Health Financia			. CENTER		of Form CMS-2552-10
	required by law (42 USC 1395				1 FORM APPROVED
payments made s	since the beginning of the co	ost reporting period being	deemed overpayment	s (42 USC 1395g).	OMB NO. 0938-0050
HOCDITAL AND HO	OSPITAL HEALTH CARE COMPLEX O	COST DEDORT CERTIFICATION	Drovidon CCN 15 006	65 Period:	EXPIRES 05-31-2019 Worksheet S
AND SETTLEMENT		OST REPORT CERTIFICATION	Provider CCN. 13-000	From 01/01/2016	Parts I-III
PART I - COST R	REPORT STATUS				
Provider	1.[X]Electronically filed	cost report		Date: 5/23/20	17 Time: 3:04 pm
	2.[] Manually submitted co				·
	3.[0] If this is an amended 4.[F] Medicare Utilization.	d report enter the number . Enter "F" for full or "L	of times the provider." for low.	er resubmitted this o	cost report
Contractor use only	5.[1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No.		10.NPR Date: 11.Contractor's Vendo 12.[0]If line 5, cc number of tim	or Code: 4 clumn 1 is 4: Enter nes reopened = 0-9.
PART II - CERTI	FICATION				

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 OF 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 (15-0065) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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

ECR: Date: 5/23/2017 Time: 3:04 pm yRlmpDHR738MBU:9m7MPqLixq4w6V0 xjd4E01E03n2:ivTgQ2rxGzvxCupN0 Xh5K1tuCCj0qLtyJ

PI: Date: 5/23/2017 Time: 3:04 pm ZsEeDAWXu8X8619RUOs66KE19t4F10 3NWM.OwCUL6djRj5MWg:OYvXF5bdBg WIMQ0DgaDc0C13:y

Officer or Administrator of Provider(s)

VP FINANCE / CFO

Title

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	228,950	196,765	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	5,120	4,978		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	234,070	201,742	0	0	200.00
I	+-!! !!-! +-!! !!-! +-!!	4l 1 l- 1 -	£ £	L 7 E -	-ll	1 212 1	

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.

Health Financial Systems SCHNECK MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0065 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 9:42 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 411 WEST TIPTON STREET PO Box: 1.00 State: IN Zi p Code: 47274-2.00 City: SEYMOUR County: **JACKSON** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 SCHNECK MEDICAL CENTER 150065 99915 07/16/1966 Ν 0 3.00 Hospi tal 4.00 Subprovi der - IPF 4.00 5.00 Subprovi der - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF SCHNECK MEDICAL CENTER 15U065 99915 03/04/1999 N Ρ N 7.00 Swing Beds - NF 8.00 SCHNECK MEDICAL CENTER 15U065 99915 03/04/1999 Ν 0 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospital -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospital -Based HHA JACKSON COUNTY HOME 12.00 157155 99915 07/01/1985 N Ρ 0 12.00 HEALTH Separately Certified ASC 13 00 14.00 Hospi tal -Based Hospi ce HOSPICE OF MEMORIAL 151529 99915 12/09/1994 14.00 HOSPI TAI 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2016 20.00 01/01/2016 21.00 Type of Control (see instructions) 21.00 8 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column N 23 00 3 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no In-State In-State Out-of Out-of 0ther Medi cai d

		Medicaid	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	833	503	0	4	1, 755	50	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	o	0	О	0	0		25.00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

In Lieu of Form CMS-2552-10 Health Financial Systems SCHNECK MEDICAL CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0065 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 9:42 am Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. 37.00 | If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40.00 Ν N no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3. 00 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 48.00 | Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. 59.00 59.00 Ν Are you claiming nursing school and/or allied health costs for a program that meets the Ν 60.00 provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) IME Direct GME IME Direct GME 3.00 1.00 2.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 0.00 61.01 0.00 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care o. od 61.02 0.00 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 0.000.00 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 0.00 0.00 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 0. od o. od 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)

alth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPL			CAL CENTER Provi der CC	CN: 15-0065 Pe	eri od:	wof Form CMS-2 Worksheet S-2	
					om 01/01/2016	Part I	pare
		Y/N	I ME	Direct GME	I ME	Direct GME	Z dii
		1.00	2. 00	3. 00	4. 00	5. 00	
1.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary		0.00				61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4.00	
I. 10 Of the FTEs in line 61.05, specif specialty, if any, and the number for each new program. (see instru- column 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents actions) Enter in in column 2, the the IME FTE				0. 00	0. 00	61
I. 20 Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 3, the IME FTE unweighted count a 4, direct GME FTE unweighted count	ne number of FTE am. (see the program name, de, enter in column and enter in column				0. 00	0. 00	61
						1.00	-
ACA Provisions Affecting the Heal							
2.00 Enter the number of FTE residents your hospital received HRSA PCRE			d in this cost	reporting per	od for which	0.00	62
2.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	iod of HRSA THC pro	gram. (:	<u>see instructio</u>		your hospital	0.00	62
B.00 Has your facility trained residen "Y" for yes or "N" for no in colu					oeriod? Enter	N	63
			,	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovi der Si te	Hospi tal	col . 2))	
				1. 00	2. 00	3. 00	1
Section 5504 of the ACA Base Year				This base year	is your cost	reporti ng	
period that begins on or after Ju Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighted ur hospital. Enter in	ty train n-priman all non d non-p n column	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1. 00		2. 00	3.00	4. 00 0. 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 5, the ratio of (column 3				0.00	0.00	0. 300000	

Health Financial Systems SCHNECK MEDI	ICAL CENTER		In	Lieu	u of Form	CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eriod: rom 01/01/	2016	Workshee Part I	t S-2
		To	12/31/	2016		e Prepared: 7 9:42 am
		<u> </u>	V 1.00		XI X 2. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the a 96.00 Does title V or XIX reduce operating cost? Enter "Y" for years.			0. 00 N		0. 00 N	
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the a	pplicable colum	nn.	0.00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (106.00) If this facility qualifies as a CAH, has it elected the al		thod of payment	N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for contraining programs? Enter "Y" for yes or "N" for no in columyes, the GME elimination is not made on Wkst. B, Pt. I, contrained in the complete Wkst. D-2, Pt. II.	mn 1. (see inst	tructions) If	N			107. 00
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
	Physi cal 1. 00	Occupati onal 2.00	Speecl 3. 00		Respirat 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		N N	109.00
					1.00	
110.00 Did this hospital participate in the Rural Community Hospithe current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)fo	r	N	110.00
				1. 00	2.00	3. 00
Miscellaneous Cost Reporting Information 115.00(Is this an all-inclusive rate provider? Enter "Y" for yes	or "N" for no i	n column 1 lf	column 1	N		0 115.00
is yes, enter the method used (A, B, or E only) in column : 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208. 1.	2. If column 2 ent for long te	is "E", enter erm care (inclu	in column des	IV		0 113.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice ins			"N" for	N N		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy is occurrence.	olicy? Enter 1	if the policy	is	1		118. 00
Grafii indae. Effet 2 11 the portey 13 decartance.		Premi ums	Losses	5	Insurar	ice
		1.00	0.00		2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 1, 026, 134	2. 00	0	3. 00	0118.01
			1.00		2. 00	
118.02 Are mal practice premiums and paid losses reported in a cos Administrative and General? If yes, submit supporting sch and amounts contained therein.			N		2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Ho §3121 and applicable amendments? (see instructions) Enter "N" for no. Is this a rural hospital with < 100 beds that the Hold Harmless provision in ACA §3121 and applicable amendments.	in column 1, "\ qualifies for t	/" for yes or the Outpatient	N		Y	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	lantable device	es charged to	Y			121. 00
122.00 Does the cost report contain state health or similar taxes' for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.			N			122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.	for yes and "N"	' for no. If	N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) befow. 126.00 f this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column		fication date				126. 00
127.00 If this is a Medicare certified heart transplant center, ein column 1 and termination date, if applicable, in column	nter the certif	fication date				127. 00
			1			128.00
128.00 f this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 120.01 f this is a Medicare certified liver transplant center, en	nter the certif 2.					
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, encolumn 1 and termination date, if applicable, in column 2.	nter the certif 2. ter the certifi	cation date in				129. 00
in column 1 and termination date, if applicable, in column 129.00 of this is a Medicare certified lung transplant center, en	nter the certif 2. ter the certifi , enter the cer olumn 2. er, enter the c	cation date in				129. 00 130. 00 131. 00

