683	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	16, 991 4, 007				21, 942 0	31.00 43.00
ANCI LLARY SERVICE COST CENTERS	4,007		/I, 12.	0	0	43.00
50. 00 05000 OPERATI NG ROOM	63, 219				0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 697 17, 559		1	-	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	12,603		403		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	55, 599		4, 221	10, 463	0	54.00
54. 01 03630 ULTRA SOUND	4, 335			, i	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57. 00 05700 CT SCAN	2, 139				0	54.02 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 898			0	0	58.00
	40, 249			-/ - · ·	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	4, 570 4, 874			0 0 0 1,622	0	63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	13, 903				0	65.00
66.00 06600 PHYSI CAL THERAPY	16, 461				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	4, 347 3, 050				0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 192			-	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	86, 075) (-	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	32, 246			0	0	72.00
75.00 03952 WOUND CARE	3, 039				0	76.00
76.02 03951 CASE MANAGEMENT	1, 711	10, 627			0	76. 02
76. 03 03950 PALN MANAGEMENT 76. 97 07697 CARDIAC REHABILITATION	14, 012 6, 098				0	
OUTPATIENT SERVICE COST CENTERS	0,098		<u>/</u>	0	0	70.97
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	708) (0 0	0	90.00
90. 01 04951 PALLIATIVE HEALTH 90. 02 09000 VEIN CENTER	1, 526 3, 140				0	90.01 90.02
90. 03 09001 0B GYN	16, 081				0	90.02
91. 00 09100 EMERGENCY	42, 760		4, 383	3, 996	0	•
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 93.00 04952 BEHAVOURAL HEALTH	3, 037	10, 828		407	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS	3,037	10, 828	9 (407	0	73.00
101.00 10100 HOME HEALTH AGENCY	17, 021	36, 826) (1, 386	0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	1	1	1			113.00
116. 00 11600 HOSPI CE	11, 373	1, 435	. (54	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	919, 306	2, 202, 062	49, 544	81, 272	208, 625	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	216	11, 363		428	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	50, 676					192.00
194.00 07950 WELLNESS	853	0	0	0 0	0	194.00
194.01 07951 PAIN MANAGEMENT 194.02 07952 EXTERNAL SVCS MARKETING	590 10, 195			0 0		194. 01 194. 02
194. 02 07952 EXTERNAL_SVCS_MARKETING 194. 03 07953 WASHINGTON_CLINIC	3, 594			1,800		194.02 194.03
194. 04 07954 PHYSI CLAN OFFI CES	12, 562	C) (0 0	0	194. 04
194. 05 07955 INTEGRATED MEDICINE	5, 152			227		194.05
194.06 07956 SURGI CAL PROFESSI ONAL 200.00 Cross Foot Adjustments	3, 542			0 0		194.06 200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	1, 006, 686	2, 488, 775	49, 544	92, 061	208, 625	202.00

Health 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 01/01/2014	Worksheet B Part II	
				To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	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	1				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 951					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	135		183, 74	0		14.00
15. 00 01500 PHARMACY	154		30			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	233			9 0	80, 134 0	16.00 18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	46			0 0	0	•
INPATIENT ROUTINE SERVICE COST CENTERS				- - -		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	916				3, 732 515	30.00
43. 00 04300 NURSERY	56			6 0	429	•
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	471				17, 810 1, 608	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	198			0 0	1, 008	•
53. 00 05300 ANESTHESI OLOGY	108			6 0	1, 265	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	341				4, 583	
54.01 03630 ULTRA SOUND 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	36			0 0 0	1, 091 555	
57. 00 05700 CT SCAN	38		3	0	8, 702	•
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	17			.8 0	2, 987	58.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	349			07 0 0 0	13, 116 243	1
64. 00 06400 I NTRAVENOUS THERAPY	43	0	6	0 0	375	•
65. 00 06500 RESPI RATORY THERAPY	170			07 0	1, 344	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	163		17	75 0 9 0	1, 250 483	•
68. 00 06800 SPEECH PATHOLOGY	30			6 0	130	•
69. 00 06900 ELECTROCARDI OLOGY	16			8 0	1, 869	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	125, 81 47, 13		2, 508 1, 373	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 295, 666	4, 696	
76.00 03952 WOUND CARE	26	0		3 0	176	
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	133	0		03 0 03 0	55 574	76.02 76.03
76. 97 07697 CARDI AC REHABI LI TATI ON	65			0	46	•
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER 90. 01 04951 PALLIATIVE HEALTH	6			5 0 0 0	40 46	
90. 02 09000 VEIN CENTER	31			3 O	417	90.02
90. 03 09001 0B GYN	192		52		496	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	479	49, 293	54	2 0	4, 395	91.00 92.00
93. 00 04952 BEHAVOURAL HEALTH	29	0	6	01 0	62	•
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	153	15, 720	22	1 0	613	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	105		14			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	5, 438	355, 559	182, 73	295, 666	80, 134	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	285		25		0	192.00
194. 00 07950 WELLNESS 194. 01 07951 PALN_MANAGEMENT	8		13	4 0 4 0		194.00 194.01
194. 0107951 PATN MANAGEMENT 194. 02 07952 EXTERNAL_SVCS_MARKETING	8	0		0 0		194.01
194. 03 07953 WASHI NGTON CLI NI C	62			.4 0	0	194.03
194. 04 07954 PHYSI CLAN OFFI CES 194. 05 07955 I NTEGRATED MEDI CLNE	74		13	88 0 79 0		194.04 194.05
194. 06 07955 TNTEGRATED MEDICINE 194. 06 07956 SURGI CAL PROFESSI ONAL	14		34			194.05
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 5, 951	0 355, 559	183, 74	0 0 0 295, 666		201.00 202.00
202.00 TOTAL (Sum TITES TID-201)	1 5, 751	1 333, 339	1 105,74	275,000	00, 134	1202.00

Heal th	Financial Systems	SCHNECK MEDI	CAL C	FNTFR		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS					Period:	Worksheet B	
						From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	pared:
		OTHER GENERAL					5/20/2015 3:4	8 pm
		SERVI CE						
	Cost Center Description	PHYSI CI AN		HYSI CI AN	Subtotal	Intern &	Total	
		PRI VATE	ANES	THETI STS		Residents Cost		
		PRACTI CE				& Post Stepdown		
						Adjustments		
	OFNERAL CERVICE COST OFNITERS	18.00	1	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 ADMINISTRATIVE & GENERAL							5.00
7.00	00700 OPERATION OF PLANT							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG							8.00 9.00
10.00	01000 DI ETARY							10.00
11.00	01100 CAFETERI A							11.00
13.00	01300 NURSING ADMINISTRATION							13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY							14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY							15.00 16.00
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE	12, 549						18.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	1	2, 849				19.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0.540.44		0.540.440	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0			2, 542, 14 313, 73		2, 542, 140 313, 736	1
43.00	04300 NURSERY	0			11, 49		11, 498	1
	ANCI LLARY SERVI CE COST CENTERS		1				,	
50.00	05000 OPERATING ROOM	0			1, 888, 88		1, 888, 888	1
51.00 52.00	05100 RECOVERY ROOM	0			15, 63		15, 631	51.00 52.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0			41, 05 42, 98		41, 057 42, 989	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			1, 317, 67		1, 317, 678	
54.01	03630 ULTRA SOUND	0			19, 58	7 0	19, 587	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0			3, 65		3, 651	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			114, 77		114, 778	
60.00	06000 LABORATORY	0			11, 83 382, 25		11, 835 382, 252	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0			4, 81		4, 813	
64.00	06400 I NTRAVENOUS THERAPY	0			169, 69		169, 694	64.00
65.00		0			119, 46		119, 464	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0			238, 76		238, 769 18, 469	
68.00	06800 SPEECH PATHOLOGY	0			3, 30		3, 306	
69.00	06900 ELECTROCARDI OLOGY	0			201, 15		201, 156	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			214, 39		214, 399	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0			80, 75		80, 755	
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE	0			374, 98 44, 71		374, 986 44, 715	
76.02	03951 CASE MANAGEMENT	0			30, 24		30, 240	
76.03	03950 PALN MANAGEMENT	0			153, 76		153, 768	
76.97	07697 CARDI AC REHABI LI TATI ON	0			6, 84	0 0	6, 840	76.97
90.00	OUTPATIENT SERVICE COST CENTERS 04953 OTHER OUTPATIENT SERVICE COST CENTER	109			2, 40	8 0	2, 408	90.00
90.00 90.01	04951 PALLIATIVE HEALTH	107			1, 82		1, 825	
90.02	09000 VEIN CENTER	549			5, 79		5, 793	
90.03	09001 OB GYN	3, 360			116, 26		116, 267	
91.00	09100 EMERGENCY	0			415, 56		415, 567	
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 04952 BEHAVOURAL HEALTH	0			46, 79	0 0	46, 790	92.00 93.00
75.00	OTHER REIMBURSABLE COST CENTERS	0	′I		40,77	0	40,770	75.00
101.00	10100 HOME HEALTH AGENCY	0)		139, 50	в О	139, 508]101.00
112 00	SPECIAL PURPOSE COST CENTERS		1			1		1112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0			113, 04	7 0	113, 047	113.00
118.00		4, 215	1	0			9, 208, 299	
	NONREIMBURSABLE COST CENTERS		1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			29, 89			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS	4, 994			698, 61 1, 79:		698, 616 1 792	192.00
	07951 PALN MANAGEMENT	0			1, 05			194.00
194.02	07952 EXTERNAL SVCS MARKETING	144			16, 41			194. 02
	07953 WASHI NGTON CLI NI C	1, 092			129, 78		129, 781	
	07954 PHYSI CLAN OFFI CES	1, 299			20, 82			194.04
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	563 242			23, 64 4, 92			194.05 194.06
174.00		1 242	1		1 4, 720	U U	4, 720	1174.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150065		Period:	Worksheet B		
				From 01/01/2014 To 12/31/2014	Date/Time Pre		
					5/20/2015 3:4	8 pm	
	OTHER GENERAL						
	SERVI CE						
Cost Center Description	PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total		
	PRI VATE	ANESTHETI STS		Residents Cost			
	PRACTI CE			& Post			
				Stepdown			
				Adjustments			
	18.00	19.00	24.00	25.00	26.00		
200.00 Cross Foot Adjustments		2, 849	2, 84	19 0	2, 849	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	12, 549	2, 849	10, 138, 09	04 0	10, 138, 094	202.00	

^{5/20/2015 3:48} pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI		CCN: 150065 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	2552-10
COST ALLOCATION - STATISTICAL DASIS		FIOVIDEI	F	rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/20/2015 3:4	pared:
	CAPI TAL REL	ATED COSTS			572072013 3.4	
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	340, 256					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	1, 301 28, 406 50, 355 1, 795 2, 601 6, 968 0 8, 199 5, 354	8, 431, 985 5, 232 1, 057, 172 3, 086, 796 1, 959 11, 278 41, 693 0 184, 393 75, 748	47, 823, 490 6, 716, 374 1, 028, 685 49, 001 800, 676 255, 995 406, 559 2, 608, 022 419, 512	-20, 475, 182 0 0 0 0 0 0 0 0 0 0 0	83, 410, 356 5, 353, 691 354, 390 1, 340, 970 675, 029 477, 308 4, 172, 103 752, 163	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00 \end{array}$
	3, 035	276, 041	1, 072, 199		3, 173, 184	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	2, 387 361	4, 716 0	916, 230 212, 570		1, 413, 450 281, 216	16.00 18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0			205, 229	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	74, 754	470 (41	4 575 005	0	0.040.007	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	5, 802	470, 641 201, 536	4, 575, 235 885, 130		8, 248, 607 1, 407, 800	30. 00 31. 00
43. 00 04300 NURSERY	0	0			331, 994	43.00
ANCI LLARY SERVI CE COST CENTERS			1 700 4 (4		5 000 1/0	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	41, 675 0	1, 049, 664 12, 633			5, 238, 169 554, 862	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	12,000	1, 123, 556		1, 454, 858	52.00
53. 00 05300 ANESTHESI OLOGY	0	51, 658			1, 044, 223	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	29,072	914, 200			4, 606, 747	54.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	26, 030 1, 605			359, 193 177, 202	54. 01 54. 02
57. 00 05700 CT SCAN	0	87, 601	231, 670		659, 834	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 054			322, 951	58.00
	5, 683	89, 933			3, 334, 885	60.00
63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	0 4, 506	0 96, 459	0 211, 799	-	378, 653 403, 811	63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	2, 603	62, 352	788, 320		1, 151, 960	65.00
66. 00 06600 PHYSI CAL THERAPY	7, 253	37, 127			1, 363, 899	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	497	1, 953 0			360, 186	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	5,044	106, 657	193, 370 90, 452		252, 733 347, 323	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			7, 131, 876	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	2, 671, 823	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03952 WOUND CARE	0	0 613	0 157, 177	0	6, 183, 104 251, 838	73.00 76.00
76. 02 03951 CASE MANAGEMENT	1, 111	850			141, 800	76.02
76. 03 03950 PALN MANAGEMENT	5, 285	11, 757			1, 161, 005	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	690	381, 250	0	505, 285	76.97
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0	2, 743	41, 758	0	58, 703	90.00
90. 01 04951 PALLI ATI VE HEALTH	0	0			126, 448	90. 01
90. 02 09000 VEI N CENTER	0	2, 753			260, 152	90.02
90. 03 09001 0B GYN 91. 00 09100 EMERGENCY	0 11, 102	176, 606 64, 854			1, 332, 396 3, 542, 921	90. 03 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	01,001	0,101,200	0	0,012,721	92.00
93. 00 04952 BEHAVOURAL HEALTH	1, 132	28, 461	157, 823	0	251, 665	93.00
OTHER REI MBURSABLE COST CENTERS	2.050	17 100	020.040	0	1 410 245	101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 850	17, 120	920, 249	0	1, 410, 345	101.00
113.00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	150	16, 124			942, 348	
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	310, 281	8, 286, 702	43, 456, 454	-20, 475, 182	76, 170, 332	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	0	0	0	17, 886	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 936	126, 882			4, 198, 881	192. 00
194.0007950 WELLNESS	0	0	41,008		70, 716	
194.01 07951 PALN MANAGEMENT 194.02 07952 EXTERNAL SVCS MARKETING	220	414 1, 067			48, 851 844, 720	
194. 03 07953 WASHI NGTON CLI NI C	5,001	0	170, 743	-	297, 778	
194. 04 07954 PHYSI CI AN OFFI CES	0	11, 999			1, 040, 814	
194. 05 07955 I NTEGRATED MEDI CI NE 194. 06 07956 SURGI CAL PROFESSI ONAL	630 0	3, 642 1, 279			426, 914 293, 464	
		1, 2/9	1 172, 430	0	273,404	

Heal th Fi	nancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/20/2015 3:4	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 122, 828	4, 517, 610	14, 101, 668	3	20, 475, 182	
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 055805	0. 535771	0. 29486	9	0. 245475	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			22, 39	1	1, 006, 686	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 000468	3	0. 012069	205.00

Health Financial Systems	SCHNECK MEDI		CON 1500/5 5		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B-1 Date/Time Pre 5/20/2015 3:4	pared:
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	
	7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						1 00
1.0000100NEW CAP REL COSTS-BLDG & FIXT2.0000200NEW CAP REL COSTS-MVBLE EQUIP4.0000400EMPLOYEE BENEFITS DEPARTMENT						1.00 2.00 4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	260, 194					5.00 7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 795					8.00
9.00 00900 HOUSEKEEPI NG	2,601	2, 637	255, 798			9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	6, 968 0	0	6, 968	40, 485 0	1, 136, 441	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	8, 199	, o	8, 199	-	71, 671	
14.00 01400 CENTRAL SERVICES & SUPPLY	5, 354	0	5, 354	1	25, 801	
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	3, 035 2, 387		3, 035 2, 387	1	29, 347 44, 581	15.00 16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	361	0	2, 367	1	5, 536	•
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	8, 801	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	74, 754	256, 798	74, 754	36, 227	174, 502	30.00
31. 00 03100 INTENSIVE CARE UNIT	5, 802				30, 425	•
43. 00 04300 NURSERY	0		C		10, 670	
ANCI LLARY SERVI CE COST CENTERS	41 / 75	40 51/	41 /75		00.070	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	41, 675 0		41, 675 C		89, 970 13, 050	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			-	37, 772	1
53.00 05300 ANESTHESI OLOGY	0	0	C	0	20, 620	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	29, 072	40, 173	29, 072 C		65, 127 6, 959	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		-	2, 805	•
57. 00 05700 CT SCAN	0	0	C	0	7, 308	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	-	3, 255	•
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	5,683		5, 683		66, 610 0	60.00 63.00
64. 00 06400 I NTRAVENOUS THERAPY	4, 506	0	4, 506		8, 193	
65. 00 06500 RESPI RATORY THERAPY	2, 603		2, 603	1 1	32, 420	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	7,253	23, 175	7, 253 497		31, 087 8, 017	•
68. 00 06800 SPEECH PATHOLOGY	0	0	477		5, 748	•
69. 00 06900 ELECTROCARDI OLOGY	5, 044	21, 062	5, 044	0	3, 091	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 07200 TMPL. DEV. CHARGED TO PATTENT 73. 00 07300 DRUGS CHARGED TO PATTENTS	0	0		0	0	
76.00 03952 WOUND CARE	0	0	C	0	4, 985	76.00
76. 02 03951 CASE MANAGEMENT	1, 111	0	1, 111	1	0	
76. 03 03950 PALN MANAGEMENT 76. 97 07697 CARDI AC REHABI LI TATI ON	5, 285 0		5, 285 C		25, 431 12, 409	•
OUTPATIENT SERVICE COST CENTERS					12, 10,	
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C		1, 193	•
90. 01 04951 PALLI ATI VE HEALTH 90. 02 09000 VEI N CENTER	0			0	2, 148 5, 982	1
90. 03 09001 0B GYN	0	0	C	0	36, 625	1
91. 00 09100 EMERGENCY	11, 102	41, 720	11, 102	0	91, 378	•
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 93. 00 04952 BEHAVOURAL HEALTH	1, 132	0	1, 132	o	5, 580	92.00 93.00
OTHER REIMBURSABLE COST CENTERS	1, 132	0	1, 132	<u> </u>	5, 580	93.00
101.00 10100 HOME HEALTH AGENCY	3, 850	0	3, 850	0	29, 142	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	1	[113.00
116. 00 11600 H0SPI CE	150	0	150	0	20, 010	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	230, 219				1, 038, 249	•
NONREI MBURSABLE COST CENTERS	1 100		1 100			100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 188 22, 936		1, 188 22, 936			190. 00 192. 00
194. 00 07950 WELLNESS	0	0	,			194.00
194. 01 07951 PALN MANAGEMENT	0	0	0	0		194.01
194. 02 07952 EXTERNAL SVCS MARKETI NG 194. 03 07953 WASHI NGTON CLI NI C	220 5, 001		220 5, 001			194. 02 194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0	3, 001			194.03
194. 05 07955 I NTEGRATED MEDI CI NE	630	0	630	0	6, 138	194. 05
194.06 07956 SURGICAL PROFESSIONAL 200.00 Cross Foot Adjustments	0	0	C	0	2, 643	194.06 200.00
200.00 Regative Cost Centers						200.00
	'	,		· ·		

Health Fir	nancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVICE)	
		FEET)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6, 667, 888	487, 384	1, 739, 52	6 1, 066, 683	594, 475	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25. 626602	1. 033592	6. 80038	9 26. 347610	0. 523102	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2, 488, 775	49, 544	92, 06	1 208, 625	5, 951	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	9. 565075	0. 105068	0. 35989	7 5. 153143	0. 005237	205.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI		CCN: 150065	In Lie Period:	u of Form CMS- Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	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	5/20/2015 3: 4 OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE (TI ME SPENT) 18.00	8 pm
GENERAL SERVICE COST CENTERS	10100	11100				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 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 NURSI NG ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY 18.00 01850 PHYSI CI AN PRI VATE PRACTICE 19.00 NONPHYSI CI AN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	659, 121 0 29, 347 0 0 0	10, 415, 179 17, 060 14, 578 531 0	1, 00	0 0 271, 877, 663 0 0 0	136, 808	1
30. 00 03000 ADULTS & PEDI ATRI CS	174, 502	100, 085		0 12, 651, 868	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	30, 425 10, 670	9, 431 331		0 1, 745, 843 0 1, 453, 875	0	31.00 43.00
ANCI LLARY SERVI CE COST CENTERS		171 700				
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	89, 970 0	171, 730 16, 920		0 60, 610, 138 0 5, 451, 791	0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	37, 772	0		0 6, 762, 994	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	2, 023		0 4, 287, 071	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	65, 127 0	42, 362 3, 558		0 15, 535, 458 0 3, 699, 567	0	54.00 54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2, 096		0 1, 880, 651	0	54.02
57. 00 05700 CT SCAN	0	1, 791		0 29, 499, 070	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	0 66, 610	1, 592 34, 419		0 10, 123, 876 0 44, 460, 835	0	58.00 60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	00,010	0		0 44, 400, 633	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	3, 397		0 1, 270, 215		64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 31, 087	5, 506 9, 937		0 4, 554, 742 0 4, 236, 285	0	65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	31,087	483		0 4, 230, 285	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	355		0 440, 046	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 091	3, 832		0 6, 334, 146		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	7, 131, 876 2, 671, 823		0 8, 502, 170 0 4, 655, 539		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 00			73.00
76.00 03952 WOUND CARE	0	169		0 598, 163		76.00
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	0	5, 290 11, 481		0 187, 467 0 1, 946, 774		76.02 76.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	4, 688		0 155, 958		76.97
OUTPATIENT SERVICE COST CENTERS		0.404		0 404 400	4 400	
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER 90. 01 04951 PALLIATIVE HEALTH	0	3, 131 12		0 134, 403 0 155, 422		•
90. 02 09000 VEIN CENTER	0	3, 020		0 1, 412, 082		
90. 03 09001 0B GYN	0	29, 516		0 1, 681, 089		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	91, 378	30, 739		0 14, 899, 631	0	91.00 92.00
93. 00 04952 BEHAVOURAL HEALTH	0	3, 453		0 210, 312	0	
OTHER REI MBURSABLE COST CENTERS	20 142	10 51/			0	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	29, 142	12, 516	I	0 2, 076, 764	0	101.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0 659, 121	8, 150 10, 357, 881		0 1, 882, 896 0 271, 877, 663		116. 00 118. 00
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 14, 406		0 0 0 0		190. 00 192. 00
194. 00 07950 WELLNESS	0	1, 948		o 0		192.00
194. 01 07951 PALN MANAGEMENT	0	7, 574		0 0		194.01
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON CLINIC	0	0 1, 357				194. 02 194. 03
194. 04 07954 PHYSI CI AN OFFICES	0	7, 825		o o		194.03
194. 05 07955 I NTEGRATED MEDI CI NE	0	4, 492		0 0		194.05
194. 06 07956 SURGI CAL PROFESSI ONAL		19, 696		uj 0	2,643	194.06

Health Fir	nancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		
						OTHER GENERAL	
			05117541	DUA DUA OV		SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PHYSI CI AN	
		ADMI NI STRATI ON	SERVICES &	(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	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 499, 610	1, 123, 911	4, 312, 59	6 1, 862, 714	364, 906	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 343855	0. 107911	4, 312. 59600	0. 006851	2.667286	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	355, 559	183, 740	295, 66	6 80, 134	12, 549	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 539444	0. 017642	295. 66600	0. 000295	0. 091727	205.00

Health Finan	cial Systems	SCHNECK MEDI CAL	CENTER	In Lieu	ı of Form CMS-2552-
COST ALLOCAT	FLON - STATISTICAL BASIS		Provider CCN: 150065	Period: From 01/01/2014	Worksheet B-1
				To 12/31/2014	Date/Time Prepared 5/20/2015 3:48 pm
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)			
OFNED		19.00			
	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT				1.0
	NEW CAP REL COSTS-DEDG & TTXT				2.0
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.0
	ADMINISTRATIVE & GENERAL				5.0
	OPERATION OF PLANT				7.0
	LAUNDRY & LINEN SERVICE HOUSEKEEPING				8. (
	DI ETARY				10. (
	CAFETERIA				11. (
	NURSING ADMINISTRATION				13. (
	CENTRAL SERVICES & SUPPLY				14. (
	PHARMACY MEDICAL RECORDS & LIBRARY				15. (
	PHYSI CI AN PRI VATE PRACTI CE				18.0
19.00 01900	NONPHYSICIAN ANESTHETISTS	1,000			19. (
	I ENT ROUTI NE SERVI CE COST CENTERS				
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT				30. (
	NURSERY				43.0
	LARY SERVICE COST CENTERS				
	OPERATING ROOM	0			50.0
	RECOVERY ROOM	0			51. (
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1,000			52. (53. (
	RADI OLOGY-DI AGNOSTI C	0			54.0
	ULTRA SOUND	0			54.0
	NUCLEAR MEDICINE - DIAGNOSTIC	0			54.0
	CT SCAN	0			57.0
	MAGNETIC RESONANCE IMAGING (MRI) LABORATORY	0			58. (60. (
	BLOOD STORING, PROCESSING, & TRANS.	0			63. (
	INTRAVENOUS THERAPY	0			64.0
	RESPI RATORY THERAPY PHYSI CAL THERAPY	0			65.0
	OCCUPATIONAL THERAPY	0			66. (67. (
	SPEECH PATHOLOGY	0			68. (
	ELECTROCARDI OLOGY	0			69.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.0
	I MPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0			72. (
	WOUND CARE	0			76.0
	CASE MANAGEMENT	0			76. (
		0			76.0
	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0			76.0
	OTHER OUTPATIENT SERVICE COST CENTER	0			90. (
	PALLI ATI VE HEALTH	0			90. (
	VEIN CENTER	0			90.0
90.03 09001 91.00 09100		0			90. (91. (
	OBSERVATION BEDS (NON-DISTINCT PART)				92.0
93.00 04952	BEHAVOURAL HEALTH	0			93. (
	REIMBURSABLE COST CENTERS				
	HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0			101. (
	INTEREST EXPENSE				113. (
116.00 11600	HOSPI CE	0			116. (
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,000			118. (
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. (
	PHYSI CLANS' PRI VATE OFFICES	0			190.0
194.0007950	WELLNESS	0			194. (
	PALN MANAGEMENT	0			194. (
	EXTERNAL SVCS MARKETING WASHINGTON CLINIC				194. (194. (
	PHYSICIAN OFFICES	0			194. (
194.0507955	INTEGRATED MEDICINE	0			194. (
	SURGI CAL PROFESSI ONAL	0			194. (
200.00 201.00	Cross Foot Adjustments Negative Cost Centers				200. (201. (
2000	1 <u>9</u> _19	ı I			1201.0