-	EX IDENTIFICATION DATA	Provi der CO	CN: 15-0065	Perion From To			2 epared:
						5/23/2017 9:	42 am
					1.00	2. 00	
33.00 f this is a Medicare certified o			ication da	te			133.00
in column 1 and termination date, 34.00 If this is an organ procurement o			in column	1			134.00
and termination date, if applicab		The of o Humber	TH COLUMN	'			
All Providers		1.61 1.1 0116					
40.00 Are there any related organization 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 co		N		140.00
1.00	2.0				3. 00		
If this facility is part of a cha office and enter the home office			ough 143 th	e name	and address	of the home	
41. 00 Name:	Contractor's Name:	ictor number.	Contra	ctor's	Number:		141.0
42.00 Street:	PO Box:						142.0
43. 00 Ci ty:	State:		Zip Co	de:			143.0
					-	1. 00	+
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Υ Υ	144. 0
45.00 f costs for renal services are c	laimad on Wks+ A liv- 74	are the es-t	c for		1. 00 N	2. 00 N	145. 0
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	" for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previon column 1. (See CMS Pub.	column 1. If for this cost usly filed cos	column 1 is reporting st report?		N N	N	146. 0
						1. 00	
47.00Was there a change in the statist 48.00Was there a change in the order o						N	147. 0
							11/10 0
				for no.		N N	
49.00 Was there a change to the simplif					Title V	N N Title XIX	
49.00Was there a change to the simplif	ied cost finding method? E	nter "Y" for y Part A 1.00	ves or "N" Part B 2.00		Title V 3.00	N Title XIX 4.00	
49.00 Was there a change to the simplif Does this facility contain a prov	ied cost finding method? E	nter "Y" for y Part A 1.00 exemption fro	ves or "N" Part B 2.00 pm the appl	i cati on	Title V 3.00 of the low	N Title XIX 4.00 er of costs	
49.00Was there a change to the simplif	ied cost finding method? E	nter "Y" for y Part A 1.00 exemption fro	ves or "N" Part B 2.00 pm the appl	i cati on	Title V 3.00 of the low	N Title XIX 4.00 er of costs	149.0
49.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from	ves or "N" Part B 2.00 om the appl A and Part	i cati on	Title V 3.00 n of the lowe 42 CFR §41	N Title XIX 4.00 er of costs 3.13)	149. 0
49.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF	ied cost finding method? E	nter "Y" for y Part A 1.00 exemption fro ent for Part A	Part B 2.00 m the appl A and Part N	i cati on	Title V 3.00 n of the lowe 42 CFR §41.	N Title XIX 4.00 er of costs 3.13)	149. 0 155. 0 156. 0 157. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from the part A N N N	Part B 2.00 om the appl A and Part N N	i cati on	Title V 3.00 of the low 42 CFR §41: N N	N Title XIX 4.00 er of costs 3.13) N N	149. 0 155. 0 156. 0 157. 0 158. 0
Does this facility contain a provor charges? Enter "Y" for yes or Hospital 55.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from Part A N N N N	Part B 2.00 The second of the	i cati on	Title V 3.00 n of the low 42 CFR §41: N N N	N Title XIX 4.00 er of costs 3.13) N N N	155. C 156. C 157. C 158. C 159. C
Does this facility contain a provor charges? Enter "Y" for yes or Hospital 55.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from the part A N N N	Part B 2.00 The appl A and Part N N N N N N N N N N N N N N N N N N	i cati on	Title V 3.00 n of the lowe 42 CFR §41: N N N N	N Title XIX 4.00 er of costs 3.13) N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
Does this facility contain a provor charges? Enter "Y" for yes or Hospital 55.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from Part A N N N N	Part B 2.00 The second of the	i cati on	Title V 3.00 n of the low 42 CFR §41: N N N	N Title XIX 4.00 er of costs 3.13) N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from Part A N N N N	Part B 2.00 The appl A and Part N N N N N N N N N N N N N N N N N N	i cati on	Title V 3.00 n of the lowe 42 CFR §41: N N N N	N Title XIX 4.00 er of costs 3.13) N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from the sent for Part A N N N N N N N N N N N N N N N N N N N	Part B 2.00 The appl A and Part N N N N N N N N N N N N N N N N N N	ication B. (See	Title V 3.00 n of the low 2.42 CFR §41: N N N N N N N N N N N N N N N N N N N	N Title XIX 4.00 er of costs 3.13) N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	ied cost finding method? E	nter "Y" for y Part A 1.00 n exemption from the sent for Part A N N N N N N N N N N N N N N N N N N N	Part B 2.00 The appl A and Part N N N N N N N N N N N N N N N N N N	ication B. (See	Title V 3.00 n of the low 2.42 CFR §41: N N N N N N N N N N N N N N N N N N N	N Title XIX 4.00 er of costs 3.13) N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 161. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	ied cost finding method? E rider that qualifies for an "N" for no for each compon ampus hospital that has on	Part A 1.00	Part B 2.00 The appl A and Part N N N N N N Susses in di	ication B. (See	Title V 3.00 n of the lowe 42 CFR §41: N N N N N CBSAS?	N Title XIX 4.00 er of costs 3.13) N N N N N N N N TITLE N N N N N N N N N N N N N N N N N N N	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ied cost finding method? E	Part A 1.00	Part B 2.00 The second of the appl A and Part N N N N N N N N N N N N N N N N N N	ication B. (See	Title V 3.00 n of the lowe 42 CFR §41: N N N N N N CBSAs?	N Title XIX 4.00 er of costs 3.13) N N N N N N N N T.00	149. C
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	ied cost finding method? E rider that qualifies for an "N" for no for each compon ampus hospital that has on	Part A 1.00	Part B 2.00 The appl A and Part N N N N N N Susses in di	ication B. (See	Title V 3.00 n of the lowe 42 CFR §41: N N N N N CBSAS?	N Title XIX 4.00 er of costs 3.13) N N N N N N N N T.00	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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	ied cost finding method? E rider that qualifies for an "N" for no for each compon ampus hospital that has on	Part A 1.00	Part B 2.00 The appl A and Part N N N N N N Susses in di	ication B. (See	Title V 3.00 n of the lowe 42 CFR §41: N N N N N CBSAS?	N Title XIX 4.00 er of costs 3.13) N N N N N N N N T.00	149. C 155. C 156. C 157. C 158. C 160. C 161. C
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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 column 5 (see instructions)	ied cost finding method? E rider that qualifies for an "N" for no for each compon ampus hospital that has on Name 0 T) incentive in the America	Part A 1.00 exemption from the second for Part A N N N N N N N N N N N N N N N N N N	Part B 2.00 In the appl A and Part N N N N N N N N N N N N N N N N N N	ication B. (See	Title V 3.00 n of the low 2.42 CFR §41: N N N N N CBSAS?	N Title XIX 4.00 er of costs 3.13) N N N N N 1.00 N FTE/Campus 5.00 O.0	149. 0 155. 0 156. 0 157. 0 158. 0 160. 0 161. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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 column 5 (see instructions) Health Information Technology (HI 67.00) Is this provider a meaningful use	ampus hospital that has on Name 0 T) incentive in the Americar under §1886(n)? Enter "	Part A 1.00 exemption from the second of t	Part B 2.00 In the appl A and Part N N N N N N N N N N N N N N N N N N	i cation B. (See	Title V 3.00 n of the lower 42 CFR §41: N N N N N CBSAS? De CBSA 4.00	N Title XIX 4.00 er of costs 3.13) N N N N N N N N O O O.0	149. 0 155. 0 156. 0 157. 0 158. 0 161. 0 165. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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 column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1	T) incentive in the Americar under \$1886(n)? Enter "05 is "Y") and is a meaning method? E	Part A 1.00 Rexemption from the second for Part A N N N N N N N N N N N N N N N N N N	Part B 2.00 In the appl A and Part N N N N N N N N N N N N N N N N N N	i cation B. (See	Title V 3.00 n of the lower 42 CFR §41: N N N N N CBSAS? De CBSA 4.00	N Title XIX 4.00 er of costs 3.13) N N N N N N N N O O O.0	148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 160. 0 161. 0 165. 0 167. 0 0168. 0
Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 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 column 5 (see instructions) Health Information Technology (HI 67.00) Is this provider a meaningful use	ied cost finding method? E rider that qualifies for an "N" for no for each compon Name 0 T) incentive in the Americ or under §1886(n)? Enter " 05 is "Y") and is a meanin HIT assets (see instructio	Part A 1.00 Examption from the second of t	Part B 2.00 The appl A and Part N N N N N N N N N N N N N N N N N N	ication B. (See	Title V 3.00 n of the lower 42 CFR §41: N N N N N N CBSAS? De CBSA 4.00	N Title XIX 4.00 er of costs 3.13) N N N N N N N N O O O.0	149. 0 155. 0 156. 0 157. 0 158. 0 161. 0 165. 0

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA		Peri od: From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginnir period respectively (mm/dd/yyyy)	ng date and ending dat	te for the reporting	10/01/2016	12/31/2016	170. 00
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider ha			N	0	171. 00
section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see inst	f column 1 is yes, er		on		

	Financial Systems SCHNECK MEDI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15_0065	In Lie Period:	u of Form CMS- Worksheet S-	
J3P1 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONWAIRE	Provider C		From 01/01/2016 To 12/31/2016	Part II	epared:
				Y/N	Date	+2 alli
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.	N for all NO re	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			_		
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
	reporting period: IT yes, enter the date of the change IT	cordiiir 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.		N			2.00
00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Danarta		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
	those of the fired financial statements: If yes, submit re	CONCITTATION.		Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the Legal operator of the program?	If yes, is the	he provider is	s N		6.00
00 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N) (A)	11.00
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see in:	structions.	N	14.00
	Bed Complement Did total beds available change from the prior cost report				N	15.00
		Y/N Par	t A Date	Par Y/N	t B Date	
		1.00	2. 00	3.00	4. 00	
	PS&R Data					
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16.00
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)	Y	03/21/2017	Y	03/21/2017	17.00
. 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.	N		N		18.00
. 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.	N		N		19.00

Health Financial Systems SCHNECK M HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	EDI CAL CENTER Provi der	CCN: 15-0065	In Lie	u of Form CMS Worksheet S	
HOSFITAL AND HOSFITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Frovider	CCN. 15-0005	From 01/01/2016 To 12/31/2016	Part II	repared:
	Desc	cription	Y/N	Y/N	
		0	1.00	3. 00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
21.00 Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21.00
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	IN .		IV		21.00
				1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (E	EXCEPT CHILDRENS	6 HOSPI TALS)			
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes,					22. 00
23.00 Have changes occurred in the Medicare depreciation exper	nse due to appra	aisals made d	uring the cost		23.00
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases end	tered into duri	ng this cost	reporting period?		24.00
If yes, see instructions 25.00 Have there been new capitalized leases entered into duri	ng the cost rep	porting perio	d? If yes, see		25. 00
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during	n the cost repo	cting period?	If was saa		26. 0
instructions.	g the cost repor	tring perrou:	11 yes, see		20.0
27.00 Has the provider's capitalization policy changed during copy.	the cost repor	ting period?	If yes, submit		27. 0
Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit	t entered into	during the co	st reporting		28. 0
period? If yes, see instructions.		3	3		
29.00 Did the provider have a funded depreciation account and		(Debt Service	Reserve Fund)		29. 0
treated as a funded depreciation account? If yes, see in 30.00 Has existing debt been replaced prior to its scheduled materials.		ew debt?lf y	es, see		30.0
instructions. 31.00 Has debt been recalled before scheduled maturity without instructions.	t issuance of ne	ew debt? If y	es, see		31.0
Purchased Services 32.00 Have changes or new agreements occurred in patient care	services furnis	shed through	contractual		32.0
arrangements with suppliers of services? If yes, see ins 33.00 If line 32 is yes, were the requirements of Sec. 2135.2	structi ons.	_			33. 0
no, see instructions. Provider-Based Physicians					
34.00 Are services furnished at the provider facility under ar	n arrangement wi	th provider-	based physicians?		34.0
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended	· ·	·			35.0
physicians during the cost reporting period? If yes, see	e instructions.	ments with th	e provider-based		33.0
			Y/N	Date	
N			1. 00	2. 00	
Home Office Costs					24 0
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement beer	n nrenared by +	ne home offic	e?		36. 00 37. 00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home					38.0
the provider? If yes, enter in column 2 the fiscal year			01		30.0
39.00 If line 36 is yes, did the provider render services to a see instructions.			es,		39. 0
40.00 If line 36 is yes, did the provider render services to t instructions.	the home office	? If yes, se	е		40.0
		1. 00	2.	00	
Cost Report Preparer Contact Information	ICE AN		TAROR		44.0
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SEAN		TABOR		41.00
respectively. 42.00 Enter the employer/company name of the cost report	BLUE AND CO.	, LLC			42.00
preparer. 43.00 Enter the telephone number and email address of the cost	t 502. 992. 3520		STABOR@BLUEAND	CO COM	43.0
report preparer in columns 1 and 2, respectively.	. 502. 772. 5520		JINDONEDLULAND	00. 00W	43.0

Health Financial Systems		SCHNECK MEDI	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH	CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared: 2 am
			3	. 00			
Cost Report Preparer Co	ontact Information						
41.00 Enter the first name,	ast name and the t	title/position	SENI OR ACCOUN	TANT			41.00
held by the cost repor	t preparer in colum	nns 1, 2, and 3,					
respectively.							
42.00 Enter the employer/com	cany name of the co	ost report					42.00
preparer.							
43.00 Enter the telephone nu	mber and email addr	ress of the cost					43.00
report preparer in col	umns 1 and 2. respe	ecti vel v.					

Heal th Fi nancial SystemsSCHNECHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0065

					To	12/31/2016	Date/Time Pre 5/23/2017 9:4	
							I/P Days /	2 (111)
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		86	31, 476	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider							3.00
4.00	HMO I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			0.4	04 47/	0.00	0	
7. 00	Total Adults and Peds. (exclude observation			86	31, 476	0. 00	0	7. 00
8. 00	beds) (see instructions)	31. 00		7	2 542	0. 00	0	8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00		/	2, 562	0.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43.00					0	1
14. 00	Total (see instructions)	45.00		93	34, 038	0. 00	0	14.00
15. 00	CAH visits			, 0	01,000	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF						ŭ	16.00
17. 00	SUBPROVI DER - I RF							17.00
	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	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
	Total (sum of lines 14-26)			93				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF			_	_			31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days					I		33.00

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Heal th Fi nancial SystemsSCHNECHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0065

Component Component Title XVIII Title XIX Total All Patients Residents Payrol 6.00 7.00 8.00 9.00 10.00 Nospital 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) 1.00 HM0 IPF Subprovider 4.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) 1.70 Days / 0/P Visits / Trips Full Time Equivalent A Residents Payrol 1, 025 9, 113 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 9, 113 1, 025 1, 025 1, 025 9, 113 1, 025 1, 025 1, 025 9, 113 1, 025 1, 025 1, 025 1, 025 1, 025 1, 025 1, 025 9, 113 1, 025 1,	s On
Patients & Residents Payrol	1.00
Patients & Residents Payrol	1.00
1.00	1.00
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) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation) 3, 665 1, 025 9, 113 9, 113 699 1, 755 0 0 0 0 39 0 221 7.00 Total Adults and Peds. (exclude observation) 3, 704 1, 025 9, 373	
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation) 8 exclude Swing Bed and Hospical Adults & Peds. Swing Bed SNF 9 0 39 221 7.00 Total Adults and Peds. (exclude observation) 8 exclude Swing Bed and Hospical Adults & Peds. Swing Bed SNF 9 0 221 7.00 Total Adults and Peds. (exclude observation) 8 exclude Swing Bed and Hospical Adults & Peds. Swing Bed SNF 9 0 39 1,025 9,373	
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation) 3,704 3,704 3,704 3,705 4,755 0 0 3,704 3,705 4,705 9,373	2.00
for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	2.00
2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	2.00
3.00 HMO IPF Subprovider 0 0 0 4.00 HMO IRF Subprovider 0 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 39 0 39 6.00 Hospital Adults & Peds. Swing Bed NF 0 221 7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	
4.00 HMO IRF Subprovider 0 0 0 39	3.00
5.00 Hospital Adults & Peds. Swing Bed SNF 39 0 39 6.00 Hospital Adults & Peds. Swing Bed NF 0 221 7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	4.00
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	5.00
7.00 Total Adults and Peds. (exclude observation 3,704 1,025 9,373	6.00
beds) (see instructions)	7.00
8. 00 INTENSIVE CARE UNIT 522 130 1, 157	8.00
9.00 CORONARY CARE UNIT	9.00
10.00 BURN INTENSIVE CARE UNIT	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)	12.00
13. 00 NURSERY 185 1, 641	13.00
	2. 13 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 NURSI NG FACI LI TY	20.00
21. 00 OTHER LONG TERM CARE	21.00
	7. 99 22. 00 23. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P.)	
24. 00 HOSPICE 8, 467 428 9, 822 0. 00 24. 10 HOSPICE (non-distinct part) 0 0 0	0. 00 24. 00 24. 10
25. 00 CMHC - CMHC	25. 00
26. 00 RURAL HEALTH CLINIC	26.00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00	0. 00 26. 25
	0. 00 20. 25
28. 00 Observation Bed Days 407 1, 911	28.00
29. 00 Ambul ance Tri ps 0	29. 00
30.00 Employee discount days (see instruction)	30.00
31.00 Employee discount days - IRF	31.00
32.00 Labor & delivery days (see instructions) 0 50 94	32.00
32.01 Total ancillary labor & delivery room	32. 01
outpatient days (see instructions)	
33.00 LTCH non-covered days	33.00