Health Financial Systems		SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS	2552-10
COST ALLOCATION - STATIS	TICAL BASIS		Provi der	CCN: 150065	Period: From 01/01/2014	Worksheet B-	1
					To 12/31/2014	Date/Time Pro 5/20/2015 3:-	
Cost Center	Description	NONPHYSI CI AN					
		ANESTHETI STS					
		(ASSI GNED					
		TIME)					
		19.00					
202.00 Cost to be a	llocated (per Wkst. B,	260, 212					202.00
Part I)							
203.00 Unit cost mu	ltiplier (Wkst. B, Part I)	260. 212000					203.00
204.00 Cost to be a	llocated (per Wkst. B,	2,849					204.00
Part II)							
	ltiplier (Wkst. B, Part	2, 849000					205.00
		2.017000					200.00
		I I					1

ealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES		CAL CENTER Provider	CCN: 150065	Peri od:	u of Form CMS-: Worksheet C	
			100000	From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
		Titl	e XVIII	Hospi tal	PPS	0 pm
				Costs		
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	1.00	2.00	3.00	4.00	5.00	
0. 00 03000 ADULTS & PEDIATRICS	15, 562, 200		15, 562, 20	0 00	15, 562, 200	30. 0
1.00 03100 INTENSIVE CARE UNIT	2, 360, 138		2, 360, 1		2, 360, 138	
3. 00 04300 NURSERY	529, 181		529, 18	81 0	529, 181	43.0
ANCI LLARY SERVI CE COST CENTERS	-					
0.00 05000 OPERATI NG ROOM	9, 157, 164		9, 157, 10		9, 157, 164	
1.00 05100 RECOVERY ROOM	737,069		737, 0		737,069	
2.00 O5200 DELIVERY ROOM & LABOR ROOM	2, 197, 209		2, 197, 20		2, 197, 209	
3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 601, 141 7, 410, 310		1, 601, 1, 7, 410, 3		1, 601, 141 7, 484, 045	
4. 01 03630 ULTRA SOUND	476, 736		476, 7		476, 736	
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	235, 278		235, 2		235, 278	
7. 00 05700 CT SCAN	1, 027, 921		1, 027, 9		1, 027, 921	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	473, 461		473, 40		473, 461	
0. 00 06000 LABORATORY	5, 236, 742		5, 236, 7		5, 306, 442	
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.	477, 246		477, 24	46 0	477, 246	63.0
4.00 06400 INTRAVENOUS THERAPY	662, 408		662, 40		662, 408	
5. 00 06500 RESPI RATORY THERAPY	1, 567, 902				1, 567, 902	
6.00 06600 PHYSI CAL THERAPY	2, 263, 590				2, 263, 590	•
7.00 06700 OCCUPATIONAL THERAPY	480, 183				480, 183	
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY	320, 833	0			320, 833	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	689, 131 9, 710, 429		689, 13 9, 710, 43		692, 600 9, 710, 429	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 647, 903		3, 647, 9		3, 647, 903	
3. 00 07300 DRUGS CHARGED TO PATIENTS	12, 122, 561		12, 122, 5		12, 122, 561	
6. 00 03952 WOUND CARE	320, 382		320, 3		320, 382	
6.02 03951 CASE MANAGEMENT	214, 489		214, 48		214, 489	
6. 03 03950 PALN MANAGEMENT	1, 645, 259		1, 645, 2	59 0	1, 645, 259	76.0
6. 97 07697 CARDI AC REHABI LI TATI ON	637, 385		637, 3	85 0	637, 385	76.9
OUTPATIENT SERVICE COST CENTERS	-					
0.00 04953 OTHER OUTPATIENT SERVICE COST CENTER	78, 178		78, 1	-	78, 178	
0. 01 04951 PALLI ATI VE HEALTH	165, 407		165, 40		165, 407	
0. 02 09000 VEIN CENTER 0. 03 09001 0B GYN	353, 098		353, 0		353, 098	
1. 00 09100 EMERGENCY	1, 791, 016 5, 731, 385		1, 791, 0 ⁻ 5, 731, 3		1, 791, 016 5, 731, 385	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 952, 528		1, 952, 52		1, 952, 528	
3. 00 04952 BEHAVOURAL HEALTH	354, 882		354, 8		354, 882	
OTHER REIMBURSABLE COST CENTERS	001/002		00170	02	0017002	1 101 0
01.00 10100 HOME HEALTH AGENCY	2, 155, 372		2, 155, 3	72	2, 155, 372	101.0
SPECIAL PURPOSE COST CENTERS]
13.00 11300 INTEREST EXPENSE						113. 0
16. 00 11600 HOSPI CE	1, 202, 781		1, 202, 78		1, 202, 781	
00.00 Subtotal (see instructions)	95, 548, 898				95, 695, 802	
01.00 Less Observation Beds	1, 952, 528		1, 952, 52		1, 952, 528	
02.00 Total (see instructions)	93, 596, 370	0	93, 596, 3	70 146, 904	93, 743, 274	J202. 0

OMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Period: From 01/01/2014	Worksheet C Part I	
					To 12/31/2014	Date/Time Pre 5/20/2015 3:4	pared 8 pm
				e XVIII	Hospi tal	PPS	• p
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Rati o	Inpatient	
		6.00	7.00	8.00	9.00	<u>Ratio</u> 10.00	
	TIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
	0 ADULTS & PEDI ATRI CS	11, 412, 659		11, 412, 65	59		1 30. 0
	O I NTENSI VE CARE UNI T	1, 745, 843		1, 745, 84			31.0
	0 NURSERY	1, 453, 875		1, 453, 87			43.0
	LLARY SERVICE COST CENTERS	.,,		.,,			1
	O OPERATING ROOM	12, 712, 677	47, 897, 461	60, 610, 13	0. 151083	0.00000	50.0
1.00 0510	O RECOVERY ROOM	898, 934	4, 552, 857	5, 451, 79	0. 135198	0.000000	51.0
2.00 05200	O DELIVERY ROOM & LABOR ROOM	6, 326, 999	435, 995	6, 762, 99	0. 324887	0.00000	52.0
	O ANESTHESI OLOGY	1, 006, 929	3, 280, 142	4, 287, 07	0. 373481	0.00000	53.
4.00 05400	0 RADI OLOGY-DI AGNOSTI C	1, 080, 078	14, 455, 380	15, 535, 45	0. 476993	0.00000	54.0
	OULTRA SOUND	453, 775	3, 245, 792	3, 699, 56	67 0. 128863	0.00000	54.
	ONUCLEAR MEDICINE - DIAGNOSTIC	91, 438	1, 789, 213			0.00000	
	O CT SCAN	3, 635, 269	25, 863, 801	29, 499, 07		0.00000	
	O MAGNETIC RESONANCE IMAGING (MRI)	779, 727	9, 344, 149	10, 123, 87	0. 046767	0.00000	
	0 LABORATORY	10, 289, 312	34, 171, 523	44, 460, 83		0.00000	
	0 BLOOD STORING, PROCESSING, & TRANS.	527, 177	296, 427			0.00000	
	0 INTRAVENOUS THERAPY	340, 514	929, 701	1, 270, 21		0.00000	
	0 RESPI RATORY THERAPY	3, 531, 574	1, 023, 168			0.00000	
	0 PHYSI CAL THERAPY	731, 144	3, 505, 141	4, 236, 28		0.000000	
	O OCCUPATIONAL THERAPY	442, 773	1, 194, 702			0.00000	
	O SPEECH PATHOLOGY	71, 848	368, 198			0.000000	
	0 ELECTROCARDI OLOGY	1, 205, 721	5, 128, 425			0.000000	
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 816, 531	5, 685, 639			0.00000	
	O IMPL. DEV. CHARGED TO PATIENT	2, 480, 720	2, 174, 819			0.00000	
	O DRUGS CHARGED TO PATIENTS	4, 753, 317	11, 166, 126			0.00000	
	2 WOUND CARE	34, 988	563, 175			0.00000	
	1 CASE MANAGEMENT	24, 625	162, 842			0.00000	
	O PAIN MANAGEMENT	2, 516	1, 944, 258			0.00000	
	7 CARDI AC REHABI LI TATI ON ATI ENT SERVI CE COST CENTERS	246	155, 712	155, 95	4. 086902	0.000000	76.
	3 OTHER OUTPATIENT SERVICE COST CENTER	0	134, 403	134, 40	0. 581669	0.000000	90.
	1 PALLIATIVE HEALTH	23, 895	134, 403			0.000000	90. 90.
	O VEIN CENTER	23, 095	1, 412, 082			0.000000	
	1 OB GYN	10, 208	1, 412, 082	1, 681, 08		0.000000	
	0 EMERGENCY	1, 557, 806	13, 341, 825			0.000000	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	1, 337, 800	1, 224, 209			0.000000	
	2 BEHAVOURAL HEALTH	5, 762	204, 550			0.000000	
	R REIMBURSABLE COST CENTERS	5,702	204, 330	210, 3	12 1.007407	0.000000	73.
	O HOME HEALTH AGENCY	0	2, 076, 764	2, 076, 76	54		101.
	I AL PURPOSE COST CENTERS		_, , / 0 /	_,			1
	OINTEREST EXPENSE						113.
16.001160		0	1, 882, 896	1, 882, 89	96		116.
00.00	Subtotal (see instructions)	70, 463, 880	201, 413, 783				200.
01.00	Less Observation Beds						201.
02.00	Total (see instructions)	70, 463, 880	201, 413, 783	271, 877, 66			202.

ealth Financial Systems OMPUTATION OF RATIO OF COSTS TO CHARGES		L CENTER Provider CCN: 150065	Peri od:	u of Form CMS-2552 Worksheet C
			From 01/01/2014 To 12/31/2014	Part I Date/Time Prepare
			10 12/31/2014	5/20/2015 3:48 pr
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS				30
1. 00 03100 I NTENSI VE CARE UNI T				31
3. 00 04300 NURSERY				43
ANCI LLARY SERVICE COST CENTERS	0 151002			50
0. 00 05000 OPERATING ROOM 1. 00 05100 RECOVERY ROOM	0. 151083 0. 135198			50
2.00 05200 DELIVERY ROOM & LABOR ROOM				51
3. 00 05300 ANESTHESI OLOGY	0. 324887 0. 373481			52
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 373481			54
4. 01 03630 ULTRA SOUND	0. 128863			54
4. 01 03050 DETRA SOUND 4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 125105			54
7. 00 05700 CT SCAN	0. 034846			57
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 046767			58
0. 00 06000 LABORATORY	0. 119351			60
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 579461			63
4. 00 06400 I NTRAVENOUS THERAPY	0. 521493			64
5. 00 06500 RESPIRATORY THERAPY	0. 344235			65
6. 00 06600 PHYSI CAL THERAPY	0. 534334			66
7. 00 06700 OCCUPATI ONAL THERAPY	0. 293246			67
8. 00 06800 SPEECH PATHOLOGY	0. 729090			68
9. 00 06900 ELECTROCARDI OLOGY	0. 109344			69
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 142112			71
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 783562			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 761494			73
6. 00 03952 WOUND CARE	0. 535610			76
6. 02 03951 CASE MANAGEMENT	1. 144143			76
6. 03 03950 PALN MANAGEMENT	0. 845121			76
6. 97 07697 CARDI AC REHABI LI TATI ON	4. 086902			76
OUTPATIENT SERVICE COST CENTERS	11000702			
0. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0. 581669			90
0. 01 04951 PALLIATIVE HEALTH	1. 064244			90
0. 02 09000 VEIN CENTER	0. 250055			90
0. 03 09001 0B GYN	1. 065390			90
1. 00 09100 EMERGENCY	0. 384666			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 575624			92
3. 00 04952 BEHAVOURAL HEALTH	1. 687407			93
OTHER REIMBURSABLE COST CENTERS				
01. 00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
13. 00 11300 I NTEREST EXPENSE				113
16. 00 11600 HOSPI CE				116
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
	1			201

ealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	SCHNECK MEDI		CCN: 150065	Peri od:	u of Form CMS-: Worksheet C	2002 1
		i i ovi dei	CCN. 150005	From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	pared.
				10 12/01/2011	5/20/2015 3:4	
	-	Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 03000 ADULTS & PEDIATRICS	15, 562, 200		15, 562, 2	0 00	15, 562, 200	30.00
1. 00 03100 I NTENSI VE CARE UNI T	2, 360, 138		2, 360, 1		2, 360, 138	
3. 00 04300 NURSERY	529, 181		529, 1		529, 181	•
ANCILLARY SERVICE COST CENTERS	- · · · ·		•		· · ·	1
0. 00 05000 OPERATI NG ROOM	9, 157, 164		9, 157, 1	64 0	9, 157, 164	50.00
1.00 05100 RECOVERY ROOM	737,069		737, 0	69 0	737, 069	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 197, 209		2, 197, 2	09 0	2, 197, 209	52.00
3. 00 05300 ANESTHESI OLOGY	1, 601, 141		1, 601, 1		1, 601, 141	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 410, 310		7, 410, 3	10 73, 735	7, 484, 045	•
4.01 03630 ULTRA SOUND	476, 736		476, 7		476, 736	
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	235, 278		235, 2		235, 278	
57.00 05700 CT SCAN	1, 027, 921		1, 027, 9		1, 027, 921	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	473, 461		473, 4		473, 461	
0. 00 06000 LABORATORY	5, 236, 742		5, 236, 7		5, 306, 442	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	477, 246		477, 2		477, 246	
4. 00 06400 I NTRAVENOUS THERAPY	662, 408		662, 4		662, 408	
55. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	1, 567, 902 2, 263, 590				1, 567, 902	
0. 00 00000 PHYSICAL THERAPY 07. 00 06700 OCCUPATIONAL THERAPY	480, 183				2, 263, 590 480, 183	
8. 00 06800 SPEECH PATHOLOGY	320, 833	-			320, 833	
9. 00 06900 ELECTROCARDI OLOGY	689, 131		689, 1		692, 600	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 710, 429		9, 710, 4		9, 710, 429	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 647, 903		3, 647, 9		3, 647, 903	
3. 00 07300 DRUGS CHARGED TO PATIENTS	12, 122, 561		12, 122, 5		12, 122, 561	
6.00 03952 WOUND CARE	320, 382		320, 3		320, 382	
6.02 03951 CASE MANAGEMENT	214, 489		214, 4		214, 489	
6. 03 03950 PALN MANAGEMENT	1, 645, 259		1, 645, 2		1, 645, 259	
6. 97 07697 CARDI AC REHABI LI TATI ON	637, 385		637, 3		637, 385	
OUTPATIENT SERVICE COST CENTERS		•				
0.00 04953 OTHER OUTPATIENT SERVICE COST CENTER	78, 178		78, 1	78 0	78, 178	
0. 01 04951 PALLIATIVE HEALTH	165, 407		165, 4	07 0	165, 407	90.0
0. 02 09000 VEIN CENTER	353, 098		353, 0		353, 098	
0. 03 09001 OB GYN	1, 791, 016		1, 791, 0		1, 791, 016	
1.00 09100 EMERGENCY	5, 731, 385		5, 731, 3		5, 731, 385	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 952, 528		1, 952, 5		1, 952, 528	
23.00 04952 BEHAVOURAL HEALTH	354, 882		354, 8	82 0	354, 882	93.00
OTHER REI MBURSABLE COST CENTERS	0.455.030		0.455.0		0.455.030	1
01. 00 10100 HOME HEALTH AGENCY	2, 155, 372		2, 155, 3	12	2, 155, 372	1101.00
SPECIAL PURPOSE COST CENTERS			1			1112 0
13. 00 11300 I NTEREST EXPENSE 16. 00 11600 HOSPI CE	1 202 701		1 202 7	01	1 202 704	113.00
	1, 202, 781		1, 202, 7		1, 202, 781 95, 695, 802	
200.00Subtotal (see instructions)201.00Less Observation Beds	95, 548, 898 1, 952, 528		95, 548, 8 1, 952, 5		95, 695, 802 1, 952, 528	
202.00 Total (see instructions)						
	93, 596, 370	I U	93, 596, 3	140, 904	73, 143, 214	1202. U

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150065	Period: From 01/01/2014	Worksheet C Part I	
				To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.		TEFRA	
			+ col. 7)	Rati o	Inpatient	
	(00	7.00	0.00	0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
D. 00 03000 ADULTS & PEDIATRICS	11, 412, 659		11, 412, 65	59		30.0
1. 00 03100 I NTENSI VE CARE UNI T	1, 745, 843		1, 745, 84			31.0
3. 00 04300 NURSERY	1, 453, 875		1, 453, 87			43.0
ANCI LLARY SERVICE COST CENTERS	1,433,073		1, 433, 01			
D. 00 05000 0PERATING ROOM	12, 712, 677	47, 897, 461	60, 610, 13	0. 151083	0, 000000	1 50.0
1.00 05100 RECOVERY ROOM	898, 934	4, 552, 857	5, 451, 79		0.000000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	6, 326, 999	435, 995	6, 762, 99		0.000000	
3. 00 05300 ANESTHESI OLOGY	1,006,929	3, 280, 142	4, 287, 07		0.000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 080, 078	14, 455, 380			0.000000	54. (
4. 01 03630 ULTRA SOUND	453, 775	3, 245, 792	3, 699, 56	0. 128863	0.000000	54.0
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	91, 438	1, 789, 213	1, 880, 65	0. 125105	0.000000	54.
7.00 05700 CT SCAN	3, 635, 269	25, 863, 801	29, 499, 07	0. 034846	0.000000	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	779, 727	9, 344, 149	10, 123, 87	76 0. 046767	0.000000	58.
D. 00 06000 LABORATORY	10, 289, 312	34, 171, 523	44, 460, 83	0. 117783	0.000000	60.
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.	527, 177	296, 427	823, 60	0. 579461	0.000000	63.
4. 00 06400 INTRAVENOUS THERAPY	340, 514	929, 701	1, 270, 21	0. 521493	0.000000	64.
5. 00 06500 RESPI RATORY THERAPY	3, 531, 574	1, 023, 168	4, 554, 74	42 0. 344235	0.000000	65.
6. 00 06600 PHYSI CAL THERAPY	731, 144	3, 505, 141	4, 236, 28	0. 534334	0.000000	66.
7.00 06700 OCCUPATI ONAL THERAPY	442, 773	1, 194, 702	1, 637, 47	0. 293246	0.00000	67.
B. 00 06800 SPEECH PATHOLOGY	71, 848	368, 198	440, 04	46 0. 729090	0.00000	68.
9. 00 06900 ELECTROCARDI OLOGY	1, 205, 721	5, 128, 425	6, 334, 14	46 0. 108796	0.00000	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 816, 531	5, 685, 639	8, 502, 17	70 1.142112	0.00000	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 480, 720	2, 174, 819	4, 655, 53	0. 783562	0.00000	
3.00 07300 DRUGS CHARGED TO PATIENTS	4, 753, 317	11, 166, 126	15, 919, 44	43 0. 761494	0.00000	73.
6.00 03952 WOUND CARE	34, 988	563, 175	598, 16	63 0. 535610	0.00000	76.
6.02 03951 CASE MANAGEMENT	24, 625	162, 842	187, 46	57 1.144143	0.00000	76.
6.03 03950 PALN MANAGEMENT	2, 516	1, 944, 258	1, 946, 77	0. 845121	0.00000	
6. 97 07697 CARDI AC REHABILI TATI ON	246	155, 712	155, 95	58 4.086902	0.00000	76.
OUTPATIENT SERVICE COST CENTERS						
D. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0	134, 403	134, 40		0.00000	90.
D. 01 04951 PALLIATIVE HEALTH	23, 895	131, 527	155, 42		0.000000	90.
D. 02 09000 VEIN CENTER	0	1, 412, 082	1, 412, 08		0.000000	
D. 03 09001 OB GYN	10, 208	1, 670, 881	1, 681, 08		0.000000	
1.00 09100 EMERGENCY	1, 557, 806	13, 341, 825	14, 899, 63		0.000000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,000	1, 224, 209			0.00000	
3. 00 04952 BEHAVOURAL HEALTH	5, 762	204, 550	210, 31	12 1.687407	0.00000	93.
OTHER REIMBURSABLE COST CENTERS	TT					
D1. 00 10100 HOME HEALTH AGENCY	0	2,076,764	2, 076, 76	54		101. (
SPECIAL PURPOSE COST CENTERS	I			1		
13. 00 11300 INTEREST EXPENSE						113.
16.00 11600 HOSPI CE	0	1, 882, 896				116.
00.00 Subtotal (see instructions)	70, 463, 880	201, 413, 783	271, 877, 66	53		200.
01.00 Less Observation Beds	70 4/0 000	004 440 700	074 077 (201.
02.00 Total (see instructions)	70, 463, 880	201, 413, 783	271, 877, 66	53		202.

ealth Financial Systems OMPUTATION OF RATIO OF COSTS TO CHARGES	SCHNECK MEDICA	Provi der CCN: 150065	Peri od:	u of Form CMS-255 Worksheet C
			From 01/01/2014 To 12/31/2014	Part I Date/Time Prepar
		Title XIX	Hospi tal	5/20/2015 3:48 p Cost
Cost Center Description	PPS Inpatient			0031
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS				30
1.00 03100 INTENSIVE CARE UNIT				31
3. 00 04300 NURSERY				43
ANCI LLARY SERVI CE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 000000			50
1.00 05100 RECOVERY ROOM	0. 000000			51
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
3. 00 05300 ANESTHESI OLOGY	0. 000000			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
4. 01 03630 ULTRA SOUND	0. 000000			54
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54
7.00 05700 CT SCAN	0. 000000			57
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
0. 00 06000 LABORATORY	0. 000000			60
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000			63
4.00 06400 I NTRAVENOUS THERAPY	0. 000000			64
5. 00 06500 RESPI RATORY THERAPY	0. 000000			65
6. 00 06600 PHYSI CAL THERAPY	0. 000000			66
7.00 06700 OCCUPATIONAL THERAPY	0. 000000			67
8. 00 06800 SPEECH PATHOLOGY	0.00000			68
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS				71
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72
3. 00 07300 DRUGS CHARGED TO PATIENTS 6. 00 03952 WOUND CARE	0. 000000			73
6.00 03952 WOUND CARE 6.02 03951 CASE MANAGEMENT	0. 000000 0. 000000			76
6. 03 03950 PALN MANAGEMENT	0. 000000			76
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76
OUTPATIENT SERVICE COST CENTERS	0.000000			//
0. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			90
0. 01 04951 PALLIATIVE HEALTH	0. 000000			90
0. 02 09000 VEIN CENTER	0. 000000			90
0. 03 09001 0B GYN	0. 000000			90
1. 00 09100 EMERGENCY	0. 000000			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
3. 00 04952 BEHAVOURAL HEALTH	0. 000000			93
OTHER REIMBURSABLE COST CENTERS	0.00000			7.
01. 00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				10
13. 00 11300 I NTEREST EXPENSE				113
16. 00 11600 HOSPI CE				116
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
02.00 Total (see instructions)				202

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014		
		T: +1	e XVIII	lloonitel	5/20/2015 3:4 PPS	8 рії
Cast Canton Description	Capi tal		Reduced	Hospi tal		
Cost Center Description		Swing Bed			Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-		- 1		
30. 00 ADULTS & PEDIATRICS	2, 542, 140	0	2, 542, 14	0 12, 888	197.25	30.00
31.00 INTENSIVE CARE UNIT	313, 736		313, 73	6 1, 322	237.32	31.00
43.00 NURSERY	11, 498		11, 49	8 1, 746	6.59	43.00
200.00 Total (lines 30-199)	2, 867, 374		2, 867, 37	4 15, 956		200.00
Cost Center Description	I npati ent	I npati 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	4,888	964, 158	3			30.00
31.00 INTENSIVE CARE UNIT	553					31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	5, 441	1, 095, 396				200.00
	1 0,111	.,070,070	1			1-00.00