				To	12/31/2016	Date/Time Pre 5/23/2017 9:4	
		Full Time	<u>'</u>	Discha	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		(963	256	2, 807	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			142	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				O		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		0(1)	25/	2 007	13.00
14.00	Total (see instructions)	0. 00	(963	256	2, 807	14.00
15.00	CAH visits						15.00
16. 00 17. 00	SUBPROVIDER - I PF	·					16. 00 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	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 9: 42 am Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION SCHNECK MEDICAL CENTER Provider CCN: 15-0065

							5/23/2017 9: 4	2 am
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	-	1. 00	2. 00	A-6) 3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
1 00	SALARI ES	200 00	F4 024 F00		F4 024 F00	1 (42 4/1 72	22.24	1 00
1. 00	Total salaries (see instructions)	200. 00	54, 824, 580	0	54, 824, 580	1, 643, 461. 73	33. 36	1.00
2.00	Non-physician anesthetist Part		0	О	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	637, 684	637, 684	4, 479. 00	142. 37	3. 00
4. 00	Physician-Part A - Administrative		307, 091	0	307, 091	1, 310. 40	234. 35	4. 00
4. 01	Physicians - Part A - Teaching		0	О	0	0. 00	0. 00	4. 01
5.00	Physician and Non		7, 010, 174	0	7, 010, 174	41, 516. 60	168. 85	5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
	servi ces		_	_				
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
	programs)							
8.00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	О	0	0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		8, 164, 187	1, 038	8, 165, 225	210, 317. 00	38. 82	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		560, 754	0	560, 754	7, 963. 25	70. 42	11.00
	Care							
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		239, 000	0	239, 000	1, 813. 00	131. 83	13.00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		0	0	0	0. 00	0. 00	14.00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		0	0		0. 00 0. 00	0. 00 0. 00	14. 01 14. 02
15. 00	Home office: Physician Part A		0	-	1	0.00	0.00	
1/ 00	- Administrative		0			0.00	0.00	1/ 00
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16.00
17. 00	Wage-related costs (core) (see		9, 405, 551	0	9, 405, 551			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		1, 984, 230	o	1, 984, 230			19.00
20. 00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		154, 963	0	154, 963			21.00
22. 00	Physician Part A - Administrative		74, 626	0	74, 626			22. 00
22. 01	Physician Part A - Teaching		1 700 511	0	_			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 703, 541 0	0	1, 703, 541 0			23.00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0		0			25. 50 25. 51
25. 52	Wage-related Home office: Physician Part A		0	О	О			25. 52
25. 53	- Administrative - wage-related Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related							

| Period: | Worksheet S-3 | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0065

					1	0 12/31/2016	Date/lime Pre 5/23/2017 9:4	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	2 (1111
		Line Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col . 5)	
				Worksheet	ŕ		ŕ	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4. 00	469, 746	0	469, 746	12, 121. 20	38. 75	26. 00
27.00	Administrative & General	5. 00	7, 303, 520	0	7, 303, 520	234, 067. 60	31. 20	27. 00
28. 00	Administrative & General under		401, 724	0	401, 724	7, 571. 00	53. 06	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	1, 352, 583		1, 352, 583	· ·		30.00
31.00	Laundry & Linen Service	8. 00	45, 044		45, 044			31.00
32.00	Housekeepi ng	9. 00	889, 555	0	889, 555	66, 752. 40	13. 33	32.00
33. 00	Housekeeping under contract (see instructions)		0	0	0	0. 00	0. 00	33. 00
34.00	Dietary	10.00	694, 487	-407, 864	286, 623	17, 469. 00	16. 41	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	407, 864	407, 864	24, 859. 00	16. 41	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
38.00	Nursing Administration	13.00	2, 265, 356	-1, 038	2, 264, 318	65, 564. 27	34. 54	38. 00
39.00	Central Services and Supply	14. 00	421, 599	0	421, 599	23, 684. 27	17. 80	39. 00
40.00	Pharmacy	15. 00	1, 168, 848	0	1, 168, 848	30, 004. 00	38. 96	40.00
41.00	Medical Records & Medical	16. 00	987, 716	0	987, 716	43, 655. 73	22. 63	41.00
	Records Library							
	Social Service	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	270, 246	0	270, 246	6, 458. 40	41. 84	43.00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0065	Period: Worksheet S-3 From 01/01/2016 Part III

					To	nom 01/01/2016 o 12/31/2016		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						l
1.00	Net salaries (see		48, 216, 130	-637, 684	47, 578, 446	1, 605, 037. 13	29. 64	1.00
	instructions)							l
2.00	Excluded area salaries (see		8, 164, 187	1, 038	8, 165, 225	210, 317. 00	38. 82	2.00
	instructions)							l
3.00	Subtotal salaries (line 1		40, 051, 943	-638, 722	39, 413, 221	1, 394, 720. 13	28. 26	3.00
	minus line 2)							l
4.00	Subtotal other wages & related		799, 754	0	799, 754	9, 776. 25	81. 81	4.00
	costs (see inst.)							l
5.00	Subtotal wage-related costs		9, 480, 177	0	9, 480, 177	0. 00	24. 05	5.00
	(see inst.)							l
6.00	Total (sum of lines 3 thru 5)		50, 331, 874	-638, 722	49, 693, 152	1, 404, 496. 38	35. 38	6.00
7.00	Total overhead cost (see		16, 270, 424	-1, 038	16, 269, 386	587, 441. 27	27. 70	7.00
	instructions)							
	,	•		•		'		

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0065	Peri od: Worksheet S-3
		From 01/01/2016 Part IV

	To 12/31/2016	Date/Time Prep 5/23/2017 9:42	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 596, 740	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6.00
7.00	Employee Managed Care Program Administration Fees	o	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	8, 056, 172	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	o	8. 02
8. 03	Health Insurance (Purchased)	o	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	o	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	69, 614	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	o	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	406, 916	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	12, 698	14.00
15.00	'Workers' Compensation Insurance	321, 024	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		l
	TAXES		l
	FICA-Employers Portion Only	3, 520, 998	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	73, 303	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14, 057, 465	24.00
	Part B - Other than Core Related Cost		I
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/23/2017 9:42 am
Cost Contar Description		Contract	Popofit Cost

			5/23/2017 9: 4	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF			4.00
5. 00	Subprovi der - (0ther)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	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

Heal th	Financial Systems	SCHNECK MEDIC	CAL CENTER		In Li∈	eu of Form CMS-2	2552-10
	BEALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-0065	Period: From 01/01/2016	Worksheet S-4	
			Component	CCN: 15-7155	To 12/31/2016		
					Home Health	PPS	2 4111
					Agency I		
0.00	In the second				1.	00	0.00
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH ACENOV CTATICTICAL DATA	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	294. 00		0.00 ployees (Full Ti		2.00
				Number of Em	proyees (ruir ii	me Equivarent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0		1.00	2. 00	3.00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3. 00
4. 00	Director(s) and Assistant Director(s)		0.00	0.0	0.00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0.0		l .	5. 00 6. 00
7. 00	Nursing Supervisor			0.0		l .	7. 00
8. 00	Physical Therapy Service			0.0			8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0			9. 00 10. 00
11.00	Occupational Therapy Supervisor			0.0	0.00	0.00	11.00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0			12. 00 13. 00
14. 00	Medical Social Service			0.0		1	
15.00	Medical Social Service Supervisor			0.0		1	
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0.0		1	
18. 00	Other (specify)			0. 0			
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				3		19. 00
	you provided services during the cost						
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			18020			20. 00
	during this cost reporting period (line 20						
20. 01	contains the first code).			31140			20. 01
20. 02		Full Fo	i codec	99915			20. 02
		Full Ep Without	With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3. 00	Epi sodes 4.00	1-4) 5. 00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4. 00		
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 030 511, 499	234 59, 010		19 15 18 3, 780	1	
23. 00	Physical Therapy Visits	1, 418	56		19 17	1	
24.00	Physical Therapy Visit Charges	415, 422	16, 464	1		1	•
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 056 308, 739	72 21, 168	1	8 10 52 2, 979		•
27. 00	Speech Pathology Visits	72	26		3 0	101	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	21, 168 16	7, 644 2		32 C 0 C		28. 00 29. 00
30.00	Medical Social Service Visit Charges	5, 808	726	1	0 0	1	
31.00	Home Health Aide Visits	675	140	1			
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	93, 825 5, 267	19, 460 530	1	0 0 79 42		
24 00	29, and 31)		0				24.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 356, 461	0 124, 472	1	0 0 58 11, 757		34. 00 35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	306			29 2		36. 00
	outlier)	300					
	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	20, 185	12 3, 395		14 112	1	37. 00 38. 00

Heal th	Financial Systems SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der Co	F	Period: From 01/01/2016 To 12/31/2016		pared:
	<u> </u>					
1. 00	If this facility contains a hospital-based SNF, were all p or was there no Medicare utilization? Enter "Y" for yes in			1.00	2.00	1.00
2. 00	complete the rest of this worksheet. Does this hospital have an agreement under either section swing beds? Enter "Y" for yes or "N" for no in column 1.					2. 00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2. 00	3. 00	4.00	
3.00		RUX				3.00
4. 00 5. 00		RUL RVX			l	4. 00 5. 00
6. 00		RVL			l	6.00
7. 00		RHX	C			7. 00
8. 00 9. 00		RHL RMX			l	8. 00 9. 00
10.00		RML				10.00
11. 00		RLX	d			11. 00
12.00		RUC	C		l e	12.00
13. 00 14. 00		RUB RUA			l e	13.00 14.00
15. 00		RVC				15.00
16. 00		RVB	C			16.00
17. 00 18. 00		RVA RHC				17. 00 18. 00
19. 00		RHB				19.00
20.00		RHA	C		l e	20. 00
21. 00 22. 00		RMC RMB				21. 00 22. 00
23. 00		RMA				23. 00
24.00		RLB	C		•	24. 00
25. 00 26. 00		RLA ES3			l	25. 00 26. 00
27.00		ES2				27.00
28. 00		ES1	C		l	28. 00
29. 00 30. 00		HE2 HE1			l	29. 00 30. 00
31.00		HD2				31.00
32.00		HD1	(32.00
33. 00 34. 00		HC2 HC1			l	33. 00 34. 00
35.00		HB2			l e	35.00
36.00		HB1	C			36.00
37.00		LE2	C		l	37.00
38. 00 39. 00		LE1 LD2			l e	38. 00 39. 00
40.00		LD1	C	0	0	40.00
41. 00 42. 00		LC2 LC1			ł	41. 00 42. 00
43.00		LB2				43.00
44.00		LB1	C		ł	44.00
45. 00 46. 00		CE2 CE1			l e	45. 00 46. 00
47. 00		CD2				47. 00
48.00		CD1	C		•	48. 00
49. 00 50. 00		CC2 CC1				49. 00 50. 00
51. 00		CB2				51.00
52.00		CB1			l e	52.00
53. 00 54. 00		CA2 CA1			l e	53. 00 54. 00
55. 00		SE3				55. 00
56.00		SE2	C		l	56.00
57. 00 58. 00		SE1 SSC			l	57. 00 58. 00
59. 00		SSB				59.00
60.00		SSA	(0	0	60.00
61. 00 62. 00		I B2 I B1			l e	61. 00 62. 00
63.00		I A2			l e	63.00
64.00		I A1	C	0	0	64.00
65. 00 66. 00		BB2 BB1				65. 00 66. 00
67.00		BA2				67.00
68. 00		BA1	c			

Health Financial Systems SCHNECK MEI	DICAL CENTER			In Lie	u of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der C	CN: 15-0065	Pe	ri od:	Worksheet S-7	
			То		5/23/2017 9: 4	<u> 2 am</u>
	Group	SNF Days			Total (sum of	
	1.00	2.00		Days	col. 2 + 3) 4.00	
69.00	PE2	2.00	0	3.00	4.00	69.00
70.00	PE1		0	0		
71. 00	PD2		0	0		
72.00	PD1		0	0		
73. 00	PC2		0	0	Ö	
74. 00	PC1		0	0	Ö	
75. 00	PB2		0	0	Ö	
76. 00	PB1		0	0	Ö	1
77. 00	PA2		0	0	0	1
78. 00	PA1		0	0	0	1
199. 00	AAA		0	39	39	199. 00
200. 00 TOTAL			0	39	39	200.00
				CBSA at	CBSA on/after	
				Beginning of	October 1 of	
				Cost	the Cost	
				Reporti ng	Reporti ng	
				Peri od	Period (if	
			ŀ	1 00	appl i cabl e)	
CNE CEDVI CEC				1. 00	2. 00	
SNF SERVICES 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CE	OSA codo if a ru	ral facility	-	99915	99915	201. 00
in effect at the beginning of the cost reporting period.			,	79915	99915	201.00
in effect on or after October 1 of the cost reporting per						
		Expenses		Percentage	Associ ated	
		'		3	with Direct	
					Patient Care	
					and Related	
					Expenses?	
		1.00		2. 00	3. 00	
A notice published in the Federal Register Volume 68, No.						
payments beginning 10/01/2003. Congress expected this inc						
expenses. For lines 202 through 207: Enter in column 1 th						
column 2 the percentage of total expenses for each catego 7, column 3. In column 3, enter "Y" for yes or "N" for no						
direct patient care and related expenses for each categor			ICI (eases assuciat	.eu wi tii	
202. 00 Staffing	y. (See Thistruc	1 0113)	0	0.00		202. 00
203. 00 Recrui tment			0	0.00		203.00
204. 00 Retention of employees			0	0.00		204.00
205. 00 Trai ni ng			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	5. 00		207.00
	-/	1	٦		ı	1=300

Heal th	ı Financial Systems		SCHNECK MEDI	CAL CENTER		In Li€	eu of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-0065	Peri od:	Worksheet S-9	
					. 45 4500	From 01/01/2016	PARTS I THROU	
				Hospi ce CC	N: 15-1529	To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared:
						Hospi ce I	3/23/2017 7.4	2 (1111
		Unduplicated				1.0001.00		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			
1.00	Hospice Continuous Home Care Hospice Routine Home Care						ļ	1.00
2. 00 3. 00	· ·			•			ļ	2. 00 3. 00
4. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care						ļ	4.00
5. 00	Total Hospice Days							5.00
3.00	Part II - CENSUS DATA FOR COST	REPORTING PER	LODS BEGLANLING	BEFORE OCTOBE	R 1 2015			3.00
6. 00	Number of patients receiving	KEI OKITIKO TEK	DEGI MITTIG	DEFORE GOTOBE	1, 2010			6.00
0.00	hospi ce care						ļ	0.00
7.00	Total number of unduplicated						ļ	7.00
	Continuous Care hours billable						ļ	
	to Medicare						ļ	
8.00	Average Length of Stay (line 5						ļ	8.00
	/ line 6)						ļ	
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTIN	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1	-		
10.00	Hospice Continuous Home Care			0	1	0 0	1	
11. 00	Hospice Routine Home Care			8, 305		0 0		11.00
12.00	Hospice Inpatient Respite Care			87		0	87	
13.00	Hospice General Inpatient Care			75 8, 467		0 0		13. 00 14. 00
14. 00	Total Hospice Days PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	ST DEDODTING D					14.00
15. 00	Hospice Inpatient Respite Care		JI KLEUKTING P	CRIODS BEGINNI		0 C		15.00
	Hospice General Inpatient Care					0 0		
10.00	mesp. so contra impationt out			1	1	51	1	

Heal th	Financial Systems	SCHNECK MEDICAL	CENTER		In lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der C	CN: 15-0065	Peri od:	Worksheet S-1	
1100111	THE SHOOM ENGINES THE THEFT GENT GARE STATE		l rovider o	014. 10 0000	From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
						1.00	
	Uncompensated and indigent care cost computa						
1. 00	Cost to charge ratio (Worksheet C, Part I Ii	ne 202 column 3 d	ivided by l	ine 202 colum	n 8)	0. 315314	1.00
0.00	Medicaid (see instructions for each line)					0 (44 0(0	0.00
2.00	Net revenue from Medicaid		8, 641, 362 Y	2.00 3.00			
3. 00 4. 00	Did you receive DSH or supplemental payments If line 3 is "yes", does line 2 include all		al navmonte	from Modicai	42	Y N	4.00
5. 00	If line 4 is "no", then enter DSH or suppler			ITOIII Wedicai	u:	4, 029, 466	5.00
6. 00	Medi cai d charges	nontai payments ii	om weareara			56, 913, 759	6.00
7. 00	Medicaid cost (line 1 times line 6)					17, 945, 705	
8. 00	Difference between net revenue and costs for	Medicaid program	(line 7 mi)	nus sum of li	nes 2 and 5: if	5, 274, 877	8.00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions	for each li	ne)			
9.00	Net revenue from stand-alone CHIP					0	9. 00
	Stand-alone CHIP charges					0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)					0	11. 00
12. 00	Difference between net revenue and costs for	stand-alone CHIP	(line 11 m	inus line 9;	if < zero then	0	12.00
	enter zero)	(!		6 !	1		
12 00	Other state or local government indigent car Net revenue from state or local indigent car				,	0	13.00
14. 00	Charges for patients covered under state or					0	14.00
14.00	10)	rocai indigent ca	re program	(NOT THE due	i ili illies o oi	U	14.00
15. 00	State or Local indigent care program cost (I	ine 1 times line	14)			0	15. 00
16. 00				e program (Li	ne 15 minus line	-	16.00
	13; if < zero then enter zero)		3				
	Uncompensated care (see instructions for each						
17. 00	1		9	,		100, 135	
18. 00	Government grants, appropriations or transfe					60, 562	1
19. 00	Total unreimbursed cost for Medicaid , CHIP	and state and loc	al indigent	care program	s (sum of lines	5, 274, 877	19. 00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1.00	2. 00	3. 00	
20. 00	Charity care charges for the entire facility	v (see instruction	s)	1, 117, 2			20.00
21. 00	Cost of patients approved for charity care			352, 2		786, 629	1
22.00	Partial payment by patients approved for cha		,	34, 5	106, 801	141, 386	22.00
23.00	Cost of charity care (line 21 minus line 22))		317, 7	327, 536	645, 243	23. 00
						1. 00	
24. 00	Does the amount in line 20 column 2 include			ond a Length	of stay limit	N	24.00
25 22	imposed on patients covered by Medicaid or o						25 22
25. 00	If line 24 is "yes," charges for patient da				ith of stay limit		25.00
26.00	Total bad debt expense for the entire hospit)		14, 311, 297	ł
27. 00	Medicare bad debts for the entire hospital of	, ,	,	us Line 27)		258, 173	
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare L Cost of non-Medicare and non-reimbursable Me				20)	14, 053, 124	1
30.00	Cost of uncompensated care (line 23 column 3		vhense (1111	e i tilles ill	ic 20)	4, 431, 147 5, 076, 390	1
	Total unreimbursed and uncompensated care co		line 30)			10, 351, 267	ı
31.00	Total an ormbursed and uncompensated care of	ost (Title 19 prus	11116 30)			10, 331, 207	1 31.00