APPOR ⁻	Financial Systems FIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/		CAL CENTER Provi der	CCN: 150065	Peri od:	u of Form CMS-: Worksheet D	2002 1
					From 01/01/2014	Part II	
					To 12/31/2014	Date/Time Pre	pared:
			T: +1	e XVIII	Hospi tal	5/20/2015 3:4 PPS	8 pm
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)	. charges	corumr 4)	
		26)	0)	2)			
		1.00	2.00	3.00	4.00	5.00	-
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50.00	05000 OPERATING ROOM	1, 888, 888	60, 610, 138	0.0311	65 6, 285, 450	195, 886	50.00
51.00	05100 RECOVERY ROOM	15, 631	5, 451, 791				•
52.00	05200 DELIVERY ROOM & LABOR ROOM	41,057					
53.00	05300 ANESTHESI OLOGY	42, 989					
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 317, 678					
54.01	03630 ULTRA SOUND	19, 587	3, 699, 567				•
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	3, 651	1, 880, 651				
57.00	05700 CT SCAN	114, 778					
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	11,835					•
50.00	06000 LABORATORY	382, 252					
53.00	06300 BLOOD STORING, PROCESSING, & TRANS.	4, 813					•
54.00	06400 I NTRAVENOUS THERAPY	169, 694					
5.00	06500 RESPI RATORY THERAPY	119, 464					•
6. 00	06600 PHYSI CAL THERAPY	238, 769					•
57.00	06700 OCCUPATI ONAL THERAPY	18, 469					
58.00	06800 SPEECH PATHOLOGY	3, 306				364	
59.00	06900 ELECTROCARDI OLOGY	201, 156					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	214, 399					
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	80, 755					
73.00	07300 DRUGS CHARGED TO PATIENTS	374, 986					
76.00	03952 WOUND CARE	44, 715				1, 500	
6. 02	03951 CASE MANAGEMENT	30, 240				0	
76.03	03950 PALN MANAGEMENT	153, 768				72	
	07697 CARDI AC REHABI LI TATI ON	6, 840					
0. 77	OUTPATIENT SERVICE COST CENTERS	0,010	100,700	010100	120	U	,,
0.00	04953 OTHER OUTPATIENT SERVICE COST CENTER	2,408	134, 403	0.0179	16 0	0	90.0
0.01	04951 PALLI ATI VE HEALTH	1,825				0	
90.02	09000 VEIN CENTER	5, 793				0	
0.03	09001 OB GYN	116, 267	1, 681, 089			3	
1.00	09100 EMERGENCY	415, 567					
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	318, 953				0	
93.00	04952 BEHAVOURAL HEALTH	46, 790				-	
200.00		6, 407, 323			25, 949, 615		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150065 Period: From 01/01/2014 To 12/31/2014 Worksheet D Part III Date/Time Prepared: 5/20/2015 3: 48 pm Title XVIII Hospital PPS Cost Center Description Nursing School Allied Health Cost Alli Other Medical Education Cost Swing-Bed Adjustment (sum of cols. Instructions) Total Costs (sum of cols. I through 3, minus col. 4) INPATIENT ROUTINE SERVICE COST CENTERS Interview Interview Interview
Cost Center Description Nursing School Allied Health All Other Swing-Bed Total Costs Medical Adjustment (sum of cols.) INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00
Image: Construction of the co
Education Cost Amount (see instructions) 1 through 3, minus col. 4) 1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS instructions minus col. 4
1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30. 00
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00
43.00 04300 NURSERY 0 0 0 43.00
200.00 Total (lines 30-199) 0 0 0 0 0 0 0 0 0 0 0
Cost Center Description Total Patient Per Diem (col. Inpatient Inpatient
Days 5 ÷ col. 6) Program Days Program
Pass-Through
Cost (col. 7 x
col. 8)
6.00 7.00 8.00 9.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRI CS 12, 888 0. 00 4, 888 0 30. 00 30. 00
31.00 03100 INTENSIVE CARE UNIT 1, 322 0.00 553 0 31.00
43. 00 04300 NURSERY 1, 746 0, 00 0 43. 00
200.00 Total (Lines 30-199) 15, 956 5, 441 0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150065 Period: THROUGH COSTS Provider CCN: 150065 From 01/01/207	Worksheet D	
To 12/31/201		pared:
Title XVIII Hospital	PPS	
Cost Center Description Non Physician Nursing School Allied Health All Other	Total Cost	
Anesthetist Medical	(sum of col 1	
Cost Education Cost	t 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	50.00
51. 00 05100 RECOVERY ROOM 0 0	0 0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0	0 0	52.00
53. 00 05300 ANESTHESI OLOGY 0 0	0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0	0 0	54.00
54. 01 03630 ULTRA SOUND 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 I MAGING (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. 0 0 0	0 0	63.00
64. 00 06400 I NTRAVENOUS 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 OCCUPATIONAL THERAPY 0 0 0	0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	0 0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0	0 0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0	0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 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 0N 0 0 0	0 0	76.97
OUTPATIENT SERVICE COST CENTERS	-	
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0	0 0	
90.01 04951 PALLI ATI VE HEALTH 0 0 0	0 0	90.01
90. 02 09000 VEI N CENTER 0 0 0	0 0	90.02
90. 03 09001 0B GYN 0 0 0	0 0	90.03
	0 0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0	0 0	
93. 00 04952 BEHAVOURAL HEALTH 0 0 0	0 0	93.00
200.00 Total (lines 50-199) 0 0	0 0	200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		CAL CENTER S Provider	CCN: 150065	Peri od:	u of Form CMS- Worksheet D	
HROUGH COSTS				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/20/2015 3:4	8 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges		t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS						
0.00 05000 OPERATI NG ROOM	0					
1.00 05100 RECOVERY ROOM	0					
2.00 O5200 DELIVERY ROOM & LABOR ROOM	0	6, 762, 994				
3. 00 05300 ANESTHESI OLOGY	0	1,20,10,1				
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	15, 535, 458				
4. 01 03630 ULTRA SOUND	0	3, 699, 567				
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	.,				
7. 00 05700 CT SCAN	0					
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10/120/0/0				
	0	44, 460, 835				
3. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0	823, 604			326, 488	
4. 00 06400 I NTRAVENOUS THERAPY 5. 00 06500 RESPI RATORY THERAPY	0	1, 270, 215			176, 064	
	0	4, 554, 742			1, 542, 486	
6.00 06600 PHYSI CAL THERAPY	0	4, 236, 285				
7. 00 06700 0CCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY	0	1, 637, 475 440, 046				
9. 00 06900 ELECTROCARDI OLOGY	0	6, 334, 146				
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 502, 170				
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 655, 539				
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	15, 919, 443				
6. 00 03952 WOUND CARE	0	598, 163			2, 080, 924 20, 071	
6. 02 03951 CASE MANAGEMENT	0	187, 467				
6. 03 03950 PALN MANAGEMENT						76.0
6. 97 07697 CARDI AC REHABI LI TATI ON						
OUTPATIENT SERVICE COST CENTERS		155, 950	0.00000	0 0.000000	123	, , 0. ,
0. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER	0	134, 403	0.00000	0 0. 000000	0	90.0
0. 01 04951 PALLIATIVE HEALTH	0				0	
0. 02 09000 VEIN CENTER		1, 412, 082			0	
0. 03 09001 0B GYN					-	
1. 00 09100 EMERGENCY		14, 899, 631				
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 239, 209				
3. 00 04952 BEHAVOURAL HEALTH		210, 312				
00.00 Total (lines 50-199)	0			0.00000	25, 949, 615	

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RALE OTHER PASS	CAL CENTER	CCN: 150065	Peri od:	Worksheet D	5-2552-1
	H COSTS	WICE OTHER TASS	riovider	CCN. 150005	From 01/01/2014		
mooc	1 00010				To 12/31/2014	1 Date/Time Pr	repared:
						5/20/2015 3:	.48 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.	9		
		x col. 10)	10.00	x col. 12)			
	ANCILLADY SEDVICE COST CENTERS	11.00	12.00	13.00			
50.00	ANCI LLARY SERVI CE COST CENTERS	0	9, 707, 886	1	0		50.00
51.00	05100 RECOVERY ROOM	0	9, 707, 880 940, 879		0		51.00
		0	940, 879		0		
	05200 DELIVERY ROOM & LABOR ROOM	0	-		0		52.00
3.00	05300 ANESTHESI OLOGY	0	605, 585		0		53.00
64.00	05400 RADI OLOGY-DI AGNOSTI C	0	2,063,146		0		54.00
	03630 ULTRA SOUND	0	861, 265		0		54.0
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	690, 936		0		54.02
	05700 CT SCAN	0	5, 665, 411		0		57.0
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2, 141, 267		0		58.0
0.00	06000 LABORATORY	0	4, 363, 968		0		60.00
3.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	103, 182		0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	541, 937		0		64.00
5.00	06500 RESPI RATORY THERAPY	0	170, 099		0		65.00
6.00	06600 PHYSI CAL THERAPY	0	0		0		66.00
7.00	06700 OCCUPATI ONAL THERAPY	0	13, 442		0		67.00
8.00	06800 SPEECH PATHOLOGY	0	0		0		68.00
9.00	06900 ELECTROCARDI OLOGY	0	1, 308, 290		0		69.00
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	978, 415		0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	534, 309		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 203, 135		0		73.00
	03952 WOUND CARE	0	283, 275		0		76.00
	03951 CASE MANAGEMENT	0	200, 2,0		0		76.02
	03950 PALN MANAGEMENT	0	216, 828		0		76.0
	07697 CARDI AC REHABI LI TATI ON	0	81, 795		0		76.9
0. , ,	OUTPATIENT SERVICE COST CENTERS		01,770		3		
0.00	04953 OTHER OUTPATIENT SERVICE COST CENTER	0	29,073		0		90.00
	04951 PALLI ATI VE HEALTH	0	18, 365		0		90.0
	09000 VEIN CENTER	0	.0,000		0		90.02
	09001 OB GYN	0	10, 494		0		90.0
	09100 EMERGENCY	0	2, 086, 776		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		315, 575		0		92.00
	04952 BEHAVOURAL HEALTH		46, 935		0		92.00
		- UI	40. 930	1	UI		1 73.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST			Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/20/2015 3:4	epared: 8 pm
			. Ti tl	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	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS			1			-
	O OPERATI NG ROOM	0. 151083			0 0	1, 466, 697	
	O RECOVERY ROOM	0. 135198			0 0	127, 205	
	O DELIVERY ROOM & LABOR ROOM	0. 324887			0 0	0	
	0 ANESTHESI OLOGY	0. 373481			0 0	226, 174	
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 476993	2, 063, 146		0 0	984, 106	54.00
	OULTRA SOUND	0. 128863			0 0	110, 985	54.01
54.02 0345	ONUCLEAR MEDICINE - DIAGNOSTIC	0. 125105	690, 936	•	0 547	86, 440	54.02
	O CT SCAN	0. 034846	5, 665, 411		0 682	197, 417	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 046767	2, 141, 267		0 138	100, 141	58.00
60.00 0600	0 LABORATORY	0. 117783	4, 363, 968	58	0 0	514, 001	60.00
63.00 0630	O BLOOD STORING, PROCESSING, & TRANS.	0. 579461	103, 182		0 0	59, 790	63.00
64.00 0640	O I NTRAVENOUS THERAPY	0. 521493	541, 937		0 0	282, 616	64.00
65.00 0650	0 RESPI RATORY THERAPY	0. 344235	170, 099	1	0 0	58, 554	65.00
66.00 0660	O PHYSI CAL THERAPY	0. 534334	0		0 0	0	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	0. 293246	13, 442		0 0	3, 942	67.00
68.00 0680	O SPEECH PATHOLOGY	0. 729090	0		0 0	0	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 108796	1, 308, 290		0 407	142, 337	69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 142112	978, 415		0 0	1, 117, 460	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENT	0. 783562	534, 309)	0 0	418, 664	
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 761494	4, 203, 135		0 25, 443	3, 200, 662	73.00
76.00 0395	2 WOUND CARE	0. 535610	283, 275		0 0	151, 725	76.00
76.02 0395	1 CASE MANAGEMENT	1. 144143			0 0	0	76.02
76.03 0395	O PALN MANAGEMENT	0. 845121	216, 828		0 0	183, 246	76.03
76.97 0769	7 CARDI AC REHABILI TATI ON	4. 086902			0 0	334, 288	
	ATIENT SERVICE COST CENTERS						
	3 OTHER OUTPATIENT SERVICE COST CENTER	0. 581669	29, 073		0 0	16, 911	90.00
	1 PALLI ATI VE HEALTH	1.064244			0 0	19, 545	
	O VEIN CENTER	0. 250055			0 0	0	
	1 OB GYN	1.065390			0 0	11, 180	
	0 EMERGENCY	0. 384666			0 0	802, 712	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	1. 575624			0 0	497, 228	
	2 BEHAVOURAL HEALTH	1. 687407			0 0	79, 198	
200.00	Subtotal (see instructions)	1.007407	37, 982, 268			11, 193, 224	
201.00	Less PBP Clinic Lab. Services-Program		57,702,200	1	0 27,217	11, 175, 224	200.00
201.00	Only Charges						201.00
		1	1	1	1		1

APPORTI ONME	ncial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND		CAL CENTER Provi der	CCN: 150065	Peri od:	u of Form CMS Worksheet D	-2552-10
					From 01/01/2014 To 12/31/2014	Part V Date/Time Pro 5/20/2015 3:4	
			Ti tl	e XVIII	Hospi tal	PPS	10 pm
		Cos			- I I		
	Cost Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	LLARY SERVICE COST CENTERS			1			
	O OPERATING ROOM	0					50.00
	O RECOVERY ROOM	0		1			51.00
	O DELIVERY ROOM & LABOR ROOM	0		1			52.00
	0 ANESTHESI OLOGY	0	0				53.00
	0 RADI OLOGY-DI AGNOSTI C	0	-				54.00
	O ULTRA SOUND	0	0				54.01
	O NUCLEAR MEDICINE - DIAGNOSTIC	0					54.02
	O CT SCAN	0					57.00
	O MAGNETIC RESONANCE I MAGING (MRI)	0	-				58.00
	0 LABORATORY	68	0				60.00
	O BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
1	O I NTRAVENOUS THERAPY	0	0	•			64.00
1	O RESPIRATORY THERAPY	0	0				65.00
	O PHYSI CAL THERAPY	0	-	•			66.00
	O OCCUPATIONAL THERAPY	0	0				67.00
	O SPEECH PATHOLOGY	0	0				68.00 69.00
	0 ELECTROCARDIOLOGY 0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44				71.00
	OIMEDICAL SUPPLIES CHARGED TO PATIENTS	0					72.00
	O DRUGS CHARGED TO PATIENT	0	19, 375				73.00
1	2 WOUND CARE	0	19, 375				76.00
	1 CASE MANAGEMENT	0	0	•			76.02
	O PALN MANAGEMENT	0					76.02
	7 CARDIAC REHABILITATION	0					76.97
	ATIENT SERVICE COST CENTERS	0	0	1			/0.9/
	3 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90.00
	1 PALLIATIVE HEALTH	0	-	1			90.01
	O VEIN CENTER	0	0				90.02
	1 OB GYN	0	0				90.03
	0 EMERGENCY	0	0				91.00
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	2 BEHAVOURAL HEALTH	0					93.00
200.00	Subtotal (see instructions)	68	-				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					200.00
201.00	Only Charges	0					201.00
1	Net Charges (line 200 +/- line 201)	68	19, 517				202.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	CAL CENTER Provi der	CCN: 150065	Peri od:	Worksheet D	2552-10
					From 01/01/2014		
					To 12/31/2014		
			T: +		lloonital	5/20/2015 3:4	8 pm
			111	Le XIX Charges	Hospi tal	Cost Costs	
	Cost Center Description	Cost to Charge	DDS Doimburcod		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coi ns			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS		2100	0.00		0.00	
	O OPERATING ROOM	0. 151083	0		0 2, 123, 318	0	50.00
	O RECOVERY ROOM	0. 135198			0 305, 696		
	O DELIVERY ROOM & LABOR ROOM	0. 324887	0		0 85, 433		
	O ANESTHESI OLOGY	0. 373481	0		0 265, 592		
	0 RADI OLOGY-DI AGNOSTI C	0. 476993	0		0 702, 488		
	O ULTRA SOUND	0. 128863			0 161, 059		
	ONUCLEAR MEDICINE - DIAGNOSTIC	0. 125105			0 52, 311	0	
	O CT SCAN	0. 034846			0 1, 336, 785		
	O MAGNETIC RESONANCE I MAGING (MRI)	0. 046767			0 430, 687	0	
	0 LABORATORY	0. 117783	0		0 2, 025, 182	-	
	O BLOOD STORING, PROCESSING, & TRANS.	0. 579461			0 9, 488		
	O I NTRAVENOUS THERAPY	0. 521493	0		0 19, 644		
	O RESPI RATORY THERAPY	0. 344235			0 77, 711		
	O PHYSI CAL THERAPY	0. 534334			0 167, 367	0	
	O OCCUPATIONAL THERAPY	0. 293246			0 63, 286	-	
	O SPEECH PATHOLOGY	0. 729090			0 56, 418		
	0 ELECTROCARDI OLOGY	0. 108796			0 231, 783		
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 142112	0		0 327, 742	0	
	O IMPL. DEV. CHARGED TO PATIENT	0. 783562	0		0 0	0	
	O DRUGS CHARGED TO PATIENTS	0. 761494			0 560, 596	0	
	2 WOUND CARE	0. 535610			0 26, 504	0	
	1 CASE MANAGEMENT	1. 144143			0 0	0	
	O PAIN MANAGEMENT	0.845121	0		0 328, 442	0	
	7 CARDI AC REHABI LI TATI ON	4. 086902	0		0 1,160		
	ATIENT SERVICE COST CENTERS						1
90.00 0495	3 OTHER OUTPATIENT SERVICE COST CENTER	0. 581669	0	1	0 5,065	0	90.00
90.01 0495	1 PALLIATIVE HEALTH	1.064244	0		0 10, 677	0	90.01
90. 02 0900	O VEIN CENTER	0. 250055	0		0 27,659		90.02
90. 03 0900	1 OB GYN	1.065390	0		0 0	0	90.03
91.00 0910	0 EMERGENCY	0. 384666	0		0 1, 462, 849	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	1. 575624	0		0 262, 693	0	92.00
93.00 0495	2 BEHAVOURAL HEALTH	1. 687407	0		0 34, 419	0	93.00
200.00	Subtotal (see instructions)		0		0 11, 162, 054	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
	Net Charges (line 200 +/- line 201)	1	0	1	0 11, 162, 054		202.00

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Cost Center Description Cost Reimbursed Subject To Ded. & Coins. Cost Reimbursed Subject To Subject To Ded. & Coins. Cost Subject To Ded. & Coins. 50.000 0500010PERATING ROOM 0 320.797 50.00 50.000 0500010PERATING ROOM 0 320.797 50.00 51.00 0500010PERATING ROOM 0 320.797 50.00 52.00 05200010PELATING ROOM 0 27.756 52.00 52.00 052000 PELIVERY ROOM 0 327.756 52.00 54.00 054000 RADIOLOGY - DI AGNOSTI C 0 335.082 54.00 54.00 05800 MURAR STIC - DI AGNOSTI C 0 46.882 57.0 58.00 05800 MURAR STIC - RESONANCE I MAGI NG (MRI) 0 23.8532 60.0 60.00 05000 INTRA VENDUS THERAPY 0 23.8532 60.0 63.00 05000 INTRA VENDUS THERAPY 0 24.755 56.00 64.00 06400 INTRAVENDUS THERAPY 0 26.751 66.00 65.00 06500 INTRA VENDUS THERAPY 0 26.751 66			Ti t	le XIX	Hospi tal	Cost	
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90.01 04951 PALLIATIVE HEALTH 0 11,363 90.0 90.02 09000 VEIN CENTER 0 6,916 90.0 90.03 09001 0B GYN 0 0 0 90.0 91.00 09100 EMERGENCY 0 562,708 91.0 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 58,079 92.0 93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.00 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 3,527,180 201.0		-1					
90.02 09000 VEIN CENTER 0 6,916 90.02 90.03 09001 0B GYN 0 0 90.02 91.00 09100 EMERGENCY 0 562,708 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DISTINCT PART) 0 413,905 92.00 93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.00 200.00 Subtotal (see instructions) 0 3,527,180 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		-					90.00
90.03 09001 0B GYN 0 0 0 91.00 09100 EMERGENCY 0 562,708 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 413,905 92.0 93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.00 93.00 200.00 Subtotal (see instructions) 0 3,527,180 200.00 201.00 01. y Charges 0 0 3,527,180 201.00 201.00 201.00 201.00 0 3,527,180 201.00 201.00 201.00 201.00 201.00 0 201.00		0					90.01
91.00 09100 EMERGENCY 0 562,708 91.0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 413,905 92.0 93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.0 200.00 Subtotal (see instructions) 0 3,527,180 200.0 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		0					90.02
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 413,905 92.00 93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.00 200.00 Subtotal (see instructions) 0 3,527,180 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		0	-				90.03
93.00 04952 BEHAVOURAL HEALTH 0 58,079 93.00 200.00 Subtotal (see instructions) 0 3,527,180 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		0					91.00
200.00Subtotal (see instructions)03,527,180200.0201.00Less PBP Clinic Lab. Services-Program00201.0Only Charges0000		0					92.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.0 Only Charges 0 0		0					93.00
Only Charges		0	3, 527, 180				200.00
		0					201.00
	3 0		3, 527, 180				202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150065	Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	I NPATI ENT DAYS			40.0//	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			13, 366 12, 888	1
00	Private room days (excluding swing-bed and observation bed days		rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d dave)		11, 271	4
00	Total swing-bed SNF type inpatient days (including private room	5 /	er 31 of the cost	269	5
00	reporting period		21 -6	0	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) arter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	209	7
00	reporting period Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5		Ũ	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	4, 888	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	269	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		com days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	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	e room days)	0	13
00	after December 31 of the cost reporting period (if calendar year			0	1.1
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	n (excluaing swing-bea	days)	0	14 15
	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 c	of the cost	0.00	17
	reporting period	0			
8. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	S after December 31 of	the cost	0.00	18
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions			15, 562, 200	21
2.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	r 31 of the cost report	ing period (line	0	22
8.00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportir	ng period (line 6	0	23
I. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		15, 562, 200	27
8. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	Line 29)		0	30
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	11118 20)		0.000000	31
	Average semi-private room per diem charge (line 29 ÷ line 3) 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	34
	Average per diem private room cost differential (line 34 x line			0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	nd private room cost di	fferential (line	15, 562, 200	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 207 50	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line)			1,207.50	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			5, 902, 260 0	39 40
	Total Program general inpatient routine service cost (line 39	, , ,		5, 902, 260	

UNPUI	ATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	2.00				42.0
	Intensive Care Type Inpatient Hospital Units	-					
3.00	INTENSIVE CARE UNIT	2, 360, 138	1, 322	1, 785. 2	8 553	987, 260	
4.00	CORONARY CARE UNIT						44. (
5.00 6.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 46.
	OTHER SPECIAL CARE (SPECIFY)						40.
	Cost Center Description						
						1.00	
8.00 9.00	Program inpatient ancillary service cost (Wks			nc)		8, 442, 868	
9.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	FI through 48)(see instructio	115)		15, 332, 388	49.
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	1, 095, 396	50.
1.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	572, 992	51.
2.00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)				1, 668, 388	52.
3.00	Total Program inpatient operating cost exclude	,	lated, non-phy	sician anesth	etist, and	13, 664, 000	
	medical education costs (line 49 minus line 5				· · ·		
	TARGET AMOUNT AND LIMIT COMPUTATION						1
4.00 5.00	Program discharges Target amount per discharge					0.00	
5.00	Target amount (line 54 x line 55)					0.00	
7.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
3. 00	Bonus payment (see instructions)	0	0			0	
9.00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996, u	pdated and co	mpounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost roport up	dated by the m	arkat baskat		0.00	60.
1.00	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than					-	
	amount (line 56), otherwise enter zero (see i	nstructions)				_	
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (coo instru	ations)			0	
5.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	05.
4.00	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)					_	
5.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s after Decemb	er 31 of the c	ost reporting	period (See	0	65.
6.00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVII	l onlv). For	0	66.
	CAH (see instructions)				<i>J</i> ,	_	
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost re	porting period	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	, costs after D	ecember 31 of	the cost repo	rting period	0	68.
0.00	(line 13 x line 20)		ecember 31 01	the cost repo	rting period		00.
9.00	Total title V or XIX swing-bed NF inpatient r	routine costs (line 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU		•			1	
0.00 1.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.
2.00	Program routine service cost (line 9 x line 7		ine /0 ÷ inne	2)			72.
3.00	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine servi						74.
5.00	Capital-related cost allocated to inpatient r	routine service	costs (from W	orksheet B, P	art II, column		75.
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.
7.00	Program capital -related costs (line 9 x line						77.
3. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·	ue line 70)		79.
0. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		UST IIMITATION	(IINE /8 MIN	us line 79)		80.
. 00	Inpatient routine service cost per drem finite Inpatient routine service cost limitation (li)				82.
3. 00	Reasonable inpatient routine service costs (s						83.
1.00	Program inpatient ancillary services (see ins	structions)					84.
5.00	Utilization review - physician compensation (85.
5. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.
	Total observation bed days (see instructions)					1, 617	87.
7.00							
7.00 8.00	Adjusted general inpatient routine cost per c	liem (line 27 ÷	line 2)			1, 207. 50	88.