	Financial Systems	SCHNECK MEDICA		ON. 15 00/5		u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JE EXPENSES	Provi der CC	N: 15-0065 I	Period: From 01/01/2016	Worksheet A	
					Го 12/31/2016	Date/Time Pre 5/23/2017 9:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	GENERAL SERVICE COST CENTERS		7 040 074	7 040 07		F 400 000	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		7, 949, 371	7, 949, 37	-2, 759, 542 3, 960, 989	5, 189, 829 3, 960, 989	1. 00 2. 00
3. 00	00300 OTHER CAPITAL RELATED COSTS		o	(0 3, 700, 707	3, 400, 404	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	469, 746	14, 509, 862	14, 979, 608	190	14, 979, 798	
5.00	00500 ADMI NI STRATI VE & GENERAL	7, 303, 520	11, 776, 817	19, 080, 33		18, 932, 177	5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	1, 352, 583 45, 044	1, 995, 167 273, 732	3, 347, 750 318, 770		2, 917, 098 318, 776	1
9. 00	00900 HOUSEKEEPI NG	889, 555	261, 957	1, 151, 512		1, 151, 686	1
10.00	01000 DI ETARY	694, 487	577, 615	1, 272, 102		525, 427	1
11. 00 13. 00	01100 CAFETERI A	0	702 100		747, 091	747, 091	
14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 265, 356 421, 599	792, 180 42, 560	3, 057, 536 464, 159		3, 056, 498 478, 497	1
15. 00	01500 PHARMACY	1, 168, 848	1, 610, 812	2, 779, 660		2, 782, 306	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	987, 716	244, 146			1, 231, 862	
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	270, 246	10, 731 0	280, 97	7 0 0 637, 684	280, 977 637, 684	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	ı o			037,004	037, 004	1 1 9. 00
30.00	03000 ADULTS & PEDIATRICS	6, 372, 629	680, 022	7, 052, 65	-1, 470, 119	5, 582, 532	
31.00	03100 INTENSIVE CARE UNIT	986, 243	73, 020	1, 059, 26		1, 081, 647	1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	0	(338, 684	338, 684	43. 00
50.00	05000 OPERATING ROOM	2, 648, 697	2, 042, 498	4, 691, 195	86, 445	4, 777, 640	50.00
51.00	05100 RECOVERY ROOM	470, 974	6, 104	477, 078		477, 078	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2 990 074	04 410		1, 261, 604	1, 261, 604	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 880, 974 2, 611, 662	94, 619 1, 181, 513	2, 975, 593 3, 793, 175		2, 359, 764 3, 810, 517	
54. 01	03630 ULTRA SOUND	240, 813	34, 775	275, 588		276, 699	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	84, 627	54, 768	139, 39		140, 403	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	253, 225 179, 495	262, 901 148, 888	516, 126 328, 383		519, 887 328, 488	
60.00	06000 LABORATORY	1, 506, 278	1, 377, 748			2, 897, 542	1
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	292, 478			292, 478	1
64.00	06400 I NTRAVENOUS THERAPY	250, 844	3, 636			260, 927	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	997, 419 989, 027	66, 045 26, 165	1, 063, 464 1, 015, 192		1, 100, 036 1, 023, 344	
67. 00	06700 OCCUPATI ONAL THERAPY	311, 535	6, 858			319, 843	
68. 00	06800 SPEECH PATHOLOGY	215, 764	6, 135	221, 899		221, 899	1
69.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	112, 024	103, 655			219, 790	1
71. 00 72. 00	07200 IMPLANTABLE DEVICES CHARGED TO		10, 426, 485 0		-2, 261, 826 2, 261, 826	8, 164, 659 2, 261, 826	
	PATI ENTS		[2,201,020	2,201,020	,2.00
	07300 DRUGS CHARGED TO PATIENTS	0	7, 469, 422			,	
76. 00 76. 02	03952 WOUND CARE (DIABETES CENTER) 03951 CASE MANAGEMENT	181, 381 351, 763	35, 891 6, 304	217, 272 358, 06		217, 360 358, 241	
	03950 PAIN MANAGEMENT	1, 206, 231	335, 206			1, 541, 437	
76. 97	07697 CARDIAC REHABILITATION	430, 510	4, 637	435, 14	11, 094	446, 241	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS 04950 OTHER OUTPATIENT SERVICE COST CENTER	0.040	4 205	14 22	906	15 101	1 00 00
90. 00 90. 01	04951 PALLIATIVE HEALTH	9, 940 237, 277	4, 285 18, 421	14, 225 255, 698		15, 131 255, 698	1
	09000 VEIN CENTER	392, 254	36, 785	429, 039		431, 148	90. 02
90.03	09001 OB GYN	2, 181, 505	64, 412	2, 245, 91		2, 253, 691	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 199, 666	347, 391	4, 547, 05	7 23, 514	4, 570, 571	91. 00 92. 00
93. 00	04952 BEHAVI ORAL HEALTH	488, 936	11, 226	500, 162	2 0	500, 162	1
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 284, 188	143, 908	1, 428, 096	4, 490	1, 432, 586	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		1, 051, 618	1, 051, 618	-1, 051, 618	0	113.00
	11600 HOSPI CE	670, 624	176, 448			847, 072	
118.00	,	48, 615, 205	66, 639, 217	115, 254, 422	-7, 680	115, 246, 742	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol		ol ol	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 989, 567	234, 095	3, 223, 662		3, 226, 346	1
194.00	07950 WELLNESS	0	0		1, 199		194. 00
	07952 EXTERNAL SVCS MARKETING	195, 019	696, 669	891, 688		891, 688	1
	07953 WASHI NGTON CLI NI C 07954 PHYSI CI AN OFFI CES	206, 152 822, 885	0 130, 081	206, 152 952, 966		206, 152 953, 035	1
	07955 I NTEGRATED MEDICINE	293, 882	17, 215	311, 09		312, 210	
194.06	07956 SURGI CAL PROFESSI ONAL	634, 733	87, 043	721, 776	88	721, 864	194. 06
	07957 PRI MARY CARE 07958 EMPLOYER CLI NI C	706, 280	96, 930 477, 310	803, 210		805, 737 705, 181	1
194.08	10/730 LWIFLUTER CLINIC	317, 871	477, 310	795, 18	1 0	795, 181	1174.08

Heal th Financ	cial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-	2552-10
RECLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 01/01/2016		
					Го 12/31/2016	Date/Time Pre	
						5/23/2017 9: 4	<u>2 am</u>
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
194. 09 07959	UROLOGY PROF	42, 986	173, 342	216, 32	3 0	216, 328	194. 09
200.00	TOTAL (SUM OF LINES 118-199)	54, 824, 580	68, 551, 902	123, 376, 482	2 0	123, 376, 482	200.00