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 542, 140	15, 562, 200	0. 16335	4 1, 952, 528	318, 953	90.00
91.00 Nursing School cost	0	15, 562, 200	0.00000	0 1, 952, 528	0	91.00
92.00 Allied health cost	0	15, 562, 200	0.00000	0 1, 952, 528	0	92.00
93.00 All other Medical Education	0	15, 562, 200	0. 00000			93.00

	Financial Systems SCHNECK MEDICAL ATION OF INPATIENT OPERATING COST SCHNECK S	Provi der CCN: 150065	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title XIX	Hospi tal	5/20/2015 3:44 Cost	8 pili
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days,	, excluding newborn)		13, 366	1.
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days,	12, 888 0	2 3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed			11, 271	4
00	Total swing-bed SNF type inpatient days (including private room reporting period	<i>y</i> , <i>y</i>		0	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	<u> </u>		209	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	911	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	ly (including private r	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX 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 after December 31 of the cost reporting period (if calendar year			0	13
. 00 . 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)			0 1, 746	
	Nursery days (title V or XIX only)			141	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing pariod (line	15, 562, 200 0	
	5 x line 17) Swing-bed cost applicable to SNF type services after December :				
	x line 18)		5 T X	0	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)		51 (0	
	Swing-bed cost applicable to NF type services after December 3 x line 20)	i of the cost reporting	period (line 8	0	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	line 21 minus line 26)		0 15, 562, 200	26 27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed of	arges)	0	28
	Private room charges (excluding swing-bed charges)		iai 903)	0	29
. 00	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 \div	line 28)		0.000000	
00	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	
. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
. 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 15, 562, 200	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 007 50	1
0.00	Adjusted general important routing arms in a set of the				
	Adjusted general inpatient routine service cost per diem (see i			1, 207. 50	
9.00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	38)		1, 207. 50 1, 100, 033 0	39

	ATION OF INPATIENT OPERATING COST		PLOVE		eriod: rom 01/01/2014	Worksheet D-1	
					o 12/31/2014		
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient Cost		Diem (col. 1 ÷		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	529, 181					42.
00	Intensive Care Type Inpatient Hospital Units	2 2/0 120	1 222	1 705 00	107	101 005	1 42
. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	2, 360, 138	1, 322	1, 785. 28	107	191, 025	43.
. 00	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL INTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	· · · · · · · · · · · · · · · · · · ·					1.00	
	Program inpatient ancillary service cost (Wks			>		1,063,467	
. 00	Total Program inpatient costs (sum of lines / PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		2, 397, 259	49.
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.
							-
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (Tr	OM WKST. D, SU	m of Parts II	0	51.
. 00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.
. 00	Total Program inpatient operating cost exclude		elated, non-phy	sician anesthe	tist, and	0	53.
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)				l	-
. 00	Program di scharges					0	54.
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	arget amount (1	ine 56 minus l	ine 53)	0	
. 00	Bonus payment (see instructions)		inger amount (i	The 50 minus i	The 33)	0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and com	pounded 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	arkat haskat		0.00	60
. 00	If line 53/54 is less than the lower of line				he amount by	0.00	
	which operating costs (line 53) are less than	n expected cost					
. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62.
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		- 04 C II				
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	emper 31 of the	cost reportin	g period (See	0	64.
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no coste (line	64 pluc line 6	E) (+; + o V)/		0	66.
. 00	CAH (see instructions)	ne costs (inne	64 prus rine d	5)(title xviii	onry). For	0	00.
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 c	f the cost rep	orting period	0	67.
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	ting period	0	68.
	(line 13 x line 20)			the boot repor	tring portion		
. 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 facili						70
. 00	Adjusted general inpatient routine service co						71
. 00	Program routine service cost (line 9 x line)			no 25)			72.
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient	•			rt II, column		75.
00	26, line 45)	22					_,
0. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess			· · · · · · · · · · · · · · · · · · ·			79.
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		cost limitation	(line 78 minu	s fine 79)		80
. 00	Inpatient routine service cost per drem find Inpatient routine service cost limitation (li)				82
. 00	Reasonable inpatient routine service costs (s						83
. 00	Program inpatient ancillary services (see ins						84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 86.
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	00.
	Total observation bed days (see instructions)					1, 617	87.
. 00 . 00	Adjusted general inpatient routine cost per o					1, 207. 50	

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 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
		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, 542, 140	15, 562, 200	0. 16335	4 1, 952, 528	318, 953	90.00
91.00 Nursing School cost	0	15, 562, 200	0.00000	0 1, 952, 528	0	91.00
92.00 Allied health cost	0	15, 562, 200	0. 00000	0 1, 952, 528	0	92.00
93.00 All other Medical Education	0	15, 562, 200	0. 00000	0 1, 952, 528	0	93.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
	Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDIATRICS			3, 572, 254		30.
. 00 03100 INTENSIVE CARE UNIT			722, 102		31.
8. 00 04300 NURSERY			722, 102		43.
ANCI LLARY SERVICE COST CENTERS					1 .0.
0. 00 05000 OPERATING ROOM		0. 15108	6, 285, 450	949, 625	50.
. 00 05100 RECOVERY ROOM		0. 1351			51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 32488			52.
8. 00 05300 ANESTHESI OLOGY		0. 37348	81 430, 576	160, 812	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 48174			54.
. 01 03630 ULTRA SOUND		0. 12886	63 215, 670	27, 792	54.
02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 12510	58, 236	7, 286	54.
7. 00 05700 CT SCAN		0. 03484	46 2, 285, 145	79, 628	57.
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.04676	67 447, 854	20, 945	58.
0. 00 06000 LABORATORY		0. 1193	51 5, 591, 850	667, 393	60.
B. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 57940	61 326, 488	189, 187	63.
. 00 06400 I NTRAVENOUS THERAPY		0. 52149	93 176, 064	91, 816	64.
5. 00 06500 RESPI RATORY THERAPY		0. 34423		530, 978	65.
0. 00 06600 PHYSI CAL THERAPY		0. 53433	34 367, 494	196, 365	66.
2. 00 06700 OCCUPATI ONAL THERAPY		0. 29324		61, 936	
B. 00 06800 SPEECH PATHOLOGY		0. 7290		35, 337	
P. 00 06900 ELECTROCARDI OLOGY		0. 10934		76, 952	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1421			
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 78356			
8. 00 07300 DRUGS CHARGED TO PATIENTS		0. 76149			
0. 00 03952 WOUND CARE		0. 5356		10, 750	
0. 02 03951 CASE MANAGEMENT		1. 14414		0	76.
0. 03 03950 PALN MANAGEMENT		0.84512		770	
0. 97 07697 CARDI AC REHABI LI TATI ON		4.08690	02 123	503	76.
OUTPATI ENT SERVICE COST CENTERS		0. 58160	69 0	0	90.
0. 01 04951 PALLIATIVE HEALTH		1. 06424			90.
0. 02 09000 VEIN CENTER		0. 25005			
0. 03 09000 VETN CENTER 0. 03 09001 0B GYN		1. 06539			
. 03 0900 08 GW		0. 38466			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 57562		320, 880	
B. 00 04952 BEHAVOURAL HEALTH		1. 68740			
0.00 Total (sum of lines 50-94 and 96-98)		1.00740	25, 949, 615		
11.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		20, 747, 010	0, 442, 000	200.
2.00 Net Charges (line 200 minus line 201)	5 (1110 01)		25, 949, 615		202

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	Worksheet D-3	
			From 01/01/2014		
	Component	t CCN: 15U065	To 12/31/2014	Date/Time Pre	pared:
	T; +1	e XVIII	Swing Beds - SNF	5/20/2015 3:4 PPS	8 pm
Cost Center Description	111	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
			Charges	$(col. 1 \times col.$	
			ondriges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		1 30. 00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					1
50. 00 05000 OPERATI NG ROOM		0. 15108	33 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 13519	98 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 32488	37 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 37348	31 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 47699	5, 695	2, 716	54.00
54. 01 03630 ULTRA SOUND		0. 12886	3, 081	397	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 12510	05 0	0	54.02
57.00 05700 CT SCAN		0. 03484	16 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 04676	57 0	0	58.00
60. 00 06000 LABORATORY		0. 11778	64, 868	7,640	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 57946	4, 886	2, 831	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 52149	93 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 34423	35 14, 207	4, 891	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 53433	95, 807	51, 193	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 29324	16 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0.72909	90 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 10879	342	37	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1421	20, 326	23, 215	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 78356	52 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 76149	94 93, 441	71, 155	73.00
76.00 03952 WOUND CARE		0. 5356	10 137	73	76.00
76.02 03951 CASE MANAGEMENT		1. 14414	13 0	0	76.02
76.03 03950 PALN MANAGEMENT		0. 84512	21 0	0	76.03
76. 97 07697 CARDI AC REHABI LI TATI ON		4.08690	02 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER		0. 58166	59 O	0	90.00
90. 01 04951 PALLI ATI VE HEALTH		1. 06424		0	
90. 02 09000 VEIN CENTER		0. 25005	55 0	0	90.02
90. 03 09001 OB GYN		1. 06539		0	
91.00 09100 EMERGENCY		0. 38466		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 57562		0	
93. 00 04952 BEHAVOURAL HEALTH		1. 68740		324	
200.00 Total (sum of lines 50-94 and 96-98)			302, 982	164, 472	
201.00 Less PBP Clinic Laboratory Services-Program only cha	arges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	302, 982		202.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
	Ti t	le XIX	Hospi tal	Cost	-
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDIATRICS		1	507, 599		30.
. 00 03100 I NTENSI VE CARE UNI T			65, 013		31.
00 04300 NURSERY			317, 519		43.
ANCI LLARY SERVI CE COST CENTERS		1			1
0. 00 05000 OPERATI NG ROOM		0. 1510	83 455, 211	68, 775	50.
. 00 05100 RECOVERY ROOM		0. 1351	98 37, 987	5, 136	51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3248	87 1, 328, 572	431, 636	52.
0. 00 05300 ANESTHESI OLOGY		0. 3734	81 202, 639	75, 682	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4769	93 40, 898	19, 508	54
. 01 03630 ULTRA SOUND		0. 1288	63 22, 791	2, 937	54
. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1251	2, 247	281	54
2. 00 05700 CT SCAN		0. 03484	46 121, 944	4, 249	57
. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0467		878	
0. 00 06000 LABORATORY		0. 11778	83 564, 411	66, 478	
. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5794		9, 199	
. 00 06400 INTRAVENOUS THERAPY		0. 5214		7,627	
0. 00 06500 RESPI RATORY THERAPY		0. 3442		53, 071	
0. 00 06600 PHYSI CAL THERAPY		0. 5343		5, 481	
0 06700 OCCUPATI ONAL THERAPY		0. 2932		1, 307	
8. 00 06800 SPEECH PATHOLOGY		0. 7290		625	
0 06900 ELECTROCARDI OLOGY		0. 1087		4, 190	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		1. 1421		156, 761	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 7835		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 7614		71, 293	
0. 00 03952 WOUND CARE		0. 5356			
0. 02 03951 CASE MANAGEMENT		1. 1441		0	
0. 03 03950 PALN MANAGEMENT		0.8451		1, 356	
07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		4.08690	02 0	0	76
0. 00 04953 OTHER OUTPATIENT SERVICE COST CENTER		0.5816	69 0	0	90
0. 01 04953 0THER OUTPATTENT SERVICE COST CENTER		1. 0642		731	
0. 02 09000 VEI N CENTER		0. 2500		0	
0. 03 09001 0B GYN		1. 0653		0	
. 00 09100 EMERGENCY		0. 3846		71, 371	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5756		0	
00 04952 BEHAVOURAL HEALTH		1. 68740		4, 197	
0.00 Total (sum of lines 50-94 and 96-98)		1.00/4	3, 456, 732	1, 063, 467	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0, 400, 702	1,000,407	200
12.00 Net Charges (line 200 minus line 201)	(3, 456, 732		202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150065	Peri od:	Worksheet D-3	
NPATIENT ANGLEEART SERVICE COST AFFORTIONMENT	FIOVICE	CCN. 150005	From 01/01/2014	WOLKSHEEL D-3	
	Componen	t CCN: 15U065		Date/Time Pre 5/20/2015 3:4	
	Ti t	le XIX	Swing Beds - NF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS		1	0		30.00
1. 00 03100 I NTENSI VE CARE UNI T			0		31.00
3. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 1510	83 0	0	50.00
1.00 05100 RECOVERY ROOM		0. 1351	98 0	0	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3248	87 0	0	52.00
3. 00 05300 ANESTHESI OLOGY		0. 3734	81 0	0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4769	93 0	0	54.00
4. 01 03630 ULTRA SOUND		0. 1288	63 0	0	54.0
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1251	05 0	0	54.02
7. 00 05700 CT SCAN		0. 03484	46 0	0	57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0467	67 0	0	58.00
0. 00 06000 LABORATORY		0. 1177		0	60.00
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5794	61 0	0	63.00
4.00 06400 INTRAVENOUS THERAPY		0. 5214		0	64.00
5. 00 06500 RESPI RATORY THERAPY		0. 3442	35 0	0	65.00
6. 00 06600 PHYSI CAL THERAPY		0. 5343		0	66.00
7.00 06700 OCCUPATI ONAL THERAPY		0. 2932		0	67.00
8.00 06800 SPEECH PATHOLOGY		0. 7290		0	68.00
9. 00 06900 ELECTROCARDI OLOGY		0. 1087		0	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1421		0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 7835		0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 7614		0	73.00
6.00 03952 WOUND CARE		0. 5356		0	76.00
6. 02 03951 CASE MANAGEMENT		1. 1441		0	76.02
6. 03 03950 PALN MANAGEMENT		0.8451		0	76.03
6. 97 O7697 CARDI AC REHABI LI TATI ON		4.08690	02 0	0	76. 9
		0.501/	(0)	0	
0.00 04953 OTHER OUTPATIENT SERVICE COST CENTER		0.5816		0	90.00
0. 01 04951 PALLI ATI VE HEALTH		1.0642		-	90.0
0. 02 09000 VELN CENTER 0. 03 09001 0B GYN		0.2500		0	90.02
1. 00 09100 EMERGENCY		1.0653 0.3846		0	90.03
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5756		0	91.00
3. 00 04952 BEHAVOURAL HEALTH		1. 5756		0	
00.00 Total (sum of lines 50-94 and 96-98)		1.08/40	0	-	200.00
01.00 Less PBP Clinic Laboratory Services-Program only charg	os (lino 61)		0	0	200.00

	Financial Systems SCHNECK MEDICAL			In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150065	Period: From 01/01/2014	Worksheet E Part A	
				To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
	· · · · · · · · · · · · · · · · · · ·	Titl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1.01	DRG amounts other than outlier payments for discharges occurrin	g prior		6, 534, 546		1.01
1.02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	g on or		2, 124, 054		1.02
1.03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.03
	discharges occurring prior to October 1 (see instructions)			0		
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.04
2.00	Outlier payments for discharges. (see instructions)			513, 259		2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 01 2. 02
3.00 4.00	Managed Care Simulated Payments	ing		0		3.00 4.00
4.00	Bed days available divided by number of days in the cost report period (see instructions)	rng		61.85		4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
	cost reporting period ending on or before 12/31/1996. (see instr	uctions)				
6.00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordanc			0.00		6.00
7.00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	dor: 10		0.00		
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 u CFR $\frac{1}{10}$ (1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
	then see instructions.					
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)(iv), 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
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.	011, see				
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9.00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9.00
	and 8,02) (see instructions)					
10.00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00		11.00
13.00	Total allowable FTE count for the prior year.			0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00		15.00
16.00 17.00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	e		0.00 0.00		16.00 17.00
18.00	Adjusted rolling average FTE count			0.00		18.00
19.00 20.00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19.00 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0		22.00 22.01
23.00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		he MMA	0.00		23.00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap				
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
	line 23 or line 24 (see instructions)					
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) Disproportionate Share Adjustment			0		29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		3.57		30.00
31.00	(see instructions) Percentage of Medicaid patient days (see instructions)			21.58		31.00
32.00	Sum of Lines 30 and 31			25. 15		32.00
33.00 34.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			9. 97 215, 816		33.00 34.00
			1	,		1

UALUUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150065		u of Form CMS-2	2552-10
	ALLON OF RELMDURSEMENT SETTLEMENT	FIOVIDER CON: 150065	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prep 5/20/2015 3:48	
		Title XVIII	Hospital Prior to October 1	On/After October 1	
,		0	1.00	2.00	
	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 885	35.00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000090256 816, 489	0. 000098918 756, 493	
	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		610, 689		
36.00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		801, 367		36. 00
	35.03) Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 throug	h 46)		
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		10, 189, 042 0		47.00 48.00
49.00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		10, 189, 042		49.00
50.00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I		764, 018		50.00
51.00	and Pt. II, as applicable) 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, line 49 see instructions).		0		52.00
	Nursing and Allied Health Managed Care payment		0		53.00 54.00
54.00 55.00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		10, 953, 060 13, 815		59.00 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10, 939, 245		61.00
62.00 63.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		1, 144, 896 2, 432		62.00 63.00
64.00	Allowable bad debts (see instructions)		13, 967		64.00
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		9, 079 10, 636		65. 00 66. 00
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		9, 800, 996 0		67.00 68.00
	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
70. 00	96).(For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50 70. 89	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment amount (see		0		70. 50 70. 89
70. 90	instructions) HSP bonus payment HVBP adjustment amount (see		0		70. 90
	instructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
	Bundled Model 1 discount amount (see instructions)		0		70. 92
	HVBP payment adjustment amount (see instructions)		22, 826		70.93

	Financial Systems SCHNECK MEDI			In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 1500	1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet E Part A Date/Time Pro 5/20/2015 3:4	epared:
		Title XVIII		Hospi tal	PPS	40 pili
				Prior to	0n/After	
				October 1	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)		(0 0		70.96
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)		201	5 57, 396		70. 97
70. 98	Low Volume Payment-3			0		70.98
	HAC adjustment amount (see instructions)			0		70.99
	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			9, 865, 288		71.00
71.01	Sequestration adjustment (see instructions)			197, 306		71.01
72.00	Interim payments			9, 638, 574		72.00
73.00	Tentative settlement (for contractor use only)			0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			29, 408		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			595, 065		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0		93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00		94.00
95.00	Time value of money for operating expenses (see instructions)			0		95.00
96.00	Time value of money for capital related expenses (see			0		96.00
	instructions)					
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					1400.07
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	(100.00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)					0 101.00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructi	one)		0		0101.00
102.00	HRR Adjustment for HSP Bonus Payment			0		
103 00	HRR adjustment factor (see instructions)			0.0000	0.000	0 103.00
	HRR adjustment amount for HSP bonus payment (see instructio	ns)		0.0000		103.00
10 1.00	mar augustinont anount for nor bonus payment (see fiisti detro			. 0		110 1.00

W VC	ULUME CALCULATION EXHIBIT 4			Provi der		eriod: rom 01/01/2014 o 12/31/2014		pared:
		W/S E, Part A line	Amounts (from	Pre/Post	e XVIII Period Prior	Hospital Period On/After 10/01	PPS Total (Col 2	
		0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0		0		1.0
01	payments DRG amounts other than outlier payments for discharges	1.01	6, 534, 546	0	6, 534, 546	0	6, 534, 546	1.0
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	2, 124, 054	0	0	2, 124, 054	2, 124, 054	1.0
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	0	0	1. C
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1.0
00	Outlier payments for discharges (see instructions)	2.00	513, 259	0				
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	-	
00 00	Operating outlier reconciliation Managed care simulated	2. 01 3. 00	0	0	0	0	0	
00	payments Indirect Medical Education Adju		0	0	0		0	4.0
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.0
00	IME payment adjustment (see instructions)	22.00	0	0	0	0	-	
01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adju	22.01	0 Add on for Soc	0	0	0	0	6.
00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7.
00	(see instructions) IME adjustment (see	28.00	0	0		0		
01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	О	0	0	8.
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	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.
. 00	Disproportionate Share Adjustme Allowable disproportionate	ant 33.00	0. 0997	0. 0997	0. 0997	0. 0997		10.
. 00	share percentage (see instructions) Disproportionate share	34.00	215, 816	O	162, 874	52, 942	215, 816	11
. 00	adjustment (see instructions) Uncompensated care payments	36.00	801, 367	0		190, 678		
. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary c 0	i scharges 0	0	0	0	12.
. 00 . 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	10, 189, 042 0	0 0	7, 714, 591 0	2, 474, 451 0	10, 189, 042 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	10, 189, 042	0	7, 714, 591	2, 474, 451	10, 189, 042	15.
00	Payment for inpatient program capital	50.00	764, 018	0	582, 119	181, 899	764, 018	16.
00	Special add-on payments for new technologies	54.00	0	0	0	0	_	
. 01 . 02	Net organ aquisition cost Capital received from manufacturers for replaced devices for applicable MS-DRGs	55.00 68.00	0 0	0 0	0 0	0 0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	Ο	0	0	0	0	18.

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
LOW VOI	LUME CALCULATION EXHIBIT 4					Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 3:4	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	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	8, 296, 71	0 2, 656, 350	10, 953, 060	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	681, 574	0	514, 47	/8 167,096	681, 574	20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	C	20. 01
21.00	Capital DRG outlier payments	2.00	82, 444	0	67,64	1 14, 803	82, 444	21.00
21.01	Model 4 BPCI Capital DRG	2. 01	0	0		0 0	0	1
	outlier payments							
	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	C	23.00
24.00	Al lowable 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	C	25.00
26.00	Total prospective capital payments (see instructions)	12.00	764, 018	0	582, 11	9 181, 899	764, 018	26.00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0. 021607		27.00
	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96				0	O	28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				57, 396	57, 396	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibit Date/Time Prep 5/20/2015 3:48	oared:
				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, 534, 546	6, 534, 54	46	6, 534, 546	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2, 124, 054		2, 124, 054	2, 124, 054	1. 02
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	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	513, 259	406, 48	32 106, 777	513, 259	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
	Indirect Medical Education Adjustment		1	1			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.0000	0. 000000		5.00
5.00 5.01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	0 0	6. 00 6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0. 000000		7.00
3. 00 3. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0 0	8. 00 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	29.01	0		0 0	0	9. 01
	Lines 6.01 and 8.01)						
	Disproportionate Share Adjustment		1				
0.00		33.00	0.0997	0.099	97 0. 0997		10.00
1.00	(see instructions) Disproportionate share adjustment (see	34.00	215, 816	162, 87	52, 942	215, 816	11.00
1.01	instructions) Uncompensated care payments	36.00	801, 367	610, 68	39 190, 678	801, 367	11. 01
	Additional payment for high percentage of ESR	D beneficiary	di scharges				
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
3.00		47.00	10, 189, 042	7, 714, 59	2, 474, 451	10, 189, 042	13. OC
4.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	14.00
5.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	10, 189, 042	7, 714, 59	2, 474, 451	10, 189, 042	15.00
6.00	Payment for inpatient program capital	50.00	764, 018	582, 1 ²	19 181, 899	764, 018	16.00
	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
17.00	Net organ aquisition cost	55.00	0		0 0	0	17.01
17.00 17.01					0 0	0	17.02
	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		с С	Ű	
7.01	replaced devices for applicable MS-DRGs	68.00 93.00	0		0 0	0	18.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION	CALCULA	TION EXHIBIT 5	Provi der	CCN: 150065		d: 01/01/2014 12/31/2014		pared:
			Titl	e XVIII	Ho	ospi tal	PPS	
		Wkst. L, line	(Amt. from					
		0	Wkst. L) 1.00	2.00		3.00	4,00	
20.00 Capital DRG other than outlier		1.00	681, 574	514, 4	78	167, 096	681, 574	20,00
20.01 Model 4 BPCI Capital DRG other than ou	ıtlier	1.00	001, 374	517, 7	0	107,070	001, 374	20.00
21.00 Capital DRG outlier payments		2.00	82, 444	67, 64	<u> </u>	14, 803	-	
21.01 Model 4 BPCI Capital DRG outlier payments	onts	2.00	02, 444	07,0	0	14,000	02, 444	21.00
22.00 Indirect medical education percentage		5.00	0.0000	0.000	0	0.0000		22.00
instructions)	(366	5.00	0.0000	0.000	50	0.0000		22.00
23.00 Indirect medical education adjustment instructions)	(see	6.00	0		0	0	0	23. 00
24.00 Allowable disproportionate share perce (see instructions)	entage	10.00	0.0000	0.000	00	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	e	11.00	0		0	0	0	25.00
26.00 Total prospective capital payments (se	ee	12.00	764, 018	582, 1 ⁻	19	181, 899	764, 018	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	r 1	70.96	0		0		0	28.00
29.00 Low volume adjustment on or after Octo	ober 1	70.97	57, 396			57, 396	57, 396	29.00
30.00 HVBP payment adjustment (see instructi	ons)	70.93	22, 826	70	51	22, 065	22, 826	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	-15, 930		0	-15, 930	-15, 930	31.00
31.01 HRR adjustment for HSP bonus payment instructions)	(see	70.91	0		0	0	0	31.01
							(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00		3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)		70.99			0	0	0	
100.00 Transfer HAC Reduction Program adjustr Wkst. E, Pt. A.	ment to		Y					100. 00

	Financial Systems SCHNECK MEDICAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150065	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/20/2015 3:4 PPS	8 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			19, 585	
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		11, 193, 224	
. 00 . 00	PPS payments Outlier payment (see instructions)			8, 304, 908 237, 924	
. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
. 00	Line 2 times line 5	,		0	6.00
. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	V and 12 Line 200		0	
0.00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, col. 13, line 200			
	Total cost (sum of lines 1 and 10) (see instructions)			19, 585	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			Γ	
	Ancillary service charges			27, 797	
3.00 4.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, c Total reasonable charges (sum of lines 12 and 13)	col. 4)		0 27, 797	
4.00	Customary charges			21,171	14.00
5.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15.00
6.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
7 00	had such payment been made in accordance with 42 CFR §413.13(e	e)		0,000000	17.00
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 27,797	
9.00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds li	ne 11) (see		19.00
	instructions)	J			
0.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
1 00	instructions)	· · · · · · · · · · · · · · · · · · ·		10 505	01.00
1.00 2.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	e finstructions)		19, 585	
2.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			8, 542, 832	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH soo instructions)		0 1, 746, 723	
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p			6, 815, 694	
	CAH, see instructions)				
8.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
0.00 1.00	Subtotal (sum of lines 27 through 29) Primary payer payments			6, 815, 694 4, 031	
2.00	Subtotal (line 30 minus line 31)			6, 811, 663	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
	Allowable bad debts (see instructions)			68, 792	
5.00 6.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		44, 715 142, 470	
7.00	Subtotal (see instructions)			6, 856, 378	
	MSP-LCC reconciliation amount from PS&R			-15	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instructions			0	
9.98	Partial or full credits received from manufacturers for replac	ced devices (see instruc	tions)	0	
9. 99 0. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			6, 856, 393	
0.01	Sequestration adjustment (see instructions)			137, 128	
1.00	Interim payments			6, 667, 662	41.00
2.00	Tentative settlement (for contractors use only)			0	
3.00	Balance due provider/program (see instructions)	no with CMS Dub 15 0	chantor 1	51, 603	
4.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ICE WILLII CINIS PUD. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
				0	
	Original outlier amount (see instructions)				
1. 00	Outlier reconciliation adjustment amount (see instructions)				91.00
91.00 92.00	5			0.00	91.00 92.00 93.00

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150065	Period: From 01/01/2014 To 12/31/2014		pared
		Ti tl	e XVIII	Hospi tal	PPS	-
		Inpatien	t Part A	Par	тв	
		mm/dd/yyyy	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 List separately each retroactive lump sum adjustment		9, 638, 5	74 0	6, 667, 662 0	1. 2. 3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02 03				0	0	3. 3.
03				0	0	
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52 53				0	0	3
53 54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		9, 638, 5	74	6, 667, 662	4
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	5
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		29, 4		51, 603	6
02	SETTLEMENT TO PROGRAM		0 4 4 7 0	0	0 4 710 245	6
00	Total Medicare program liability (see instructions)		9, 667, 9	82 Contractor	6, 719, 265 NPR Date	7
				Number	(Mo/Day/Yr)	

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			Period: From 01/01/2014 To 12/31/2014		pared:
		Ti tl	e XVIII S	Swing Beds - SNI		
		I npati er	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		43, 18	9	0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0'
3. 02				0	0	3. 02
3.03				0	0	
3.04				0	0	
3. 05	Dravidar to Dragram			0	0	3. 0
3.50	Provider to Program ADJUSTMENTS TO PROGRAM	1	1	0	0	3.5
3.50 3.51				0	0	
8.52				0	0	3.5
8.53				0	0	
3.54				0	0	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.9
1.00	Total interim payments (sum of lines 1, 2, and 3.99)		43, 18	9	0	4.0
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	1				
5.00	desk review. Also show date of each payment. If none,					5.0
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER			0	0	
5. 02 5. 03				0	0	
0.03	Provider to Program			0	0	5.0
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5.51				0	0	5.5
5. 52				0	0	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER			0	0	
. 02	SETTLEMENT TO PROGRAM			0	0	
. 00	Total Medicare program liability (see instructions)		43, 18		0	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
			Э С	1.00	2.00	
3.00	Name of Contractor					8.0

Health Fin	nancial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
CALCULATI	DN OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150065	Period: From 01/01/2014 To 12/31/2014		
			Title XVIII	Hospi tal	PPS	
					1.00	
	BE COMPLETED BY CONTRACTOR FOR NON STANDARI					
	LTH INFORMATION TECHNOLOGY DATA COLLECTION					
	al hospital discharges as defined in AARA			14	3, 416	
	licare days from Wkst. S-3, Pt. I, col. 6 s		2		5, 441	2.00
	licare HMO days from Wkst. S-3, Pt. I, col.				74	3.00
	al inpatient days from S-3, Pt. I col. 8 s		2		12, 593	4.00
	al hospital charges from Wkst C, Pt. I, co				271, 877, 663	
	al hospital charity care charges from Wkst				4, 244, 367	6.00
	l only - The reasonable cost incurred for the ne 168	he purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00 Cal	culation of the HIT incentive payment (see	instructions)			545, 759	8.00
9.00 Sec	uestration adjustment amount (see instruct	i ons)			10, 915	9.00
10.00 Cal	culation of the HIT incentive payment after	r sequestration (s	ee instructions)		534, 844	10.00
INP	ATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30. 00 I ni	tial/interim HIT payment adjustment (see i	nstructions)			704, 508	30.00
31.00 Oth	ner Adjustment (specify)				0	31.00
32.00 Bal	ance due provider (line 8 (or line 10) min	us line 30 and lin	e 31) (see instruction	s)	-169, 664	32.00

Heal th	Financial Systems	SCHNECK MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BED	S	Provider CCN: 1500 Component CCN: 15U	F	Period: From 01/01/2014 To 12/31/2014		pared:
			Title XVIII	c	Swing Beds - SNF	5/20/2015 3: 4 PPS	s pm
]J	Part A	Part B	
					1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (se	ee instructions)			45, 742	0	1.00
2.00	Inpatient routine services - swing bed on (se	,			10, 712	0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, li		and sum of Wkst [ר			3.00
0.00	Part V, cols. 6 and 7, line 202 for Pt. B) (Fe			- 1			0.00
4.00	Per diem cost for interns and residents not in					0.00	4.00
	instructions)		5 1 5 7 7 7 7				
5.00	Program days				269	0	5.00
6.00	Interns and residents not in approved teaching	g program (see ins	tructions)			0	6.00
7.00	Utilization review - physician compensation -				0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines	6 and 7)	3		45, 742	0	8.00
9.00	Primary payer payments (see instructions)	·			0	0	9.00
10.00	Subtotal (line 8 minus line 9)				45, 742	0	10.00
11.00	Deductibles billed to program patients (exclud	de amounts applica	ole to physician		0	0	11.00
	professional services)						
12.00	Subtotal (line 10 minus line 11)				45, 742	0	12.00
13.00	Coinsurance billed to program patients (from professional services)	provider records)	(exclude coinsurand	ce	1, 672	0	13.00
14.00	80% of Part B costs (line 12 x 80%)					0	14.00
15.00	Subtotal (enter the lesser of line 12 minus li	ine 13 or line 14)		44,070	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))		44,070	0	
16.50	Pioneer ACO demonstration payment adjustment				0	0	
16.55	410A RURAL DEMONSTRATION PROJECT				0	0	16.55
17.00	Allowable bad debts (see instructions)				0	0	
17.00	Adjusted reimbursable bad debts (see instructi	ons)			0	0	17.01
18.00	Allowable bad debts for dual eligible benefici		rtions)		0	0	
19.00	Total (see instructions)				44,070	0	
19.01	Sequestration adjustment (see instructions)				881	0	19.00
20.00	Interim payments				43, 189	0	20.00
21.00	Tentative settlement (for contractor use only))			10, 10,	0	21.00
22.00	Balance due provider/program (line 19 minus li		d 21)		0	0	22.00
23.00	Protested amounts (nonallowable cost report i			-2.	0	0	23.00
20.00	§115. 2			-1	0	0	_0.00

Heal th	Financial Systems SCHNECK	MEDICAL CENTER	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 150065	Peri od:	Worksheet E-2	2
		Component CCN: 15U065	From 01/01/2014 To 12/31/2014	Date/Time Pro	anarod
		component con. 150005	10 12/31/2014	5/20/2015 3:4	
		Title XIX	Swing Beds - NF	Cost	
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instruc		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instruction		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for		0		3.00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, se				
4.00	Per diem cost for interns and residents not in approved	d teaching program (see	0.00		4.00
F 00	instructions)				F 00
5.00	Program days	(:	0		5.00
6.00	Interns and residents not in approved teaching program		0		6.00
7.00	Utilization review - physician compensation - SNF optic	onal method only	0		7.00 8.00
8.00 9.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		9,00
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		0		9.00
10.00 11.00		o appliable to physician	0		11.00
11.00	Deductibles billed to program patients (exclude amounts professional services)	s appricable to physician	0		11.00
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider)	records) (exclude coinsurance	0		13.00
	for physician professional services)				
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	r line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see inst	ructions)	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 instructions)		0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)	0		18.00
19.00	Total (see instructions)		0		19.00
19.01	Sequestration adjustment (see instructions)		0		19.01
20.00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.0		0		22.00
23.00	Protested amounts (nonallowable cost report items) in a	accordance with CMS Pub. 15-2,	0		23.00
	§115. 2				

LANCE S	nancial Systems SCHNECK MEDI SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column onl	Provi der		eriod: rom 01/01/2014	u of Form CMS-: Worksheet G	
			Т	o 12/31/2014	Date/Time Pre 5/20/2015 3:4	
		General Fund	Purpose Fund	Endowment Fund		
CU	IRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	19, 499, 790	0	0	0	1.
00 Te	emporary investments	8, 000, 000	0	0	0	2.
	otes receivable	0	0	0	0	3
	ccounts receivable	13, 093, 059		-	0	
		0	0	-	0	5
	Iowances for uncollectible notes and accounts receivable nventory	3, 954, 646	0	-	0	6
	repaid expenses	20, 602, 722		-	0	8
	ther current assets	2, 147, 139		-	0	9
	ue from other funds	0	0	-	0	10
00 To	otal current assets (sum of lines 1-10)	67, 297, 356	0	0	0	11
FL	XED ASSETS					
	and	6, 320, 117			0	
	and improvements	4, 019, 428		-	0	13
	ccumulated depreciation	0 014 277	-	-	0	14
	uildings ccumulated depreciation	80, 914, 377 -77, 497, 801	0	-	0	15
	easehold improvements	-77, 497, 801 0		-	0	17
	ccumul ated depreciation	0	0	-	0	18
	xed equipment	6, 369, 578		-	0	19
	ccumulated depreciation	0	0	0	0	20
. 00 AL	utomobiles and trucks	0	0	0	0	21
	ccumulated depreciation	0	0	-	0	22
	ajor movable equipment	50, 976, 893		-	0	23
	ccumulated depreciation	0	0	-	0	24
	nor equipment depreciable ccumulated depreciation	0	0	0	0	25 26
	T designated Assets	0	0	0	0	27
	ccumulated depreciation	0	0	-	0	28
	nor equi pment-nondepreci abl e	0	0	-	0	29
	otal fixed assets (sum of lines 12-29)	71, 102, 592			0	
	HER ASSETS					
	nvestments	10, 895, 424			0	31
	eposits on leases	0	0	-	0	32
	ue from owners/officers ther assets	124, 500, 464	-	-	0	33
	otal other assets (sum of lines 31-34)	135, 395, 888		-	0	35
	otal assets (sum of lines 11, 30, and 35)	273, 795, 836		-	0	
	IRRENT LI ABI LI TI ES	,	-	-	-	
. 00 Ac	ccounts payable	2, 457, 858	0	0	0	37
	alaries, wages, and fees payable	5, 719, 999			0	
	ayroll taxes payable	0		0	0	
	otes and loans payable (short term)	1, 510, 402		0	0	
	eferred income		0	0	0	41
	ccelerated payments ue to other funds	0	0	0	0	
1	ther current liabilities	11, 990, 820			0	
	otal current liabilities (sum of lines 37 thru 44)	21, 679, 079			0	
	NG TERM LIABILITIES				-	
. 00 Mc	ortgage payable	0	0	0	0	46
. 00 No	otes payable	34, 267, 142	0	0	0	47
	nsecured Loans	0	0	-	0	
	ther long term liabilities	7, 896, 883		-	0	
	otal long term liabilities (sum of lines 46 thru 49	42, 164, 025			0	
	otal liabilites (sum of lines 45 and 50) PITAL ACCOUNTS	63, 843, 104	0	0	0	51
	eneral fund balance	209, 952, 732				52
	beci fi c purpose fund	,,,,,,,,,,	0			53
	ponor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
. 00 Gc	overning body created - endowment fund balance			0		56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	200 052 722	_	_	0	E 0
	otal fund balances (sum of lines 52 thru 58) otal liabilities and fund balances (sum of lines 51 and	209, 952, 732 273, 795, 836			0	59 60
	Traditional and the barances (sum of times of and	210,170,030	I U	U U	0	1 00

Heal th	Financial Systems	SCHNECK MEDIC	CAL CENTER			In Lie	u of Form CMS	-2552	2-10
STATEM	ENT OF CHANGES IN FUND BALANCES			CCN: 150065	То	01/01/2014 12/31/2014	Worksheet G- Date/Time Pi 5/20/2015 3:	epare 48 pm	
		General	Fund	Speci al	Purpo	se Fund	Endowment Fur	d	
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1	. 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ \end{array}$	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		209, 952, 732 00, 952, 732			0		2. 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 10. 11. 0 12. 0 13. 0 14. 0 15. 0 16.	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 209, 952, 732			0 0			. 00 . 00
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0			2. 3. 4. 5. 6. 7. 8.	. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000	0 0 0 0 0 0		0 0			10. 11. 12. 13. 14. 15. 16. 17. 18.	0. 00 . 00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.	

STATEN	Financial Systems SCHNECK MEDICA IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150065		ri od:	Worksheet G-2	2552-10
					om 01/01/2014	Parts I & II Date/Time Pre 5/20/2015 3:4	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services		10.0// -			40.044.700	
1.00	Hospi tal		12, 866, 7	/29		12, 866, 729	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER			~		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00 8.00	SKILLED NURSING FACILITY						7.00 8.00
8.00 9.00	OTHER LONG TERM CARE						9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		12, 866, 7	220		12, 866, 729	
10.00	Intensive Care Type Inpatient Hospital Services		12, 000, 7	29		12, 000, 729	10.00
11.00	INTENSIVE CARE UNIT		1, 745, 8	24.2		1, 745, 843	11.00
12.00	CORONARY CARE UNIT		1, 740, 0	5-5		1, 745, 045	12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 745, 8	343		1, 745, 843	
10.00	11-15)	111105	1, 110, 0	, 10		1, 710, 010	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14, 612, 5	572		14, 612, 572	17.00
18.00	Ancillary services	/	56, 106, 6		185, 453, 778	241, 560, 434	
19.00	Outpatient services		5, 177, 0		21, 050, 244	26, 227, 299	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	о	0	21.00
22.00	HOME HEALTH AGENCY				2, 076, 764	2, 076, 764	22.00
23.00	AMBULANCE SERVI CES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE			0	1, 895, 818	1, 895, 818	26.00
27.00	NON-REIMBURSABLE COST CENTERS		2, 301, 8	353	7, 736, 951	10, 038, 804	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	78, 198, 1	36	218, 213, 555	296, 411, 691	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1				
29.00	Operating expenses (per Wkst. A, column 3, line 200)				114, 980, 129		29.00
30.00	ADD (SPECI FY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00	Tatal deductions (cum of lines 27 (1)			0			41.00
42.00 43.00	Total deductions (sum of lines 37-41)	2) (+====================================			114 000 100		42.00
$\mu \leq \mu(1)$	Total operating expenses (sum of lines 29 and 36 minus line 4	ZUTTANSTER	1	1	114, 980, 129		43.00

Heal th	Financial Systems	SCHNECK MEDICAL (ENTER		In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN	I: 150065	Peri od:	Worksheet G-3	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
						372072013 3.4	5 pm
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I	, column 3, line :	28)			296, 411, 691	1.00
2.00	Less contractual allowances and discounts on p	atients' accounts				182, 078, 451	2.00
3.00	Net patient revenues (line 1 minus line 2)					114, 333, 240	3.00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 43)			114, 980, 129	4.00
5.00	Net income from service to patients (line 3 mi	nus line 4)				-646, 889	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					-200, 311	6.00
7.00	Income from investments					-1, 916, 544	7.00
8.00	Revenues from telephone and other miscellaneou	s communication s	ervi ces			-13, 556	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					-115, 984	10.00
11.00	Rebates and refunds of expenses					-85, 000	
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 guest	S				-398, 180	
15.00	Revenue from rental of living quarters					0	15.00
16.00	Revenue from sale of medical and surgical supp		n patients			0	16.00
17.00	Revenue from sale of drugs to other than patie					-202, 073	
18.00	Revenue from sale of medical records and abstr					-38, 953	
19.00	Tuition (fees, sale of textbooks, uniforms, et	,				-4,035	
20.00	Revenue from gifts, flowers, coffee shops, and	canteen				-8, 379	20.00
21.00	Rental of vending machines					0	21.00
22.00	Rental of hospital space					-39, 011	
23.00	Governmental appropriations					0	23.00
24.00	CONTRACT REVENUE					-1, 315, 518	24.00 24.02
24.02	GRANT REVENUE					-57, 132	
24.03						-5, 811	
24. 04 24. 05	UNREALI ZED GAI N/LOSS EHR I NCENTI VE					-108, 644	24.04 24.05
24.05 24.06	DSH/UPL PAYMENTS					-525, 647 -7, 110, 394	
24.06	Total other income (sum of lines 6-24)					-12, 145, 172	
26.00	Total (line 5 plus line 25)					-12, 145, 172	26.00
	OTHER EXPENSES (SPECIFY)					-12, 792, 001	28.00
	Total other expenses (sum of line 27 and subsc	rints)				0	27.00
	Net income (or loss) for the period (line 26 m					-12, 792, 061	
27.00					I	12, 772, 001	/ . 00

	i Financial Systems SIS OF PROVIDER-BASED HOME HEALT	H AGENCY COSTS	SCHNECK MEDI		CCN: 150065 P	eri od:	u of Form CMS-2 Worksheet H	2552-1
	SIS OF TROVIDER-DASED HOWE HERET	II Adeliter COSTS		HHA CCN:		rom 01/01/2014	Date/Time Pre 5/20/2015 3:43	
						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	0.00	1.00	0.00	0.00	
00	Capital Related - Bldg. &			0		0	0	1.00
00	Fixtures Capital Related - Movable			0		0	0	2.00
	Equi pment			_			-	
00	Plant Operation & Maintenance	0	C		0	0	0	3.0
00 00	Transportation Administrative and General	0 215, 845	(2,922	27, 057	0 111, 598	0 357, 422	4.0 5.0
00	HHA REIMBURSABLE SERVICES	215, 645	(2,722	21,031	111, 370	557,422	5.0
00	Skilled Nursing Care	262, 481	C		0	0	262, 481	6.0
00	Physical Therapy	226, 095	C	0 0	0	0	226, 095	7.0
00	Occupational Therapy	136, 320	C	0	0	0	136, 320	8.0
00	Speech Pathology	13, 410	C	0	0	0	13, 410	
). 00	Medical Social Services	0	C		0	0	0	
1.00 2.00	Home Health Aide Supplies (see instructions)	65, 161 0				0 8, 132	65, 161 8, 132	
2.00 3.00	Drugs	0				0, 132	0, 132	
1.00	DME	0	C	-	0	-	0	
	HHA NONREI MBURSABLE SERVI CES			, <u> </u>		<u> </u>	0	1
5.00	Home Dialysis Aide Services	0	C	0	0	0	0	15.0
5.00	Respiratory Therapy	0	C	0	0	0	0	
7.00	Private Duty Nursing	0	C		0	0	0	
3.00	Clinic Health Promotion Activities	0	(0	0	0	
9.00).00	Day Care Program	0				0	0	
1.00	Home Delivered Meals Program	0	(0	0	0	
2.00	Homemaker Service	0	C	0	0	0	0	
3.00		0	C	0	0	0	0	23.00
1.00	Total (sum of lines 1-23)	919, 312	C	2, 922		119, 730	1, 069, 021	24.00
		Recl assi fi cati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocation			
		UII	(col. 6 +		(col. 8 + col.			
			col . 7)		9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
~ ~						1		1
00	Capital Related - Bldg. &	0	C	C	0			1.0
	Fixtures	0	(_	-			1.00
00 00		_	_	_	0			1.00 2.00
	Fixtures Capital Related - Movable	_	_) C	-			2.0
00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0 2, 097 0	C 2, 097 C		0 2, 097 0			2. 0 3. 0 4. 0
00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	0 2, 097	C 2, 097 C		0 2, 097 0			2. 0 3. 0 4. 0
00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 2, 097 0 0	2, 097 0 357, 422) C C C C C C C C C C C C C C C C C C C	0 2, 097 0 357, 222			2.00 3.00 4.00 5.00
00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care	2, 097 0 0	2, 097 0 357, 422 262, 481) C C C C C C C C C C C C C C C C C C C	2, 097 0 357, 222 262, 481			2. 0 3. 0 4. 0 5. 0 6. 0
00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	0 2, 097 0 0	2, 097 0 357, 422 262, 481 226, 095		2, 097 0 357, 222 262, 481 226, 095			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0
00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care	0 2, 097 0 0 0	2, 097 0 357, 422 262, 481		2, 097 0 357, 222 262, 481			2.0 3.0 4.0 5.0 6.0 7.0 8.0
00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	0 2, 097 0 0 0 0 0 0 0	2, 097 0 357, 422 262, 481 226, 095 136, 320		0 2, 097 0 357, 222 262, 481 226, 095 136, 320			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 2, 097 0 0 0 0 0 0 0 0 0 0	2, 097 (357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161		2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 2,097 0 0 0 0 0 937 0 0 0 0 937 0	2, 097 (357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132		2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 2, 097 0 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 (2) 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132		2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 2,097 0 0 0 0 0 937 0 0 0 0 937 0	2, 097 (357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132		2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 2, 097 0 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 (2) 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 2, 097 0 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0	2, 097 0 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0 0		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0
00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2. 0 3. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 15. 0 17. 0
00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 15. 0 14. 0 15. 0 14. 0 15. 0 14. 0 15. 0 14. 0 15. 0 13. 0 14. 0 15. 0 14. 0 15. 0 10. 0 11. 0 13. 0 14. 0 15. 0 14. 0 15. 0 10. 0 11. 0 13. 0 14. 0 15. 0 14. 0 15. 0 16. 0 17. 0 17. 0 18. 0 19.
00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2. 0 3. 0 4. 0 5. 0 7. 0 8. 0 9. 0 11. 0 12. 0 13. 0 14. 0 15. 0 14. 0 15. 0 17. 0 18. 0 17. 0 18. 0 19. 0
00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 18. 0 19. 0 20. 0 0 18. 0 19. 0
00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0			2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 20.0 21.0
00 00 00 00 00 00 00 00 00 00 00 00 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 2, 097 0 0 0 0 0 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 097 C 357, 422 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 C C		0 2, 097 0 357, 222 262, 481 226, 095 136, 320 13, 410 937 65, 161 8, 132 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 5/20/2015 3:48 pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

HHA CCN: 157155 From 01/01/2014 Par Dat 5/2 Home Heal th Agency I Ret Expenses for Cost Fixtures Bldgs & Movable Fixtures Equipment Operation & Costs (co	rksheet H-1 rt I te/Time Prep 20/2015 3:48 PPS	ared:
Capital Related Costs Home Health Agency I Net Expenses for Cost Bldgs & Fixtures Movable Equipment Plant Operation & Transportation S (column)		
Capital Related CostsNet ExpensesBldgs & MovablePlantTransportationSfor CostFixturesEquipmentOperation &(colspan="2">(colspan="2">(colspan="2")		
for Cost Fixtures Equipment Operation & (co		
Allocation (from Wkst. H, col. 10)	Gubtotal ols. 0-4)	
0 1.00 2.00 3.00 4.00	4A. 00	
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 0	0	1.00
Fixtures 2.00 Capital Related - Movable 0 0	0	2.00
Equipment Equipment 3.00 Plant Operation & Maintenance 2,097 0 0 2,097 4.00 Transportation 0 0 0 0 0	О	3.00 4.00
5.00 Administrative and General 357,222 0 0 2,097 0 HHA REIMBURSABLE SERVICES	359, 319	5.00
6.00 Skilled Nursing Care 262, 481 0 0 0 0	262, 481	6.00
7.00 Physical Therapy 226,095 0 <td>226, 095 136, 320</td> <td>7.00 8.00</td>	226, 095 136, 320	7.00 8.00
9.00 Speech Pathol ogy 13,410 0 <td>13, 410</td> <td>9.00</td>	13, 410	9.00
10.00 Medical Social Services 937 0		10.00
11.00 Home Health Aide 65,161 0 0 0 0 12.00 Supplies (see instructions) 8,132 0 0 0 0		11.00 12.00
13. 00 Drugs 0 0 0 0		13.00
14.00 DME 0 0 0 0	0	14.00
HHA NONREI MBURSABLE SERVI CES 15.00 Home Dial vsis Aide Servi ces 0 0 0 0	0	15 00
15.00 Home Dialysis Aide Services 0 <t< td=""><td>-</td><td>15.00 16.00</td></t<>	-	15.00 16.00
17.00 Private Duty Nursing 0 0 0 0 0	-	17.00
18.00 Clinic 0 0 0 0		18.00
19.00 Health Promotion Activities 0 </td <td></td> <td>19.00 20.00</td>		19.00 20.00
21.00Home Delivered Meals Program0000		21.00
22.00 Homemaker Service 0 0 0 0 0		22.00
23.00 All Others (specify) 0 <td>0 1, 071, 855</td> <td>23.00</td>	0 1, 071, 855	23.00
Admini strati ve Total (col s.	1,071,855	24.00
& General 4A + 5)		
GENERAL SERVICE COST CENTERS		
1.00 Capital Related - Bldg. &		1.00
Fixtures 2.00 Capital Related - Movable		2 00
2.00 Capital Related - Movable Equipment		2.00
3.00 Plant Operation & Maintenance		3.00
4.00 Transportation 5.00 Administrative and General 359, 319		4.00 5.00
5.00 Administrative and General 359,319 HHA REIMBURSABLE SERVICES		5.00
6.00 Skilled Nursing Care 132, 363 394, 844		6.00
7.00 Physical Therapy 114,016 340,111 8.00 0ccupational Therapy 68,744 205,064		7.00 8.00
9.00 Speech Pathol ogy 6, 762 20, 172		8.00 9.00
10. 00 Medical Social Services 473 1, 410		10.00
11. 00 Home Heal th Ai de 32, 860 98, 021		11.00
12.00 Supplies (see instructions) 4,101 12,233 13.00 Drugs 0 0		12.00 13.00
14. 00 DME 0 0		14.00
HHA NONREI MBURSABLE SERVI CES		45 00
15.00Home Dialysis Aide Services0016.00Respiratory Therapy00		15. 00 16. 00
17. 00 Private Duty Nursing 0 0		17.00
18.00 Clinic 0 0		18.00
19.00Health Promotion Activities0020.00Day Care Program00		19.00 20.00
20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0		20.00
22.00 Homemaker Service 0 0		22.00
23.00 All Others (specify) 0 0 24.00 Tatal (sum of lines 1.22) 1.071.955		23.00
24.00 Total (sum of lines 1-23) 1,071,855	I	24.00