 Health Financial
 Systems
 SCHNECK M

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0065

Peri od: Worksheet A From 01/01/2016 Date/Time Prepared: 5/23/2017 9:42 am

			5/23/2017 9: 4	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation	_	
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS			, I	
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-602, 189	4, 587, 640		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	0		l e e e e e e e e e e e e e e e e e e e	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	14 070 700		3.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-	14, 979, 798		4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	-4, 708, 804	14, 223, 373 2, 917, 098		7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	318, 776		8.00
9. 00 00900 HOUSEKEEPI NG	0	1, 151, 686	1	9.00
10. 00 01000 DI ETARY	-134	525, 293		10.00
11. 00 01100 CAFETERI A	-378, 721	368, 370		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-370, 721	3, 056, 498		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	478, 497		14.00
15. 00 01500 PHARMACY	-162, 540	2, 619, 766		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-26, 297	1, 205, 565		16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTICE	0	280, 977		18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	-637, 684	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS	5577551		1	17.00
30. 00 03000 ADULTS & PEDIATRICS	-148, 166	5, 434, 366		30.00
31. 00 03100 INTENSIVE CARE UNIT	0			31.00
43. 00 04300 NURSERY	0		l control of the cont	43.00
ANCILLARY SERVICE COST CENTERS	'		1	1
50. 00 05000 OPERATING ROOM	-586, 320	4, 191, 320		50.00
51.00 05100 RECOVERY ROOM	0	477, 078	3	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 261, 604		52.00
53. 00 05300 ANESTHESI OLOGY	-2, 243, 290	116, 474		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-596, 478	3, 214, 039		54.00
54. 01 03630 ULTRA SOUND	0	276, 699		54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	140, 403		54. 02
57. 00 05700 CT SCAN	-5, 160	514, 727		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	328, 488	3	58. 00
60. 00 06000 LABORATORY	-181, 324	2, 716, 218		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	292, 478		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	260, 927	1	64. 00
65. 00 06500 RESPI RATORY THERAPY	-93, 934	1, 006, 102		65.00
66. 00 06600 PHYSI CAL THERAPY	-469	1, 022, 875		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	-10	319, 833		67.00
68. 00 06800 SPEECH PATHOLOGY	0	221, 899		68.00
69. 00 06900 ELECTROCARDI OLOGY	-1, 679	218, 111		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 164, 659		71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	0	2, 261, 826		72.00
PATIENTS		7 4/0 400		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7, 469, 422		73.00
76. 00 03952 WOUND CARE (DIABETES CENTER)	0	217, 360		76.00
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PAI N MANAGEMENT	-351, 763 -515, 422	6, 478	l control of the cont	76.02
76. 03 03950 PATN MANAGEMENT 76. 97 07697 CARDIAC REHABILITATION	-515, 422	1, 026, 015		76. 03 76. 97
OUTPATIENT SERVICE COST CENTERS		446, 241		70.97
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	15, 131		90.00
90. 01 04951 PALLI ATI VE HEALTH	-6, 750			90.00
90. 02 09000 VEIN CENTER	-244, 019	187, 129		90.02
90. 03 09001 0B GYN	-1, 617, 052	636, 639		90.03
91. 00 09100 EMERGENCY	-1, 718, 901	2, 851, 670		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		_, _, , , , , ,		92.00
93. 00 04952 BEHAVI ORAL HEALTH	0	500, 162		93.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>		•	1
101. 00 10100 HOME HEALTH AGENCY	0	1, 432, 586		101.00
SPECIAL PURPOSE COST CENTERS				1
113. 00 11300 I NTEREST EXPENSE	0	0		113.00
116. 00 11600 HOSPI CE	-58	847, 014		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-14, 827, 164	100, 419, 578	3	118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	3, 226, 346)	192. 00
194. 00 07950 WELLNESS	0	1, 199		194. 00
194.02 07952 EXTERNAL SVCS MARKETING	0	891, 688	3	194. 02
194. 03 07953 WASHINGTON CLINIC	0	206, 152	2	194. 03
194.04 07954 PHYSICIAN OFFICES	0	953, 035	<u>;</u>	194. 04
194. 05 07955 INTEGRATED MEDICINE	0	312, 210		194. 05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	721, 864		194. 06
194. 07 07957 PRI MARY CARE	-425	805, 312		194. 07
194.08 07958 EMPLOYER CLINIC	0	795, 181		194. 08
194. 09 07959 UROLOGY PROF	0	216, 328	3	194. 09

Health Financial Systems	SCHNECK MEDIC	CAL CENTER		In Lieu	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co	CN: 15-0065	Peri od:	Worksheet A	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
				l .	5/23/2017 9: 4	<u>2 am</u>
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7. 00				
200, 00 TOTAL (SUM OF LINES 118-199)	-14, 827, 589	108, 548, 893				200.00

Peri od: From 01/01/2016 To 12/31/2016 Worksheet A-6 Date/Time Prepared: 5/23/2017 9:42 am Provider CCN: 15-0065

					10 12/31/2	5/23/2017 9: 42 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1 00	A - CAFETERIA	11 00	407.074	220 227		1.00
1. 00	TOTALS		40 <u>7, 864</u> 407, 864	339, 227		1.00
	B - PROPERTY INSURANCE		407, 864	339, 227		
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	100, 071		1.00
2. 00	CAP REL COSTS-BEDG & TTXT	2. 00	0	49, 758		2.00
2.00	TOTALS			149, 829		2.00
	C - BIO-MED		<u> </u>	147, 027		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	190		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	ő	1, 669		2.00
3. 00	HOUSEKEEPI NG	9. 00	ő	174		3.00
4. 00	DI FTARY	10.00	o	416		4.00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	14, 338		5. 00
6. 00	PHARMACY	15. 00	o	2, 646		6.00
7. 00	ADULTS & PEDIATRICS	30.00	o	121, 881		7.00
8. 00	INTENSIVE CARE UNIT	31.00	o	22, 384		8.00
9.00	NURSERY	43.00	O	8, 288		9.00
10.00	OPERATING ROOM	50.00	O	86, 445		10.00
11.00	ANESTHESI OLOGY	53.00	o	21, 855		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	o	17, 342		12.00
13.00	ULTRA SOUND	54. 01	O	1, 111		13.00
14.00	NUCLEAR MEDICINE -	54. 02	o	1, 008		14.00
	DI AGNOSTI C			,		
15.00	CT SCAN	57.00	О	3, 761		15. 00
16.00	MAGNETIC RESONANCE IMAGING	58. 00	0	105		16.00
	(MRI)					
17.00	LABORATORY	60.00	0	13, 516		17. 00
18.00	INTRAVENOUS THERAPY	64.00	0	6, 447		18.00
19.00	RESPI RATORY THERAPY	65. 00	0	36, 572		19.00
20.00	PHYSI CAL THERAPY	66. 00	0	8, 152		20.00
21.00	OCCUPATI ONAL THERAPY	67. 00	0	1, 450		21.00
22.00	ELECTROCARDI OLOGY	69. 00	0	4, 111		22.00
23.00	WOUND CARE (DIABETES CENTER)	76. 00	0	88		23.00
24.00	CASE MANAGEMENT	76. 02	0	174		24.00
25.00	CARDIAC REHABILITATION	76. 97	0	11, 094		25. 00
26.00	OTHER OUTPATIENT SERVICE	90. 00	0	906		26.00
	COST CENTER					
27. 00	VEIN CENTER	90. 02	0	2, 109		27. 00
28. 00	OB GYN	90. 03	0	7,774		28.00
29. 00	EMERGENCY	91. 00	0	23, 514		29.00
30.00	HOME HEALTH AGENCY	101. 00	0	3, 452		30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 684		31.00
32.00	WELLNESS	194. 00	0	1, 199		32.00
33.00	PHYSICIAN OFFICES	194. 04	0	69		33.00
34.00	INTEGRATED MEDICINE	194. 05	0	1, 113		34.00
35.00	SURGI CAL PROFESSI ONAL	194. 06	0	88		35.00
36. 00	PRI MARY CARE	1 <u>94.</u> 07		<u>2, 527</u>		36.00
	TOTALS		0	430, 652		
1 00	D - DEPRECIATION	2 00	ما	0.044.004		1.00
1. 00	CAP REL COSTS-MVBLE EQUIP			3, 911, 231		1.00
	TOTALS		U	3, 911, 231		
1 00	E - BOND INTEREST	1 00		1 051 /10		1.00
1. 00	CAP REL COSTS-BLDG & FIXT		0	1, 051, 618		1.00
	TOTALS		0	1, 051, 618		
1 00	F - NURSERY	42.00	220, 204			1.00
1.00	NURSERY	43. 00	330, 396	0		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	5200	1, 261, 604	0		2.00
	TOTALS G - CRNA		1, 592, 000	U		
1 00	-	10.00	(27 (04	0		1 00
1. 00	NONPHYSI CI AN ANESTHETI STS		637, 684	0		1.00
	TOTALS H - HHA MSW		637, 684	U		
1 00	HOME HEALTH AGENCY	101 00	1 020			1 00
1. 00	TOTALS	1 <u>01.</u> 00	1,038	0		1.00
			1, 038	U		
1 00	I - IMPLANTABLE DEVICES IMPLANTABLE DEVICES CHARGED	72.00	0	2 261 024		1 00
1. 00	TO PATIENTS	72.00	۷	2, 261, 826		1.00
	TOTALS	+		2, 261, 826		
500 00	Grand Total: Increases		2, 638, 586	8, 144, 383		500.00
JUU. UU	piranu rotar. ITICI eases		2, 030, 300	0, 144, 303		300.00