	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider HHA CCN:	CCN: 150065 157155	Period: From 01/01/2014 To 12/31/2014	Worksheet H-1 Part II Date/Time Pre 5/20/2015 3:4	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
			Movable Equipment (DOLLAR VALUE)	(SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				1	-		
1.00	Capital Related - Bldg. & Fixtures	3, 850				0		1.00
2.00	Capital Related - Movable Equipment		17, 120			0		2.00
3.00	Plant Operation & Maintenance	0	0	3, 850)	0		3.00
4.00	Transportation (see	0	0	C)	0		4.00
	instructions)							
5.00	Administrative and General	3, 850	17, 120	3, 850		0 -359, 319	712, 536	5.00
(00	HHA REI MBURSABLE SERVI CES						0/0.404	1 / 00
6.00 7.00	Skilled Nursing Care Physical Therapy	0	-	C		0 0	262, 481 226, 095	6.00 7.00
7.00 8.00	Occupational Therapy	0	0			0 0	136, 320	
9.00	Speech Pathol ogy		0			0 0	13, 410	
10.00	Medical Social Services	0	0	C		0 0	937	
11.00	Home Health Aide	0	0	C)	0 0	65, 161	
12.00	Supplies (see instructions)	0	0	C)	0 0	8, 132	12.00
13.00	Drugs	0	0	C)	0	0	13.00
14.00	DME	0	0	C		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES	1	1		1			
15.00	Home Dialysis Aide Services	0	0	C		0 0	0	
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0			0 0	0	
18.00	Clinic		0			0 0		
19.00	Health Promotion Activities		0			0 0	0	
20.00	Day Care Program	0	0	C		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	C)	0 0	0	21.00
22.00	Homemaker Service	0	0	C		0 0	0	22.00
23.00	All Others (specify)	0	-	C		0 0	0	
24.00	Total (sum of lines 1-23)	3, 850				0 -359, 319	712, 536	
25.00	Cost To Be Allocated (per	0	0	2, 097		0	359, 319	25.00
24 00	Worksheet H-1, Part I)	0,000000	0,000000	0 544475	0.0000	00	0 504202	24 00
∠0. UU	Unit Cost Multiplier	0. 000000	0. 000000	0. 544675	0.0000	00	0. 504282	20. U

LLOCA	Financial Systems TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	SCHNECK MEDI		CCN: 150065	Peri od:	u of Form CMS-2 Worksheet H-2	
				HHA CCN:		From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/20/2015 3:4	pare 8 pm
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FI XT	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, 965	9, 172				
00	Skilled Nursing Care	394, 844	0	0				
00 00	Physical Therapy	340, 111	0	0				
00	Occupational Therapy Speech Pathology	205, 064 20, 172	0	0	1 .0,		60, 205 5, 922	
00	Medical Social Services	1, 410	0	C				
00	Home Health Aide	98, 021	0	C	1			
00	Supplies (see instructions)	12, 233	0	C		0 12, 233	3, 003	8
00	Drugs	0	0	C		0 0	0	
00	DME	0	0	0		0 0	0	
00 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0	1
00	Private Duty Nursing	0	0	0		0 0	0	
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	C		0 0	0	15
00	Day Care Program	0	0	0		0 0	0	
00	Home Delivered Meals Program	0	0	0		0 0	0	
00	Homemaker Service	0	0	0		0 0	0	
. 00 . 00	All Others (specify) Total (sum of lines 1–19) (2)	1, 071, 855	57, 965	9, 172		0 0 53 1, 410, 345	0 346, 204	
. 00	Unit Cost Multiplier: column	1, 071, 000	37,703	7, 172	271, 50	0. 000000	540, 204	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	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT	LINEN SERVICE				ADMI NI STRATI ON	
00	Admini streetive and Consume	7.00	8.00	9.00	10.00	11.00	13.00	1
00 00	Administrative and General Skilled Nursing Care	98, 662 0	0	26, 181 0		0 3, 288 0 4, 663		
00	Physical Therapy	0	0	0		0 2,884		
00	Occupational Therapy	0	0	C)	0 2,034		
00	Speech Pathology	0	0	C		0 166	2, 645	5
00	Medical Social Services	0	0	0		0 16		
00	Home Health Aide	0	0	0		0 2, 193		
00 00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
00	DME	0	0	0		0 0	0	
	Home Dialysis Aide Services	0	0	Ő		0 0	0	
00	Respiratory Therapy	0	0	C)	0 0	0	12
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	0	
00	Day Care Program Home Delivered Meals Program	0	0			0 0	0	
00	Homemaker Service	0	0	0		0 0	0	
. 00	All Others (specify)	0	Ö	0		0 0	0	
. 00	Total (sum of lines 1-19) (2)	98, 662	О	26, 181		0 15, 244	243, 157	20
. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus							21
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							

(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.
5/20/2015 3:48 pm J: \50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

LOCATION OF GENERAL SERVICE COSTS T	U HHA CUSI CENI	ERS			Period: From 01/01/2014		
			HHA CCN:	157155	To 12/31/2014	5/20/2015 3:48	pared 8 pm
					Home Health Agency I	PPS	
Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	OTHER GENERA SERVI CE PHYSI CI AN PRI VATE		Subtotal	
	SUPPLY 14.00	15.00	LI BRARY 16.00	PRACTICE 18.00	19.00	24.00	
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home All Others (specify) Total (sum of Lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 	14.00 0 0 0 0 0 1,351 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 228 0 0 0 0 0 0 0 0 0 0 0 0	18.00	19.00 0	24.00 357,687 667,216 555,525 339,949 32,859 2,366 183,183 16,587 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
6 decimal places. Cost Center Description	Intern & Residents Cost & Post Stepdown	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
	Adjustments 25.00	26.00	27.00	28.00	_		
200 Administrative and General 200 Skilled Nursing Care 200 Physical Therapy 200 Occupational Therapy 200 Occupational Therapy 200 Speech Pathology 200 Medical Social Services 200 Drugs 200 Drugs 200 Meme Dalysis Aide Services 200 Private Duty Nursing 200 Private Duty Nursing 200 Clinic 200 Heal th Promotion Activities 200 Day Care Program 200 Home Delivered Meals Program 200 Home Delivered Meals Program 200 Home Delivered Meals Program 200 Home Col (sum of Lines 1-19) (2) 200 Unit Cost Multiplier: column 26, Line 1 divided by the sum <t< td=""><td></td><td>357, 687 667, 216 555, 525 339, 949 32, 859 2, 366 183, 183 16, 587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>132, 757 110, 533 67, 640 6, 538 471 36, 448 3, 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>799, 97 666, 05 407, 58 39, 39 2, 83 219, 63</td><td>88 99 77 77 77 77 77 77 77 77 70 0 0 0 0 0</td><td></td><td>1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 10.</td></t<>		357, 687 667, 216 555, 525 339, 949 32, 859 2, 366 183, 183 16, 587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	132, 757 110, 533 67, 640 6, 538 471 36, 448 3, 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	799, 97 666, 05 407, 58 39, 39 2, 83 219, 63	88 99 77 77 77 77 77 77 77 77 70 0 0 0 0 0		1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 10.

(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.
5/20/2015 3:48 pm J: \50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

	Financial Systems		SCHNECK MEDI				u of Form CMS-2	
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS	FO HHA COST CEN	TERS STATISTICA	L Provider HHA CCN:	CCN: 150065 157155	Period: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part II Date/Time Pre 5/20/2015 3:4	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	onADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	1	1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	3, 850	17, 120	215, 845		0 130, 783	3, 850	1
2.00 3.00	Skilled Nursing Care	0	0	262, 481		0 472, 242 0 406, 779	0	
3.00 4.00	Physical Therapy Occupational Therapy	0	0	226, 095 136, 320		0 408, 779	0	
5.00	Speech Pathol ogy	0	0	13, 410		0 24, 126	0	
6.00	Medical Social Services	0	0	937		0 1, 686	0	
7.00	Home Health Aide	0	0	65, 161		0 117, 235		7.00
8.00	Supplies (see instructions)	0	0	C		0 12, 233		
9.00	Drugs	0	0	0		0 0		
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	C		0 0	0	
14.00	Clinic	0	0	C		0 0	0	14.00
15.00	Health Promotion Activities	0	0	C		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	
17.00 18.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
18.00	All Others (specify)	0	0	0			0	19.00
20.00	Total (sum of lines 1-19)	3, 850	17, 120	920, 249		1, 410, 345	3, 850	
21.00	Total cost to be allocated	57, 965	9, 172	271, 353		346, 204	98, 662	21.00
22.00	Unit cost multiplier	15. 055844	0. 535748	0. 294869		0. 245475		22.00
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE	DI ETARY (MEALS	CAFETERIA (HOURS OF	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
		(POUNDS OF	FEET)	SERVED)	SERVICE)	ADMINI STRATION	SUPPLY	
		LAUNDRY)	,	,		(DI RECT	(COSTED	
						NRSING HRS)	REQUIS.)	
1.00	Administrative and General	8.00	<u>9.00</u> 3,850	10.00 0	11.00 6,2	13.00 85 6,285	14.00 0	1.00
2.00	Skilled Nursing Care	0	3, 850	0				
3.00	Physical Therapy	0	0	0			0	
4.00	Occupational Therapy	0	0	C	3, 8	3, 889	0	4.00
5.00	Speech Pathol ogy	0	0	C	-	17 317	0	
6.00	Medical Social Services	0	0	0		30 30		
7.00 8.00	Home Health Aide	0	0	0		92 4, 192 0 0	12 514	
8.00 9.00	Supplies (see instructions) Drugs	0	0	0		0 0	12, 516 0	
10.00	DME	0	0	C		0 0		
11.00	Home Dialysis Aide Services	0	0	C		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic Health Promotion Activities	0	0	0		0 0	0	
15. 00 16. 00	Day Care Program		0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	C		0 0	0	1
18.00	Homemaker Service	0	Ő	0		0 0	0	
19.00	All Others (specify)	0	0	C		0 0	0	19.00
20.00	Total (sum of lines 1-19)	0	3, 850	C	29, 1			
21.00	Total cost to be allocated Unit cost multiplier	0. 000000	26, 181 6. 800260	0 0. 000000				
ZZ. UU	louir cost murtipiter	0.000000	υ. δυυ260	0.00000	η 0.5230 [°]	74 ð. 343808	0. 107942	ZZ. UU

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA	AL Provider	CCN: 150065	Period:	Worksheet H-2	
BASIS			HHA CCN:	157155	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narod
			THA CON.	157155	10 12/31/2014	5/20/2015 3:4	
					Home Health	PPS	
					Agency I		
			OTHER GENERAL				
			SERVI CE				
Cost Center Description	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSI CI A			
	(COSTED	RECORDS &	PRI VATE	ANESTHETI ST	S		
	REQUIS.)	LIBRARY	PRACTICE	(ASSI GNED			
		(GROSS	(TIME	TIME)			
	15.00	CHARGES)	SPENT)	19.00			-
1.00 Administrative and General	15.00	16.00 2,076,764	18.00	19.00	0		1.00
2.00 Skilled Nursing Care	0	2,070,704	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 Pathol ogy	0	0	0		0		5.00
6.00 Medical Social Services	0	0	0		0		6.00
7.00 Home Heal th 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		10.00
11.00 Home Dialysis Aide Services	0	0			0		11.00
12.00 Respiratory Therapy	0	0			0		12.00
13.00 Private Duty Nursing	0	0	0		0		13.00
14.00 Clinic	0	0	0		0		14.00
15.00 Health Promotion Activities	0	0	0		0		15.00
16.00 Day Care Program	0	0			0		16.00
17.00 Home Delivered Meals Program	0	0	0		0		17.00
18.00 Homemaker Service	0	0	0		0		18.00
19.00 All Others (specify)	0	0	0		0		19.00
20.00 Total (sum of lines 1-19)	0	2,076,764	0		0		20.00
21.00 Total cost to be allocated	0	14, 228			0		21.00
22.00 Unit cost multiplier	0. 000000			0.0000			22.00
the first of a state of the sta					1		

MARCHI LOWENT OF PATIENT SLAVICE COSTS Provider COST ISDAB HAL COST Part of the Distribution Distribution Part 1 Description Total Visit Cost Center Description H-2, Part 1. Instruct (Cost 28, Hrw H-2, Part 1) Description Cost 20, Cost 1, Cos	Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
HAA COR: 157165 To 127121 Dist The Propered. The Write Market Mar			S			CCN: 150065	Period:	Worksheet H-3	
Cost Center Description From West. (Cron West. b) Fact II ty Cost. (Cron West. b) Fact II ty Cost. (Cron West. b) Total West. (Cron West. b) Total West. (Cron West. b) Total West. (Cron West. b) Total West. (Cron West. b) Average Cost. (Cron West. b) PART I - COMPUTATION OF LESSER OF ACCREATE PROFAM LIMITATION Dest. II de Cost. Limit At Cost. 2.00 3.100 4.00 5.00 PART I - COMPUTATION OF LESSER OF ACCREATE PROFAM LIMITATION Dest. II de Cost. Limit At Cost. 2.00 2.00 7.99,973 3.146 2.24.28 1.00 0 obt. II de Cost. Limit At Cost. 2.00 The AccREATE PROFAM LIMITATION Dest. II de Cost. Center Description 2.00 7.99,973 3.146 2.24.28 1.00 0.00 Description Cost. Limit 1s Cost. Conter Description Cost. Limit 1s Cost. Limit 1s Cost. Cost. Computation 0 1.00 2.00 3.00 4.00 5.00 0.01 1.00 2.00 3.00 4.00 5.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00					HHA CCN:	157155		Date/Time Pre	pared: 8 pm
Cost Center Description Fram, Kitzt H-2, Part I) Cost (crost (crost) (crost) Total HRA (crost) (crost) Total HRA (crost) (crost) Total HRA (crost) (crost) Total HRA (crost) (crost) Total HRA (crost) (crost) Total HRA (crost)					Titl	e XVIII		PPS	
D 1 D 3 0 2 0 5 0 1 0 1 0 1 0 1 0 1 0 1		Cost Center Description	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	Total Visits	Per Visit	
Description 0 1.00 2.00 3.00 4.00 5.00 BART I - COMMUTATION DELESER OF AGGEGATE PROGRAM COST. ASSREGATE OF THE PROGRAM LIMITATION COST. EARLY USL TOILUTATION COST. COST. CONC. COST. CONC. COST. C			col. 28, line	H-2, Part I)		+ 2)			
BEREFICIARY COST LIMITATION Cost Ferv Visit Computation 709,973 799,973 5,146 254,28 1,00 Cost Ferv Visit Computation 2.00 799,973 0 799,973 5,146 254,28 1,00 Cost Ferv Visit Computation Therapy 4.00 407,599 0 407,599 1,003 2226,06 3,00 6,02 2,037 1,013 2246,04 4,04			0	1.00		3.00	4.00		
OST Her Visit Computation 799,973 3,146 25.21 1.00 2.00 Physical Therapy 3.00 666,058 0 666,058 2,373 220.68 2.00 799,973 3,146 25.20 3.00 20.00 60,058 0 666,058 0 666,058 0 3.03 227.97 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 3.23,977 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.135,485 0 2.00 0 2.00 0 2.00 0.00 0.00 0.00			OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIN	ITATION COST, OF	R	
1.00 Skilled Nursing Care 2.00 799, 973 799, 973 3.146 2.56.2 1.00 0.00 Projectional Therapy 3.00 407, 589 0 646, 058 0.373 2.146 2.56.6 3.00 0.00 Specie Arbid ogy 5.00 3.939 1.41 2.974 4.00 3.939 1.41 2.974 4.00 3.00 407, 589 1.00 2.357 1.30 2.45.93 3.00 47.55 5.00 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353, 485 9 2.353 1.00 2.00 3.00 4.00 5.00 11.39 6.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.0									+
2.00 Physical Therapy 3.00 666,058 0 666,058 2.03 2.03 2.00 4.00 39,397 0 39,397 1.11 2/7.64 4.00 4.00 Speech Pathology 5.00 2.9,337 1.03 2/7.63 30,397 1.11 2/7.64 4.00 6.00 Meme Health Aide 7.00 2.15,463 0 2.15,465 6.03 4.00 5.33 7.00 2.16,345 6.00 2.15,465 6.00 7.00 2.01 3.09 4.00 5.00 7.00 2.00 3.00 4.00 5.00 7.00 7.00 7.00 2.00 3.00 4.00 5.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 8.00 1.00 8.00 1.00 8.00 1.00 8.00 1.00 8.00 1.00 8.00 1.00 8.00 1.00 1.00 8.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <td>1.00</td> <td></td> <td>2.00</td> <td>799, 973</td> <td></td> <td>799, 97</td> <td>3 3, 146</td> <td>254.28</td> <td>1.00</td>	1.00		2.00	799, 973		799, 97	3 3, 146	254.28	1.00
4.00 Speech Pathology 5.00 39,397 0 39,397 141 272.41 4.00 6.00 Hedical Social Socia	2.00	5	3.00	666, 058	C	666, 05	8 2, 373	280. 68	2.00
5.00 Medical Social Services 6.00 2.837 2.837 3.00 94.57 5.00 0.00 Total (sum of lines 1-6) 0 219,631 0 219,631 0.00 219,631 0.00 219,631 0.00 213,548 0.52 7.00 0.00 Total (sum of lines 1-6) 0 1.00 2.00 2.013,485 0.00 2.135,485 0.00 2.135,485 0.00 2.135,485 0.00 2.135,485 0.00 2.013,485 0.00 2.013,5485 0.00 2.013,485 0.00 2.013,485 0.00 2.014,400 0.00	3.00								•
6.00 Home Heal th Aide 7.00 219, 631 213, 645 213, 645 213, 645 213, 645 7.00 211, 35, 645 0, 7.00 211, 35, 645 0, 7.00 211, 35, 645 0, 7.00 7.00 Cost Center Description Cost Limits CBSA No. (1) Part A Pergram Visits					C				•
Z.00 Total (sum of lines 1-6) Z. 135, 485 O Z. 135, 485 O Z. 135, 485 S. 532 Z. 0 Cost Center Description Cost Limits CBSA No. (1) Part A Subject to Subject t									•
Cost Center Description Cost Limits CBSA No. (1) Part A Program Visits Part B 0 1.00 2.00 3.00 4.00 5.00 8.00 5kilitel Nursing Care 99915 0 1,710 8.00 9.01 Physical Therapy 99915 0 1,710 8.00 9.01 Physical Therapy 99915 0 1,710 8.00 9.02 Physical Therapy 99915 0 1,404 9.00 9.02 Physical Therapy 18020 0 4.00 2.00 9.02 Physical Therapy 31140 0 2.00 5.00 10.00 Occupational Therapy 31140 0 2.00 5.00 10.00 Occupational Therapy 18020 0 1,004 9.00 10.01 Occupational Therapy 31140 0 0 10.00 10.02 Occupational Therapy 31140 0 0 10.00 10.00 10.00 10.00			7.00		(
Cost Center Description Cost Limits CBS No. (1) Part A Not Source to Subject to Subje	7.00			2,100,100					7.00
Limitation Cost Computation 0 1.00 2.00 3.00 4.00 5.00 8.01 Skilled Nursing Care 18020 0 8.00 8.01 Skilled Nursing Care 8.00 8.01 Skilled Nursing Care 9.00 1.710 8.00 8.01 Skilled Nursing Care 9.01 Physical Therapy 18020 0 4.00 2.0 8.01 8.01 Skilled Nursing Care 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.00 1.006 2.1 9.00 9.01 9.00 9.01 9.00 1.006 2.1 9.00 10.00 10.00 0.01 0.02 9.01 10.00 1.006 10.00 10.01 10.01 10.01 10.01 10.01 10.01 10.02 10.01 10.02 10.01 10.02 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01						Pa	nrt B		
Image: constraint of the		Cost Center Description	Cost Limits	CBSA No. (1)	Part A				
Unitation Cost Computation 0 1.00 2.00 3.00 4.00 5.00 Skilled Nursing Care 8.01 Skilled Nursing Care 9.00 0 1.00 0 1.00 8.00 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.00 1.00 0 1.00 8.00 8.00 9.01									
Limitation Cost Computation Biology Bio			0	1.00	2.00			5,00	
8.01 Skilled Nursing Care 99915 0 1,710 8.02 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.01 8.02 8.01 8.02 8.01 8.02 8.01 8.02 8.01 8.02 8.01 8.02 8.01 8.02 8.01 8.02 8.02 8.01 8.02 9.00 9.02 9.02 9.02 9.01 9.02 9.01 9.02 9.02 9.02 9.02 9.02 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.01 9.02 9.01 9.02 9.01 9.02 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 </td <td></td> <td>Limitation Cost Computation</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		Limitation Cost Computation							
8.02 Skilled Nursing Care 31140 0 4 8.02 9.00 Physical Therapy 18020 0 47 9.00 9.01 Physical Therapy 99915 0 1.404 9.00 9.02 Physical Therapy 18020 0 58 10.00 0.02 physical Therapy 18020 0 58 10.00 0.02 physical Therapy 18020 0 58 10.00 0.02 physical Therapy 31140 0 21 9.00 1.0.02 Speech Pathol Gay 18020 0 0 11.00 1.0.02 Speech Pathol Gay 31140 0 0 11.00 1.0.01 Speech Pathol Gay 31140 0 0 11.00 1.0.02 Speech Pathol Gay 31140 0 0 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 10.00 12.00 13.00	8.00								8.00
9.00 Physical Therapy 901 Physical Therapy 902 Physical Therapy 902 Physical Therapy 902 Compational Therapy 903 Structure Physical Therapy 904 Structure Physical Therapy 905 Structure Physical Therapy 905 Structure Physical Therapy 905 Structure Physical Therapy 906 Structure Physical Therapy 907 Structure Physical Therapy 909 Structure Physical Structure	8.01								8.01
9.01 Prvsical Therapy 9.02 Prvsical Therapy 9.02 Prvsical Therapy 9.02 Prvsical Therapy 9.02 Prvsical Therapy 9.02 Prvsical Therapy 9.02 Prvsical Therapy 9.03 T140 0.02 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.02 Prvsical Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.02 Prvsical Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.02 Prvsical Therapy 9.00 O 0 9.00 O 0 9.00 O 0 9.00 O 0 11.00 9.00 O 0 11.00 9.00 O 0 11.00 9.00 T1.00 9.00 T1.00 9.00 T1.00 9.00 Total Charges 9.00 O 0 10.00 Cost of Medical Sucel Supplies 0 Total Charges 9.00 O 0 10.00 Cost of Medical Supplies 0 Total Computations 15.00 Cost of Medical Supplies 0 Total Cost Conter Description 15.00 Cost of Medical Supplies 0 10.00 10.00 4.00 5.00 15.00 Cost of Medical Supplies 0 10.00 10.00 10.00 10.00 10.00 10.00 10.									•
9.02 přýsícal Therapý 0.00 Occupational Therapy 19.02 Occupational Therapy 19.02 Occupational Therapy 10.00 Oc									•
10.00 Occupational Therapy 18020 0 58 10.00 10.01 Occupational Therapy 31140 0 2 10.00 10.02 Speech Pathol ogy 18020 0 0 0 10.00 11.00 Speech Pathol ogy 18020 0 0 11.00 11.00 11.01 Speech Pathol ogy 31140 0 0 11.00 11.00 11.02 Medical Social Services 18020 0 0 11.00 11.00 12.01 Medical Social Services 31140 0 0 12.00 12.00 12.00 12.01 10.00 12.00 12.01 13.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 10.00 12.00 12.00 12.00 13.00 14.00 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 14.00 13.									9.02
10.02 Occupational Therapy 31140 0 2 10.02 11.00 Speech Pathology 18020 0 0 11.00 11.01 Speech Pathology 31140 0 0 0 11.00 11.02 Speech Pathology 31140 0 0 0 11.00 11.02 Speech Pathology 31140 0 0 0 11.00 11.02 Medical Social Services 99915 0 14 12.00 11.00 12.01 Medical Social Services 31140 0 0 0 12.00 13.00 Home Healt h Aide 18020 0 5.08 13.00 13.00 13.01 Home Healt h Aide 99915 0 497 13.00 13.00 14.00 Total (sum of lines 8-13) From Wkst. H-2, Part I) Costs (from Wkst. + 2) 16.05 5.00 + col4) 15.00 Cost of Medical Supplies 8.00 19.887 0 0	10.00				C				10.00
11.00 Speech Pathology 11.00 Speech Pathology 11.00 11.01 Speech Pathology 31140 0 0 11.01 11.02 Speech Pathology 31140 0 0 11.01 11.00 Speech Pathology 31140 0 0 11.01 12.00 Medical Social Services 99915 0 14 12.01 12.01 Medical Social Services 31140 0 0 14.01 12.01 13.00 Home Health Aide 18020 0 59 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.01 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00	10. 01	Occupational Therapy			C	1, 09	6		10.01
11.01 Speech Pathol ogy 99915 0 91 11.01 12.00 Medical Social Services 18020 0 0 11.02 12.01 Medical Social Services 18020 0 0 12.01 12.01 Medical Social Services 31140 0 0 0 12.01 12.01 Medical Social Services 31140 0 0 0 12.01 12.01 Medical Social Services 31140 0 0 0 13.00 13.00 Home Healt h Aide 99915 0 497 13.01 13.02 Home Healt h Aide 99915 0 497 13.00 14.00 Total (sum of lines 8-13) 10 0 5.083 14.00 15.00 Cost of Medical Suplies 8.00 19.887 0 19.887 29.113 0.683097 15.00 16.00 Cost of Drugs 9.00 0 0 10.077 0.000000 16.00 16.00 <td< td=""><td>10. 02</td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td>10.02</td></td<>	10. 02				-				10.02
11. 02 Speech Pathology 31140 0 0 0 0 11. 02 Medical Social Services 18020 0 0 12. 00 Medical Social Services 99915 0 14 12. 00 Medical Social Services 99915 0 14 12. 00 12. 00 Medical Social Services 99915 0 14 12. 00 12. 00 13. 01 Memethealth Aide 18020 0 0 0 12. 00 13. 01 14. 00 14. 00 0 0 13. 01 14. 00 13. 01 14. 00 13. 02 14. 00 0 0 13. 02 14. 00 13. 02 14. 00 13. 02 14. 00 14 14. 00 14 14. 00 14 14. 00 14. 00 14 14					-		-		•
12.00 Medical Social Services 18020 0 0 12.01 Medical Social Services 12.01 Medical Social Services 12.01 13.01 13.01 13.01 13.01 13.01 13.01 13.01 13.01 13.01 13.01 13.01 13.02 13.01 13.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></td<>									•
12.01 Medical Social Services 99915 0 14 12.01 14 12.01 12.01 14 12.01 12.01 14 12.01 14 12.01 12.01 14 12.01 12.01 12.01 12.01 12.02 14.00 0 0 0 0 12.02 12.02 12.01 12.01 12.01 12.01 12.01 12.02 0 0 0 0 0 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.02 13.01 14.01 16.01 14.01 16.01 16.01 16.01 16.01 16.01 16.01 16.01 16.01 16.01							-		•
13.00 Home Health Aide 18020 0 59 497 13.01 13.01 Home Health Aide 99915 0 497 0 13.02 13.02 Home Health Aide 99915 0 497 0 13.02 14.00 Total (sum of lines 8-13) From Wkst. H-2 Facility Costs Shared Total HHA Record) * col	12.00								12.00
13.01 Home Health Aide Home Home Home Home Home Home Home Home	12.02	Medical Social Services		31140	C		0		12.02
13.02 Home Heal th Ai de Total (sum of Lines 8-13) 31140 0 0 5,083 13.02 14.00 14.00 Total (sum of Lines 8-13) From Wkst. H-2 Facility Costs Part I, col. 28, line Shared Part I, col. 28, line Total HHA H-2, Part I) Total Charges Costs (cols. 1 Part II) Ratio (col. 3 + col. 4) + col. 4) <	13.00				-				13.00
14.00 Total (sum of lines 8-13) o 5,083 14.00 Cost Center Description From Wkst. H-2 (28, line) Facility Costs (and 12, 28, line) Shared (brow Wkst. H-2, Part I) Total HHA (and 11 ary Costs (from Part II) Total Charges (from HHA (and 12, 28, line) Ratio (col. 3 (col 3, 1) Ratio (col. 4) Ratio (col 4)	13.01				-		7		13.01
Supplies Cost Center Description From Wkst. H-2 Part I, col. 28, in e Facility Costs (from Wkst. H-2, Part I) Shared Anciliary Costs (cols. 1 H+2) Total Charges (from HHA Record) Ratio (col. 3 + col. 4) Supplies and Drugs Cost Computations 0 1.00 2.00 3.00 4.00 5.00 Supplies and Drugs Cost Computations 0 1.00 2.00 3.00 4.00 5.00 16.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 16.00 Cost Center Description Part A Porgram Visits Cost of Supect to Deductibles & Coinsurance Part B Not Subject to Deductibles & Coinsurance Part B Not Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Not Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Not Subject to Deductibles & C				31140	-		0		•
Part I, col. (from Wkst. 28, line Ancillary H-2, Part I) Costs (cols. 1 Part I) (from HHÅ Record) + col. 4) 0 1.00 2.00 3.00 4.00 5.00 5.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 15.00 16.00 Cost of Medical Supplies 8.00 19,887 0 10,577 0.000000 16.00 16.00 Cost of Drugs 9.00 0 0 10,577 0.000000 16.00 Cost of Medical Supplies 8.00 19,887 0 10,577 0.000000 16.00 Cost of Drugs Part B Part B Part B Deductibles & Cost of Services Deductibles & Coinsurance	14.00		From Wkst H-2	Facility Costs				Ratio (col 3	14.00
Supplies and Drugs Cost Computations 0 1.00 2.00 3.00 4.00 5.00 15.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 15.00 16.00 Cost of Drugs 9.00 0 0 0 10,577 0.000000 16.00 Cost of Drugs Program Visits Cost of Services Part B Not Subject to Deductibles & Deductibles & Deductibles & Deductibles & Deductibles & Coinsurance Part B Not Subject to Deductibles & Coinsurance Deductibles & Coinsurance				J J					
Supplies and Drugs Cost Computations 0 1.00 2.00 3.00 4.00 5.00 15.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 15.00 16.00 Cost of Drugs 9.00 0 0 0 10,577 0.000000 16.00 Program Visits Cost of Services Program Visits Cost of Services Cost Center Description Part A Not Subject to Deductibles & Coinsurance Cost Computation Cost Center Description Part A Not Subject to Deductibles & Coinsurance Coinsurance <td< td=""><td></td><td></td><td>28, line</td><td>H-2, Part I)</td><td>•</td><td>+ 2)</td><td>Record)</td><td></td><td></td></td<>			28, line	H-2, Part I)	•	+ 2)	Record)		
Supplies and Drugs Cost Computations 15.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 15.00 16.00 Cost of Drugs 9.00 0 0 0 0 10,577 0.000000 16.00 Program Visits Cost of Services Part B Cost Center Description Part A Not Subject to Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Consurance Subject to Deductibles & Coinsurance Coinsuranc				1.00		2.00	4.00	F 00	
15.00 Cost of Medical Supplies 8.00 19,887 0 19,887 29,113 0.683097 15.00 16.00 Cost of Drugs 9.00 0 0 0 0 10,577 0.000000 16.00 Program Visits Cost of Services Part B Not Subject to Deductibles & Coinsurance Part B Not Subject to Deductibles & Coinsurance Not Subject to Deductibles & Coinsurance Deductibles & Coinsurance		Supplies and Drugs Cost Compute		1.00	2.00	3.00	4.00	5.00	
16.00 Cost of Drugs 9.00 0 0 0 0 10,577 0.000000 16.00 Frogram Visits Program Visits Cost of Services Part B P	15.00			19, 887	C) 19, 88	29, 113	0. 683097	15.00
Services Services Services Services Services Part B Part B Part B Part B Not Subject to Deductibles & Coinsurance Part A Not Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Deductibles & Coinsurance Deductibles & Coinsurance Subject to Deductibles & Coinsurance Subject to Coinsurance Subje	16.00	Cost of Drugs					0 10, 577	0. 000000	16.00
Part BPart BCost Center DescriptionPart APart BPart BNot Subject to Deductibles & CoinsurancePart BNot Subject to Deductibles & CoinsurancePart APart BPart BNot Subject to Deductibles & CoinsuranceObject to Deductibles & Coinsurance6.007.00Part APart BNot Subject to Deductibles & CoinsurancePART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, Cost Per Visit ComputationNot Subject to Deductibles & Coinsurance1.00Skilled Nursing CareO1,794O456,1781.002.00Physical TherapyO1,472O456,1781.003.00Occupational TherapyO1,156O261,3253.004.00Speech PathologyO91O1,3245.006.00Home Heal th AideO556O117,5336.00				Program Visits					
Cost Center DescriptionPart ANot Subject to Deductibles & CoinsurancePart ANot Subject to Deductibles & CoinsurancePart ANot Subject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsurancePART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATIONPart ANot Subject to Deductibles & Coinsurance1.00Skilled Nursing Care01,7940456,1781.002.00Physical Therapy01,4720413,1612.003.00Occupational Therapy01,1560261,3253.004.00Speech Pathology091025,4264.005.00Medical Social Services01401,3245.006.00Home Heal th Aide05560117,5336.00				Dava	+ D	Servi ces	Daviet D		
Deductibles & Coinsurance Deductibles & Coinsurance Deductibles & Coinsurance Deductibles & Coinsurance Deductibles & Coinsurance Deductibles & Coinsurance PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR Intervention 1.00 Skilled Nursing Care 0 1,794 0 456,178 1.00 2.00 Physical Therapy 0 1,472 0 413,161 2.00 3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 1,156 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00		Cost Center Description	Part A			Part A		Subject to	
Coinsurance		cost center beschiption							
PART I COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation Image: Cost Per Visit Computation 1.00 Skilled Nursing Care 0 1,794 0 456,178 1.00 2.00 Physical Therapy 0 1,472 0 413,161 2.00 3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00									
BENEFICIARY COST LIMITATION Cost Per Visit Computation 1.00 Skilled Nursing Care 0 1,794 0 456,178 1.00 2.00 Physical Therapy 0 1,472 0 413,161 2.00 3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00									
1.00 Skilled Nursing Care 0 1,794 0 456,178 1.00 2.00 Physical Therapy 0 1,472 0 413,161 2.00 3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00		BENEFICIARY COST LIMITATION	OF AGGREGATE F	PRUGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	TTATION COST, OF	K	-
2.00 Physical Therapy 0 1,472 0 413,161 2.00 3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Ai de 0 556 0 117,533 6.00	1 00			1 704			0 /56 170		1 00
3.00 Occupational Therapy 0 1,156 0 261,325 3.00 4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00		5	-						2.00
4.00 Speech Pathology 0 91 0 25,426 4.00 5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00	3.00								3.00
5.00 Medical Social Services 0 14 0 1,324 5.00 6.00 Home Heal th Aide 0 556 0 117,533 6.00	4.00		-						4.00
	5.00						0 1, 324		5.00
7.00 Total (sum of Lines 1-6) 0 5,083 0 1,274,947 7.00	6.00								6.00
	7.00	TOTAL (SUM OF LINES 1-6)	I 0	5, 083	l	1	u 1,274,947	I	J 7.00

	Financial Systems IONMENT OF PATIENT SERVICE COST	S	SCHNECK MEDI		CCN: 150065	Peri od:	u of Form CMS- Worksheet H-3	
				HHA CCN:	157155	From 01/01/2014 To 12/31/2014		
				Titl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description							
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
$\begin{array}{c} 8.\ 00\\ 8.\ 01\\ 8.\ 02\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 11.\ 00\\ 11.\ 01\\ 11.\ 02\\ 12.\ 00\\ 12.\ 01\\ 12.\ 02\\ 13.\ 00\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8.00 8.01 8.02 9.00 9.01 9.02 10.00 10.01 10.02 11.00 11.01 11.02 12.00 12.01 12.02 13.00
13. 01 13. 02	Home Health Aide Home Health Aide							13.01
	Total (sum of lines 8-13)							14.00
		Prog	ram Covered Cha	arges	Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Subject to Deductibles & Coinsurance		
	[6.00	7.00	8.00	9.00	10.00	11.00	
15.00	Supplies and Drugs Cost Computa Cost of Medical Supplies	ations 0	0	0				15.00
16.00	Cost of Drugs		68			0	(16.00
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER	12.00						
	BENEFICIARY COST LIMITATION	OF AGGREGATE I	PROGRAM CUST, A	GOREGATE OF TH	E PROGRAM LI	WITATION COST, OF	C C	
	Cost Per Visit Computation							
1.00 2.00	Skilled Nursing Care Physical Therapy	456, 178 413, 161						1.00
3.00	Occupational Therapy	261, 325	5					3.00
4.00	Speech Pathology Medical Social Services	25, 426						4.00
5.00 6.00	Home Health Aide	1, 324 117, 533						5.00
7.00	Total (sum of lines 1-6)	1, 274, 947						7.00
	Cost Center Description	12.00	-					-
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care							8.00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care							8. 01 8. 02
9.02 9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10. 00 10. 01	Occupational Therapy Occupational Therapy							10.00
10. 02	Occupational Therapy							10. 02
11. 00 11. 01	Speech Pathol ogy Speech Pathol ogy							11.00
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
	Medical Social Services Home Health Aide							12. 02 13. 00
13.01	Home Health Aide							13.01
13.02	Home Health Aide Home Health Aide Total (sum of lines 8-13)							13.01 13.02 14.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERV	ICE COSTS		Provi der		Peri od:	Worksheet H-3	
					From 01/01/2014		
			HHA CCN:	157155	To 12/31/2014	Date/Time Prep 5/20/2015 3:48	
			Ti +1	e XVIII	Home Health	PPS	<u>s pili</u>
			11 (1	e vill		FFJ	
Cast Castas Daars		Cast to Charac			Agency I		
Cost Center Descr		Cost to Charge		HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from		Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT	OF COST OF HHA SERV	CES FURNI SHED B	BY SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 0	0 0. 534334	C		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.0	0 0. 293246	C		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.0	0 0. 729090	C)	0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplie	es 71.0	0 1. 142112	C		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.0	0 0. 761494	C		0 col. 2, line 1	5. 00	5.00

ALCULA	Financial Systems SCHNECK MEDICAL C TION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150065	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	157155	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Home Health Agency I	PPS	
					t B	
			Part A		Deductibles &	
			1.00	Coi nsurance	Coi nsurance	
			1.00	2.00	3.00	_
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA Reasonable Cost of Part A & Part B Services	AKT CHARGE	.3			-
0	Reasonable cost of services (see instructions)		1	0 0	0	i i
	Total charges			0 0		
	Customary Charges			· ·		
	Amount actually collected from patients liable for payment for s	servi ces		0 0	0	1 :
	on a charge basis (from your records)					
	Amount that would have been realized from patients liable for pa			0 0	0	1 4
	for services on a charge basis had such payment been made in acc	cordance				
	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
	Total customary charges (see instructions)		0.0000	0 0.00000	0.000000	
	Excess of total customary charges over total reasonable cost (co	omplete		0 0	0	
	only if line 6 exceeds line 1)					
0	Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	
	1 exceeds line 6)					
00	Primary payer amounts			0 0	-	
				Part A Services	Part B Services	
				1.00	2.00	+
F	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00	Total reasonable cost (see instructions)			0		1
	Total PPS Reimbursement - Full Episodes without Outliers			0		
	Total PPS Reimbursement - Full Episodes with Outliers			0	4, 690	
	Total PPS Reimbursement - LUPA Episodes			0	16, 992	
	Total PPS Reimbursement - PEP Episodes			0	6, 731	
	Total PPS Outlier Reimbursement – Full Episodes with Outliers Total PPS Outlier Reimbursement – PEP Episodes			0	82	
	Total Other Payments			0	0	
	DME Payments			0	0	
	Oxygen Payments			0	0	
00	Prosthetic and Orthotic Payments			0	0	2
	Part B deductibles billed to Medicare patients (exclude coinsura	ance)			0	2
	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
	Excess reasonable cost (from line 8)			0	0	
	Subtotal (line 22 minus line 23)			0		
	Coinsurance billed to program patients (from your records)			0	0 867, 512	
	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0	007, 512	2
	Reimbursable bad debts for dual eligible beneficiaries (see inst	tructions)				2
$00 \square$	Total costs - current cost reporting period (line 26 plus line 2			0	867, 512	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0		
00	, , , ,			0	0	
00	Pioneer ACO demonstration payment adjustment (see instructions)			0	867, 512	3
00 ¹ 00 50	Ploneer ACU demonstration payment adjustment (see instructions) Subtotal (see instructions)					1
. 00 . 00 . 50 . 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			0	17, 350	3
. 00 . 00 . 50 . 00 . 01 . 00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)			0	850, 230	32
. 00 . 00 . 50 . 00 . 01 . 00 . 00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)				850, 230 0	32
. 00 . 00 . 50 . 00 . 01 . 00 . 00 . 00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)			0	850, 230	32 33 34

5/20/2015 3:48 pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

	IS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED M BENEFICIARIES		rovider IA CCN:	CCN: 150065 157155	Period: From 01/01/2014 To 12/31/2014	Date/Time Prep	pared
					Home Health	<u>5/20/2015</u> 3:48 PPS	8 pm
		1	npati en	t Part A	Agency I Pa	rt B	
		mm/dd		Amount	mm/dd/yyyy	Amount	
		1.	00	2.00	3.00	4.00	
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 0	850, 230 0	1. (2. (
	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					1	
01					0	0	3.0
02					0	0	3.0
03					0	0	3.
04					0	0	3.
05					0	0	3.
	Provider to Program				0	0	2
50					0	0	3.
51					0	0	3.
52					0	0	3.
53					0	0	3.
54					0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines				0	0	3.
	3. 50-3. 98)						
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				0	850, 230	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						
01					0	0	5.
02					0	0	5.
03					0	0	5.
	Provider to Program					1	
50					0	0	5.
51					0	0	5.
52					0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on						6.
1	the cost report. (1)						,
01	SETTLEMENT TO PROVIDER				0	0	6.
	SETTLEMENT TO PROGRAM				0	68	6.
00	Total Medicare program liability (see instructions)				0	850, 162	7.
					Contractor Number	NPR Date (Mo/Day/Yr)	
			C)	1.00	2.00	8.

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150065	Peri od:	Worksheet K	
			Hospi ce (CCN: 151529	From 01/01/2014 To 12/31/2014		narod
			nospi ce (JON. 131327	10 12/31/2014	5/20/2015 3:4	
					Hospi ce I		-
		Salaries (from	Employee	Transportati	on Contracted	Other	
		Wkst. K-1) B	enefits (from	(see inst.)	Services (from		
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1		1	-		
1.00	Capital Related Costs-Bldg and Fixt.				0	12, 675	•
2.00	Capital Related Costs-Movable Equip.				0	88, 214	•
3.00	Plant Operation and Maintenance	0	0		0 0	0	
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	200 (74	0		0 0	0 01 700	
6.00	Administrative and General	209, 674	0		0 0	81, 788	6.00
7.00		0	0		0 0	0	7.00
7.00 8.00	Inpatient - General Care Inpatient - Respite Care	0	0		0 0	-	
0.00	VI SI TI NG SERVI CES	U U	0		0 0	0	0.00
9.00	Physi ci an Servi ces	0	0	1	0 0	307	9.00
10.00	Nursi ng Care	239, 768	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	237,700	0			0	
12.00	Physical Therapy	0	0		0 0	0	1
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	43, 670	0		0 0	0	
17.00	Dietary Counseling	0	0		0 0	0	
18.00	Counseling - Other	0	0		0 0	0	•
19.00	Home Health Aide and Homemaker	83, 484	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
	OTHER HOSPICE SERVICE COSTS]
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	17, 924	22.00
23.00	Anal gesi cs	0	0		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	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	1, 991	•
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	9, 382	•
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		0	0	1	0 0	0	34.00
35.00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs	0	0		0 0	0	35.00
35.00	Volunteer Program Costs	0	0		0 0	0	
36.00	Fundrai si ng	0	0				
37.00	Other Program Costs	0	0			0	•
	Total (sum of lines 1 thru 38)	576, 596	0		0 0	-	
57.00		570, 570	0	I	0	212,201	1 57.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150065	Period:	Worksheet K	
			Hospi ce (From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
					Hospi ce I	0/20/2010 0.1	
			Reclassi fi cati		. Adjustments	Total (col. 8	
		<u> </u>	on 7.00	6 ± col. 7) 8.00	9,00	<u>± col. 9)</u> 10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
1.00	Capital Related Costs-Bldg and Fixt.	12, 675	C	12, 6	75 0	12, 675	1.00
2.00	Capital Related Costs-Blug and Fixt.	88, 214				88, 214	2.00
2.00		00,214			0 0	00, 214	3.00
	Plant Operation and Maintenance	0	-				
4.00	Transportation - Staff	0	C		0 0	0	
5.00	Volunteer Service Coordination	0	C		0 0	0	5.00
6.00	Administrative and General	291, 462	C	291, 4	52 -140	291, 322	6.00
7 00	I NPATI ENT CARE SERVI CE	0			0	0	7 00
7.00	Inpatient - General Care	0			0 0		
8.00	Inpatient - Respite Care	0	C		0 0	0	8.00
	VI SI TI NG SERVI CES		-	-			
9.00	Physician Services	307	C	-	07 0		9.00
10.00	Nursing Care	239, 768					
11.00	Nursing Care-Continuous Home Care	0	C		0 0	0	
12.00	Physical Therapy	0	C		0 0		
13.00	Occupational Therapy	0	C		0 0	0	
14.00	Speech/ Language Pathol ogy	0	C		0 0	0	
15.00	Medical Social Services	0	C		0 0	0	
16.00	Spiritual Counseling	43, 670	C	43, 6	70 0	43, 670	•
17.00	Dietary Counseling	0	C		0 0	0	17.00
18.00	Counseling - Other	0	C		0 0	0	18.00
19.00	Home Health Aide and Homemaker	83, 484	C	83, 4	34 0	83, 484	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	20.00
21.00	Other	0	C		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	17, 924	-17, 924		0 0	0	22.00
23.00	Anal gesi cs	0	C)	0 0	0	23.00
24.00	Sedatives / Hypnotics	0	C		0 0	0	24.00
25.00	Other - Specify	0	c c		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	C C		0 0	0	26.00
27.00	Patient Transportation	1, 991	C C	1, 9	91 0	1, 991	27.00
28.00	Imaging Services	0	C C		0 0	0	28.00
29.00	Labs and Diagnostics	0	l c		0 0	0	29.00
30.00	Medical Supplies	9, 382	-9, 382		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	l c	1	0 0	0	31.00
32.00	Radiation Therapy	0	l c		0 0	0	32.00
33.00	Chemotherapy	0			0 0	0	33.00
34.00	Other	0			0 0	-	
011.00	HOSPI CE NONREI MBURSABLE SERVI CE				<u> </u>		
35.00	Bereavement Program Costs	0	C		0 0	0	35.00
36.00	Volunteer Program Costs				0 0	0	36.00
37.00	Fundrai si ng	0			0 0	0	
38.00	Other Program Costs				0 0	0	
	Total (sum of lines 1 thru 38)	788, 877	-27, 306	761, 5	71 -140		
57.00	The sear (sum of thiss i this ob)	1 700,077	27,300	1 ,01,0		1 701, 401	1 0 7. 00

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER			In Lie	u of Form CMS-:	2552-10
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150065		eri od:	Worksheet K-1	
						om 01/01/2014		
			Hospi ce C	CN: 151529	To	12/31/2014	Date/Time Pre	
							5/20/2015 3:4	8 pm
				<u> </u>	L	Hospi ce I		
		Admi ni strator	Director	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00								1.00
2.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip.							2.00
			0		0	0	0	
3.00	Plant Operation and Maintenance	0	0		~	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0	•		0	100,000	0	5.00
6.00	Administrative and General	0	52, 105		0	128, 888	0	6.00
7 00	I NPATI ENT_CARE_SERVI CE					0	0	7 00
7.00	Inpatient - General Care	0	0		0	0	0	7.00
8.00	Inpatient - Respite Care	0	0		0	0	0	8.00
	VI SI TI NG SERVI CES							
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	239, 768	10.00
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	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Dietary Counseling	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
21.00	Other	0	0		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	0	0	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	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	52, 105		0	128, 888	239, 768	39.00

	Financial Systems	SCHNECK MEDIC				u of Form CMS-2552-1
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provider (CCN: 150065	Period:	Worksheet K-1
			Hospi ce C	CN: 151529	From 01/01/2014 To 12/31/2014	Date/Time Prepared:
			nospi ce o	101027	10 12/01/2011	5/20/2015 3:48 pm
					Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapi sts				
		6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	T T				
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					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	28, 6	81 209, 674	6. 00
	I NPATI ENT_CARE_SERVI CE					
7.00	Inpatient - General Care		0		0 0	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
	VI SI TI NG SERVI CES	T T	d			
9.00	Physi ci an Servi ces		0		0 0	9.00
10.00	Nursing Care		0		0 239, 768	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		0		0 0	15.00
16.00	Spiritual Counseling		0	43, 6		16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		83, 484		0 83, 484	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00			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		0		0 0	26.00 27.00
27.00	Patient Transportation		0		0 0	
28.00 29.00	I maging Services		0		0 0	28.00
29.00 30.00	Labs and Diagnostics		0		0 0	30.00
30.00	Medical Supplies		0		0 0	30.00
	Outpatient Services (including E/R Dept.)		0		0	
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0 0 0	33.00
34.00	Other		0		0 0	34.00
25 00	HOSPICE NONREI MBURSABLE SERVICE	1	0		0 0	25.00
35.00	Bereavement Program Costs		0		0 0 0 0	35.00
36.00	Volunteer Program Costs		0			36.00 37.00
37.00 38.00	Fundrai si ng		0		0 0	37.00
	Other Program Costs		0 404	70 0	0	
37.00	Total (sum of lines 1 thru 38)	0	83, 484	72, 3	51 576, 596	39.00

5/20/2015 3:48 pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 150065	Peri od:	Worksheet K-4	
				454500	From 01/01/2014		
			Hospi ce C	CN: 151529	To 12/31/2014	Date/Time Pre 5/20/2015 3:4	
					Hospi ce I	572072015 5.4	
			CAPI TAL RE	LATED COST			
			on the RE	ENTED 0001			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MALNT.		
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	12, 675	12, 675				1.00
2.00	Capital Related Costs-Movable Equip.	88, 214		88, 2 ⁻	14		2.00
3.00	Plant Operation and Maintenance	0	0		0 0		3.00
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	291, 322	12, 675	88, 2 ⁻	14 0	0	
0.00	I NPATI ENT_CARE_SERVI CE	271, 322	12,075	00, 2	14 0	0	0.00
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	-	
0.00	VI SI TI NG SERVI CES	0	0		0 0	0	0.00
9.00	Physi ci an Servi ces	307	0		0 0	0	9.00
10.00	Nursing Care	239, 768	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	43, 670	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	83, 484	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
	OTHER HOSPICE SERVICE COSTS						1
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		0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	1, 991	0		0 0	0	1
28.00	Imaging Services	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	
33.00	Chemotherapy		0		0 0	0	
34.00	Other		0		0 0	0	
54.00	HOSPICE NONREIMBURSABLE SERVICE	0	0		0	0	34.00
25 00		0	0		0 0	0	25 00
35.00	Bereavement Program Costs		0			0	
	Volunteer Program Costs	0	0		0 0	0	36.00
36.00	Eundrai ai ng				0	~	27 00
37.00	Fundrai si ng	0	0		0 0	0	07100
37. 00 38. 00		0 0 761, 431	0 0 12, 675	88, 2 [,]	0 0	0	38.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		Inlie	u of Form CMS-	2552-10
	LLOCATION - HOSPICE GENERAL SERVICE COST	Connective meet		CCN: 150065	Peri od:	Worksheet K-4	
					From 01/01/2014	Part I	
			Hospi ce (CCN: 151529	To 12/31/2014	Date/Time Pre	
					lleoni ee l	5/20/2015 3:4	18 pm
		VOLUNTEER	SUBTOTAL		Hospi ce I /ETOTAL (col. 5A		
		SERVICES	(cols. 0 - 5)	& GENERAL	\pm col. 6)		
		COORDINATOR			1 COL. 0)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS	0.00	0,1	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1.00	Capital Related Costs-Bldg and Fixt.						1,00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3,00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	392, 211	392, 2	11		6.00
	I NPATI ENT CARE SERVI CE			•			
7.00	Inpatient - General Care	0	0		0 0		7.00
8.00	Inpatient - Respite Care	0	0		0 0		8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	307	3	26 633		9.00
10.00	Nursing Care	0	239, 768	3 254, 6	99 494, 467		10.00
11.00	Nursing Care-Continuous Home Care	0	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 Pathology	0	0		0 0		14.00
15.00	Medical Social Services	0	0	1	0 0		15.00
16.00	Spiritual Counseling	0	43, 670	46, 3	39 90, 059		16.00
17.00	Dietary Counseling	0	0	D	0 0		17.00
18.00	Counseling - Other	0	0	D	0 0		18.00
19.00	Home Health Aide and Homemaker	0	83, 484				19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0		20.00
21.00	Other	0	0		0 0		21.00
	OTHER HOSPICE SERVICE COSTS						1
22.00	Drugs, Biological and Infusion Therapy	0			0 0		22.00
23.00	Anal gesi cs	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	Pati ent Transportati on	0	1, 991				27.00
28.00	I magi ng Servi ces	0	0		0 0		28.00
29.00	Labs and Diagnostics	0	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	1	0 0		32.00
33.00	Chemotherapy	0			0 0		33.00
34.00		0	(<u>и</u>	0 0		34.00
35.00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs	0	(0 0		35.00
35.00	Volunteer Program Costs				0 0		35.00
36.00	Fundrai si ng						36.00
37.00	Other Program Costs			Ś.	0 0		37.00
	Total (sum of lines 1 thru 38)	0	761, 431	íl	761, 431		38.00
57.00		1 0	1 701,431	'1	701,431		1 3 7. 00

	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150065	Period:	Worksheet K-4	Ļ
			Hospi ce 0	CN: 151529	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narad
			nospi ce c	CN. 151529	10 12/31/2014	5/20/2015 3:4	
					Hospi ce I		
		CAPI TAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &		SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.	, í	COORDI NATOR	
				FT.)		(HOURS)	
	1	1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	Capital Related Costs-Bldg and Fixt.	150					1.00
2.00	Capital Related Costs-Movable Equip.	0	16, 124				2.00
3.00	Plant Operation and Maintenance	0	0		50		3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0 50 0	0	
6.00	Administrative and General	150	16, 124	1	50 0	0	6.00
7.00	Inpatient - General Care	0	0		0 0	0	7.00
7.00 8.00	Inpatient - Respite Care	0	0		0 0	0	
0.00	VI SI TI NG SERVI CES	0	0		0 0	0	0.00
9.00	Physician Services	0	0		0 0	0	9.00
10.00	Nursi ng 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 Pathology	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0	1	0 0	0	17.00
18.00	Counseling - Other	0	0	1	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
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS			1			
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	
23.00	Anal gesi cs	0	0		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00 28.00	Patient Transportation Imaging Services	0	0		0 0	0	
28.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medi cal Supplies	0	0		0 0	0	
30.00	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	
	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>					1
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	
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	12, 675	88, 214		0 0	0	39.00
	Unit Cost Multiplier	84. 500000	5. 470975	0.0000	0. 000000	0.000000	1 40 00

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS	-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150065	Period:	Worksheet K-	4
			Hospi ce C	CCN: 151529	From 01/01/2014 To 12/31/2014	Part II Date/Time Pr	onarod
			nospi ce c	JUN. 101029	10 12/31/2014	5/20/2015 3:	
					Hospi ce I		
		RECONCILIATION A	DMI NI STRATI VE				
			& GENERAL				
			(ACC. COST)				
		6A	6.00				
	GENERAL SERVICE COST CENTERS	-		1			
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	-392, 211	369, 220				6.00
	I NPATI ENT CARE SERVI CE	ı		1			
7.00	Inpatient - General Care	0	0				7.00
8.00	Inpatient – Respite Care	0	0				8.00
	VI SI TI NG SERVI CES	i i		1			
9.00	Physician Services	0	307	•			9.00
10.00	Nursing Care	0	239, 768				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	43, 670	1			16.00
17.00	Dietary Counseling	0	0				17.00
18.00	Counseling - Other	0	0				18.00
19.00	Home Health Aide and Homemaker	0	83, 484				19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.00
21.00	Other	0	0				21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0				22.00
23.00	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	1, 991	1			27.00
28.00	Imaging Services	0	0				28.00
29.00	Labs and Diagnostics	0	0				29.00
30.00	Medical Supplies	0	0				30.00
31.00	Outpatient Services (including E/R Dept.)	0	0				31.00
32.00	Radiation Therapy	0	0				32.00
33.00	Chemotherapy	0	0				33.00
34.00	Other	0	0				34.00
	HOSPICE NONREIMBURSABLE SERVICE						
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)		392, 211	•			39.00
40.00	Unit Cost Multiplier		1.062269				40.00

5/20/2015 3:48 pm J:\50760000 Schneck Medical Center\2014\Hfs\2014 Schneck.mcrx

	Financial Systems	SCHNECK MEDI				u of Form CMS-2	
ALLOCA	TI ON OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der Hospi ce (CCN: 150065 CCN: 151529	Period: From 01/01/2014 To 12/31/2014	Worksheet K-5 Part I Date/Time Pre 5/20/2015 3:4	pared:
					Hospi ce I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Hospice Trial Balance (1)	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Bar anos (1)		20011	DEPARTMENT		
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		2, 258	8, 6	39 61, 826	72, 723	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	Physician Services	633	0		0 0	633	4.00
5.00	Nursing Care	494, 467	0		0 70, 700	565, 167	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	90, 059	0		0 12, 877	102, 936	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 Homemaker	172, 166	0		0 24, 617	196, 783	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, 106	0		0 0	4, 106	
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	33.00
34.00	Total (sum of lines 1 thru 33) (2)	761, 431	2, 258	8, 6	39 170, 020	942, 348	34.00
25 00	Unit Cost Multiplier (see instructions)	1		1		0.000000	1 35 00

Heal th	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	Peri		Worksheet K-5	
						01/01/2014	Part I	
			Hospi ce C	CCN: 151529	То	12/31/2014	Date/Time Pre	
					L 1	lospi ce I	5/20/2015 3:4	8 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &		USEKEEPI NG	DI ETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVIC		JUSEKLEFTING	DILIANI	
		5.00	7.00	8,00		9.00	10, 00	
1.00	Administrative and General	17,852	3, 844		0	1, 020	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	Physician Services	155	0		0	0	0	4.00
5.00	Nursing Care	138, 735	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	25, 268	0		0	0	0	11.00
12.00	Di etary Counsel i ng	0	0		0	0	0	12.00
13.00	Counsel i ng - Other	0	0		0	0	0	13.00
14.00	Home Health Aide and Homemaker	48, 305	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	1,008	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	
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)	231, 323	3, 844		0	1, 020	0	34.00
35.00		201,020	5, 044		5	1, 020	0	35.00
00.00		1	I	I	1	I I		1 30.00

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			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, 575			0 0		1.00
2.00	Inpatient - General Care	0			0 0		2.00
3.00	Inpatient - Respite Care	0	0		0 0		3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursi ng Care	4,058	0		0 0	12,900	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	Medi cal Soci al Servi ces	0	0		0 0	0	10.00
11.00	Spiritual Counseling	925	0		0 0	0	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 Homemaker	2,909	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 0	21.00
22.00	Patient Transportation	0	0		0 0	0 0	22.00
23.00	Imaging Services	0	0		0 0	0 0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0 0	24.00
25.00	Medical Supplies	0	0	8	79 C	0 0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0 0	26.00
27.00	Radiation Therapy	0	0		0 0	0 0	27.00
28.00	Chemotherapy	0	0		0 0	0 0	28.00
29.00	Other	0	0		0 0	0 0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0 0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0 0	31.00
32.00	Fundrai si ng	0	0		0 0	0 0	32.00
33.00	Other Program Costs	0	0		0 0	0 0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	10, 467	0	8	79 C	12, 900	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	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der Hospi ce (CCN: 150065 CCN: 151529	Period: From 01/01/2014 To 12/31/2014		pared:
			_		Hospi ce I		
	Cost Center Description	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal (col s. 4A-23	Intern & B) Residents Cost & Post	Subtotal (cols. 24 ± 25)	
					Stepdown Adjustments		
		18.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	0	(98,0	14		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	Physician Services	0	0	7	88 O	788	4.00
5.00	Nursing Care	0		720, 8		720, 860	
6.00	Nursing Care-Continuous Home Care	0			0 0	0	6.00
7.00	Physical Therapy	0			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			0 0	0	
11.00	Spiritual Counseling	0		129, 1	29 0	129, 129	
12.00	Di etary Counsel i ng	0		12771	0 0	0	
13.00	Counseling - Other	0			0 0	0	
14.00	Home Health Aide and Homemaker	0		247,9	97 0	247, 997	
15.00	HH Aide & Homemaker - Cont. Home Care	0		2, ,	0 0	0	
16.00	Other	0			0 0	0	
17.00	Drugs, Biological and Infusion Therapy	0			0 0	0	
18.00	Anal gesi cs	0			0 0	0	
19.00	Sedatives / Hypnotics	0			0 0	0	
20.00	Other - Specify	0			0 0	0	
21.00	Durable Medical Equipment/Oxygen	0			0 0	0	
22.00	Patient Transportation	0		5,1	14 0	5, 114	
23.00	Imaging Services	0		5	0 0	0	23.00
24.00	Labs and Diagnostics	0			0 0	0	
25.00	Medi cal Supplies	0		8	79 0	879	
26.00	Outpatient Services (including E/R Dept.)	0))	0 0	0	26.00
27.00	Radi ati on Therapy	0			0 0	0	27.00
28.00	Chemotherapy	0			0 0	0	28.00
29.00	Other	0			0 0	0	29.00
30.00	Bereavement Program Costs	0			0 0	0	30.00
31.00	Volunteer Program Costs	0			0 0	0	31.00
32.00	Fundrai si ng	0			0 0	0	32.00
33.00	Other Program Costs					0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0		1, 202, 7	81 0	1, 202, 781	
	Unit Cost Multiplier (see instructions)					1,202,701	35.00
55.00		1	I	1	I	I	00.00

Health Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE	COST CENTERS	Provider CC	CN: 150065	Period:	Worksheet K-5
		Hospi ce CCN	J· 151529	From 01/01/2014 To 12/31/2014	Part I Date/Time Prepared:
		nospi ce cei	131327	10 12/31/2014	5/20/2015 3:48 pm
				Hospi ce I	
Cost Center Description		Fotal Hospice			
		Costs (cols.			
	(See Part II) 27.00	26 ± 27) 28.00			
1.00 Administrative and General	27.00	20.00			1,00
2.00 Inpatient - General Care	0	o			2.00
3.00 Inpatient - Respite Care	0	0			3.00
4.00 Physician Services	70	858			4.00
5.00 Nursi ng Care	63, 954	784, 814			5.00
6.00 Nursing Care-Continuous Home Care	0	0			6.00
7.00 Physical Therapy	o	0			7.00
8.00 Occupational Therapy	o	0			8.00
9.00 Speech/ Language Pathology	0	0			9.00
10.00 Medical Social Services	0	0			10.00
11.00 Spiritual Counseling	11, 456	140, 585			11.00
12.00 Dietary Counseling	0	o			12.00
13.00 Counseling - Other	0	0			13.00
14.00 Home Health Aide and Homemaker	22, 002	269, 999			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
18.00 Anal gesi cs	0	0			18.00
19.00 Sedatives / Hypnotics	0	0			19.00
20.00 Other - Specify	0	0			20.00
21.00 Durable Medical Equipment/Oxygen	0	0			21.00
22.00 Patient Transportation	454	5, 568			22.00
23.00 I maging Services	0	0			23.00
24.00 Labs and Diagnostics	0	0			24.00 25.00
25.00 Medical Supplies26.00 Outpatient Services (including E/R Dept.	78	957 0			25.00
27.00 Radiation Therapy		o			28.00
28.00 Chemotherapy	0	0			27.00
29.00 Other	0	0			28.00
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
34.00 Total (sum of lines 1 thru 33) (2)		1, 202, 781			34.00
35.00 Unit Cost Multiplier (see instructions)	0. 088719				35.00

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (F	Period: From 01/01/2014 To 12/31/2014	Worksheet K-5 Part II Date/Time Pre 5/20/2015 3:43	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 SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	150	16, 124	209, 674	l 0	72, 723	1.00
2.00	Inpatient - General Care	0	0	c c	0 0	0	2.00
3.00	Inpatient – Respite Care	0	0	c c	0 0	0	3.00
4.00	Physician Services	0	0	c c	0 0	633	4.00
5.00	Nursing Care	0	0	239, 768	3 0	565, 167	5.00
6.00	Nursing Care-Continuous Home Care	0	0	c c	0 0	0	6.00
7.00	Physi cal Therapy	0	0	l c	0 0	0	7.00
8.00	Occupational Therapy	0	0	l d	0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0	l c	0 0	0	9.00
	Medical Social Services	0	0	l d	0	0	10.00
11.00	Spiritual Counseling	0	0	43, 670	0	102, 936	11.00
	Dietary Counseling	0	0	C	0	0	12.00
	Counseling - Other	0	0	l d	0	0	13.00
	Home Health Aide and Homemaker	0	0	83, 484	0	196, 783	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	c c	0 0	0	15.00
16.00	Other	0	0	l d	0	0	16.00
	Drugs, Biological and Infusion Therapy	0	0	l d	0	0	
	Anal gesi cs	0	0	l d	0	0	
	Sedatives / Hypnotics	0	0	l d	0	0	
	Other - Specify	0	0	l d	0	0	20.00
	Durable Medical Equipment/Oxygen	0	0	l d	0	0	21.00
	Patient Transportation	0	0	l d	0	4, 106	
	Imaging Services	0	0	C	0	0	
	Labs and Diagnostics	0	0	c c	0 0	0	24.00
	Medical Supplies	0	0	c c	0 0	0	25.00
	Outpatient Services (including E/R Dept.)	0	0	c c	0 0	0	26.00
	Radiation Therapy	0	0	l c	0	0	27.00
28.00	Chemotherapy	0	0	c	0	0	28.00
29.00	Other	0	0	c c	0 0	0	29.00
	Bereavement Program Costs	0	0	c c	0	0	30.00
	Volunteer Program Costs	0	0	c c	0	0	31.00
	Fundrai si ng	0	0	c	0	0	32.00
	Other Program Costs	0	0	c	0	0	33.00
	Total (sum of lines 1 thru 33) (2)	150	16, 124	576, 596		942, 348	
	Total cost to be allocated	2, 258	8, 639	170, 020			
33.00		2,230	0, 039	170,020	/ I	231, 323	35.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS			CCN: 150065 CCN: 151529	Period: From 01/01/2014	Worksheet K-5 Part II	pared:
					Hospi ce I	372072013 3.40	
	Cost Center Description	(SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPIN (SQUARE FEET)	G DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	
	1	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	150	C		50 0	4, 923	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	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	7, 758	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	0			0 0	1, 768	11.00
12.00	Dietary Counseling	0			0 0	0	12.00
13.00 14.00	Counseling - Other	0		1	0 0	-	13.00 14.00
14.00	Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care	0			0 0	5, 561 0	14.00
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	C		0 0	0	22.00
23.00	I maging 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	Chemotherapy	0	C)	0 0	0	28.00
29.00	Other	0	C		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)	150	C	1	50 0	20, 010	34.00
35.00	Total cost to be allocated	3, 844	C	1, 0	20 0	10, 467	35.00
36.00	Unit Cost Multiplier (see instructions)	25. 626667	0. 000000	6.8000	0. 000000	0. 523088	36.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	r centers	Provi der	CCN: 150065		ri od:	Worksheet K-5	
STATI S	STICAL BASIS			454500		om 01/01/2014	Part II	
			Hospi ce (CCN: 151529	То	12/31/2014	Date/Time Pre 5/20/2015 3:4	
						Hospi ce I	572072015 5.4	
						neoprice i	OTHER GENERAL	
							SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	PHYSI CI AN	
		ADMI NI STRATI ON	SERVICES &	(COSTED		RECORDS &	PRI VATE	
			SUPPLY	REQUIS.)		LI BRARY	PRACTI CE	
		(DI RECT	(COSTED			(GROSS	(TIME	
		NRSING HRS)	REQUIS.)	15.00		CHARGES)	SPENT)	
1 00	Administrations and Conservat	13.00	14.00	15.00	0	16.00	18.00	1.00
1.00	Administrative and General	0	0		0	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 5.00	Physician Services Nursing Care	0	0		0	1, 882, 896	0	4.00 5.00
5.00 6.00	Nursing Care-Continuous Home Care	0	0		0	1, 002, 090	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	Medi cal Social Services	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	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 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		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	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	8, 150		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 Other	0	0		0	0	0	28.00 29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
30.00	Volunteer Program Costs		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	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	8, 150		0	1, 882, 896	0	34.00
35.00	Total cost to be allocated	0	879		0	12, 900	0	35.00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 107853		00	0. 006851	0. 000000	
	,			•		'		•

	Financial Systems	SCHNECK MEDI CAL			u of Form CMS	
	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST STICAL BASIS	CENTERS	Provider CCN: 150065	Period: From 01/01/2014	Worksheet K-	5
STATE	STICAL DASIS		Hospice CCN: 151529		Date/Time Pr	epared:
				Hospice I	5/20/2015 3:	48 pm
	Cost Center Description	NONPHYSI CI AN		Hospice I		
	cost center bescription	ANESTHETI STS				
		(ASSI GNED				
		TIME)				
		19.00				
1.00	Administrative and General	0				1.00
2.00	Inpatient - General Care	0				2.00
3.00	Inpatient - Respite Care	0				3.00
4.00	Physi ci an Servi ces	0				4.00
5.00	Nursing Care	0				5.00
6.00	Nursing Care-Continuous Home Care	0				6.00
7.00	Physical Therapy	0				7.00
8.00	Occupational Therapy	0				8.00
9.00	Speech/ Language Pathol ogy	0				9.00
10.00	Medical Social Services	0				10.00
11.00	Spiritual Counseling	0				11.00
12.00	Dietary Counseling	0				12.00
13.00	Counseling - Other	0				13.00
14.00	Home Health Aide and Homemaker	0				14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0				15.00
16.00	Other	0				16.00
17.00	Drugs, Biological and Infusion Therapy	0				17.00
18.00	Anal gesi cs	0				18.00
19.00	Sedatives / Hypnotics	0				19.00
20.00	Other - Specify	0				20.00
21.00	Durable Medical Equipment/Oxygen	0				21.00
22.00	Patient Transportation	0				22.00
23.00	I magi ng Servi ces	0				23.00
24.00	Labs and Diagnostics	0				24.00
25.00	Medical Supplies	0				25.00
26.00	Outpatient Services (including E/R Dept.)	0				26.00
27.00	Radiation Therapy	0				27.00
28.00	Chemotherapy	0				28.00
29.00	Other	0				29.00
30.00	Bereavement Program Costs	0				30.00
31.00	Volunteer Program Costs	0				31.00
32.00 33.00	Fundrai si ng	0				32.00
	Other Program Costs Total (sum of lines 1 thru 33) (2)	0				
34.00 35.00	Total (sum of lines thru 33) (2) Total cost to be allocated	0				34.00
35.00 36.00		0.000000				35.00
30.00	Unit Cost Multiplier (see instructions)	0.000000				30. UU

COMPUTATION OF TOTAL HOSPICE SHARED COSTS Provider CCN: 150065 Hospice CCN: 151529 Period: From 01/01/2014 To 12/31/2014 Worksheet K-5 Part III Date/Time Prepared 5/20/2015 3:48 pm Cost Center Description Wkst. C, Part I, col. 11 line Cost to Charge Ratio Total Hospice Hospice Shared Ancillary (Provider Costs (cols. 1 Records) Ancillary x 2) ANCILLARY SERVICE COST CENTERS 0 1.00 2.00 3.00	INECK MEDICAL CENTER In Lieu of Form CMS-25	52-10
Hospice CCN: 151529 To 12/31/2014 Date/Time Prepared 5/20/2015 3:48 pm Hospice Cost Center Description Wkst. C, Part Cost to Charge Cost to Charge Charges Ancillary (Provider Costs (cols. 1) Ine ANCILLARY SERVICE COST CENTERS 0 1.00 2.00 3.00		
Cost Center Description Wkst. C, Part Cost to Charge Total Hospice Hospice Ancillary I, col. 11 Ratio Charges Ancillary Iine 0 1.00 2.00 3.00		
Cost Center Description Wkst. C, Part Cost to Charge Total Hospice Hospice Shared I, col. 11 Ratio Charges Ancillary Iine 0 1.00 2.00 3.00		
Cost Center Description Wkst. C, Part Cost to Charge I, col. 11 Line Total Hospice Hospice Shared Ancillary Charges (Provider Costs (cols. 1) Records) x 2) ANCILLARY SERVICE COST CENTERS Ancillary Cost Center Cost Centers		рш
I, col. 11 Ratio Charges Ancillary line (Provider Records) Costs (cols. 1) ANCILLARY SERVICE COST CENTERS 0 1.00 2.00		
Line (Provider Records) Costs (col s. 1 x 2) 0 1.00 2.00 3.00		
ANCI LLARY SERVICE COST CENTERS Records x 2)		
O 1.00 2.00 3.00 ANCI LLARY SERVICE COST CENTERS		
ANCI LLARY SERVICE COST CENTERS		
	0 1.00 2.00 3.00	
	66.00 0.534334 0 0	1.00
		2.00
		3.00
		4.00
		5.00
		6.00
		6.01
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1.142112 0 0 7.0	71.00 1.142112 0 0	7.00
8.00 BEHAVOURAL HEALTH 93.00 1.687407 0 0 8.0	93.00 1.687407 0 0	8.00
		9.00
10.00 WOUND CARE 76.00 0.535610 0 0 10.0	76.00 0.535610 0 0	10. 00
10. 02 CASE MANAGEMENT 76. 02 1. 144143 0 0 10. 0	76.02 1.144143 0 0	10. 02
10. 03 PAIN MANAGEMENT 76. 03 0. 845121 0 0 10. 0	76.03 0.845121 0 0	10. 03
10. 97 CARDIAC REHABILITATION 76. 97 4. 086902 0 0 10. 9	76.97 4.086902 0 0	10. 97
		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 01/01/2014 To 12/31/2014		
		-	Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				1, 202, 781	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				8, 978	2.00
3.00 Average cost per diem (line 1 divided by line 2)				133.97	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	8, 498				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	1, 138, 477				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		30	06		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)		40, 9	95		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	641				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	85, 875	1			9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)		1!	57		10.00
11.00 Aggregate NF cost (line 3 times line 10)		21, 0	33		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			174		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			23, 311		13.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150065	Period: From 01/01/2014 To 12/31/2014		
		Title XVIII	Hospi tal	PPS	8 pili
		· · · · · · · · · · · · · · · · · · ·			
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
00	CAPITAL FEDERAL AMOUNT			(04 574	
. 00 . 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			681, 574 0	1. 1.
. 00	Capital DRG outlier payments			82, 444	2.
. 00	Model 4 BPCI Capital DRG outlier payments			02, 444	
. 00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	34.93	
. 00	Number of interns & residents (see instructions)	opor thig period (see thist		0,00	
. 00	Indirect medical education percentage (see instructions)			0.00	
. 00	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines 1 and 1.01)	0	6.
. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)			0.00	7.
. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8.
.00	Sum of lines 7 and 8			0.00	
D. 00	Allowable disproportionate share percentage (see instruction	ıs)		0.00	10.
1.00	Disproportionate share adjustment (line 10 times the sum of	lines 1 and 1.01)		0	11.
2.00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		764, 018	12.
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	1.
00	Program inpatient ancillary capital cost (see instructions)			0	2.
00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
. 00	Capital cost payment factor (see instructions)			0	4.
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	1.
00 00	Program inpatient capital costs for extraordinary circumstar	ices (see instructions)		0	2. 3.
00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
	Adjustment to capital minimum payment level for extraordinar		line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)			0	
	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9.
00			less line 9)	0	
00 00					11.
00 00 . 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)		or year	0	
00 00 . 00 . 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	capital payment (from pri	, ,	0	
00 00 0.00 .00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri payments (line 10 plus lin	e 11)	-	12.
00 00 00 00 00 00 00 00 00 00 00 00 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	capital payment (from pri payments (line 10 plus lin er the amount on this line	e 11)	0	12. 13.
00 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	capital payment (from pri payments (line 10 plus lin er the amount on this line capital payment for the f	e 11)	0	12. 13. 14.
00 00 00 0.00 1.00 2.00 3.00 4.00 5.00 5.00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment (from pri payments (line 10 plus lin er the amount on this line capital payment for the f	e 11)	0 0 0	12. 13. 14. 15.