Health Financial Systems RECLASSIFICATIONS SCHNECK MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 15-0065

| Peri od: | Worksheet A-6 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared:

						5/23/2017	Prepared: 9:42 am
		Decreases		0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 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	1000	407, 864	339, 227			1. 00
	TOTALS		407, 864	339, 227			_
1 00	B - PROPERTY I NSURANCE	F 00	O	140,000	10		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	149, 829 0			1. 00 2. 00
2.00	TOTALS — — — —		- — 	149, 829			2.00
	C - BIO-MED	1		,			
1. 00	OPERATION OF PLANT	7. 00	0	430, 652			1.00
2.00		0.00	0	0			2.00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	0			5. 00
6. 00		0. 00	Ö	0			6.00
7.00		0.00	0	0	0		7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0			9.00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12. 00		0.00	o	0			12.00
13. 00		0.00	O	0			13.00
14.00		0. 00	0	0	O		14.00
15.00		0. 00	0	0			15. 00
16.00		0.00	0	0			16.00
17. 00 18. 00		0. 00 0. 00	0	0			17. 00 18. 00
19. 00		0. 00	o	0			19. 00
20.00		0.00	0	0			20.00
21. 00		0.00	0	0			21.00
22. 00		0.00	0	0			22.00
23. 00 24. 00		0. 00 0. 00	0	0			23. 00 24. 00
25. 00		0.00	ol Ol	0			25.00
26. 00		0. 00	o	0			26. 00
27.00		0.00	O	0	0		27. 00
28. 00		0.00	0	0			28. 00
29. 00		0.00	0	0			29.00
30. 00 31. 00		0. 00 0. 00	0	0			30. 00 31. 00
32. 00		0.00	0	0			32.00
33. 00		0.00	O	0			33.00
34.00		0.00	0	0			34.00
35.00		0.00	0	0	0		35.00
36. 00	TOTALS — — — —		0	0 430, 652	<u> </u>		36. 00
	D - DEPRECIATION		- υ _Ι	430, 032			
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 911, 231	9		1.00
	TOTALS			3, 911, 231			
	E - BOND INTEREST						
1. 00	INTEREST EXPENSE	113.00		<u>1, 051, 618</u>			1.00
	TOTALS F - NURSERY		0	1, 051, 618			
1. 00	ADULTS & PEDIATRICS	30. 00	1, 592, 000	0	0		1.00
2. 00		0.00	О				2.00
	TOTALS		1, 592, 000	0			
4.00	G - CRNA	50.00					4.00
1. 00	ANESTHESI OLOGY	53.00	637, 684	0	0		1.00
	TOTALS H - HHA MSW		637, 684	0			
1. 00	NURSING ADMINISTRATION	13. 00	1, 038	0	0		1.00
	TOTALS		1, 038	0			
	I - IMPLANTABLE DEVICES						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 261, 826	0		1.00
	PATI ENTS	+		2, 261, 826	 		
500. 00	Grand Total: Decreases		2, 638, 586	8, 144, 383			500.00
		ı		.,, 200	1		1

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS SCHNECK MEDICAL CENTER Provi der CCN: 15-0065

					o 12/31/2016	Date/Time Pre 5/23/2017 9:4	
				Acqui si ti ons		372372017 7.4	2 (1111
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	7, 351, 960	674, 538		674, 538		1.00
2.00	Land Improvements	4, 064, 163	20, 128	C	20, 128		2.00
3.00	Buildings and Fixtures	81, 818, 538	3, 098, 817	C	3, 098, 817	1, 299, 450	3.00
4. 00	Building Improvements	0	0	C	0	0	4.00
5.00	Fi xed Equi pment	6, 388, 839	133, 647	C	133, 647		5.00
6. 00	Movable Equipment	52, 095, 711	3, 449, 418	C	3, 449, 418	5, 358, 433	
7. 00	HIT designated Assets	0	0	C	0	0	7.00
8. 00	Subtotal (sum of lines 1-7)	151, 719, 211	7, 376, 548	C	7, 376, 548	7, 976, 211	8.00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	151, 719, 211	7, 376, 548	C	7, 376, 548	7, 976, 211	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	8, 026, 498	0				1.00
2.00	Land Improvements	3, 962, 746	0				2.00
3.00	Buildings and Fixtures	83, 617, 905	0				3.00
4.00	Building Improvements	0	0				4. 00
5. 00	Fixed Equipment	5, 325, 703	0				5.00
6. 00	Movable Equipment	50, 186, 696	0				6.00
7. 00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	151, 119, 548	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	151, 119, 548	0				10.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0065	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
						5/23/2017 9: 4	2 am
			SL	JMMARY OF CAP	TIAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	7, 949, 371	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	7, 949, 371	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	7, 949, 371				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7, 949, 371				3.00
	·	•	-	•			•

Heal th	n Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Pre 5/23/2017 9:4	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	0.00	col . 2)	4.00	F 00	
	DART III DECONCILIATION OF CARLTAL COSTS C	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	100, 932, 851	0	100, 932, 85	0. 667901	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	50, 186, 696				·	2. 00
3. 00	Total (sum of lines 1-2)	151, 119, 547		151, 119, 54			3. 00
3.00	Total (Sum of Titles 1-2)		TION OF OTHER (F CAPITAL	3.00
		ALLOCA	TION OF OTHER V	CALLIAL	JOININIAR T	CALLIAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
	·		Capi tal -Rel at	col s. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 4, 038, 140		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0 3, 911, 231		2.00
3.00	Total (sum of lines 1-2)	0	0)	0 7, 949, 371	-54, 718	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	cost center bescription	Titterest	(see	instructions			
			instructions)	Tristi detrons,	ed Costs (see		
					instructions)	, timough in	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	504, 147	100, 071		0 0	4, 587, 640	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	49, 758	3	0 0	3, 960, 989	2.00
3.00	Total (sum of lines 1-2)	504, 147	149, 829	1	0	8, 548, 629	3.00

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0065

				To	12/31/2016	Date/Time Pre	
				Expense Classification on	Worksheet A	5/23/2017 9: 4	2 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL	1. 00 A		CAP REL COSTS-BLDG & FIXT	1.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2)		0		0. 00	0	3.00
0.00	(chapter 2)				0.00		0.00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of	В	-97 788	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
0.00	expenses (chapter 8)	b	,,,,,	The state of the s	0.00	J	0.00
6. 00	Rental of provider space by	В	-54, 718	CAP REL COSTS-BLDG & FIXT	1. 00	10	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	_5 193	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter	^	-5, 103	ADMINISTRATIVE & GENERAL	3.00	0	7.00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physi ci an	A-8-2	-8, 121, 401			0	10.00
11 00	adjustment		0		0.00	0	11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12.00	Related organization	A-8-1	0			0	12.00
40.00	transactions (chapter 10)				0.00		40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-378 721	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		0	SAL ETERNA	0.00	0	15.00
4, 00	and others				0.00		4, 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	26 207	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
10.00	abstracts	Ь	-20, 247	WIEDI CAE RECORDS & ELBRART	10.00	O	10.00
19. 00	Nursing school (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines	В	7 007	ADMINISTRATIVE & GENERAL	E 00	0	20.00
21. 00	Income from imposition of	Б	-7,007	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	
	interest, finance or penalty						
22.00	charges (chapter 21)				0.00	0	22.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medi care overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation			cost center bereted	114.00		25.00
	(chapter 21)		_			_	
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP	_					
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant	Α	-637, 684	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30.00	Adjustment for occupational	A-8-3		OCCUPATIONAL THERAPY	67. 00	U	30.00
	therapy costs in excess of				37.30		
20.00	limitation (chapter 14)		_	ADULTS & DEDLATELOS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		"	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)		I	l l	I		l

Health Financial Systems			SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0065	Peri od:	Worksheet A-8	}
					From 01/01/2016		norod.
					To 12/31/2016	Date/Time Pre 5/23/2017 9:4	epareu: 2 am
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Alliourt	Cost center	LITIE #	Ref.	
		1. 00	2. 00	3.00	4.00	5. 00	
32. 00	CAH HIT Adjustment for	11.00	0		0.00	0.00	32. 00
	Depreciation and Interest		_			_	
33.00	MISC INCOME - A&G	В	-33, 650	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	MISC INCOME - PHARMACY	В	-162, 540	PHARMACY	15. 00	0	33. 01
33.02	MISC INCOME - EMERGENCY	В	-151	EMERGENCY	91.00	0	33. 02
34.00	UNNECESSARY BORROWING	Α	-113, 465	CAP REL COSTS-BLDG & FIXT	1.00	11	34.00
35.00	TELEPHONE BENEFITS	Α	-240	ADMINISTRATIVE & GENERAL	5. 00	0	35.00
36.00	HAF & PHYS RECRUITMENT	Α		ADMINISTRATIVE & GENERAL	5. 00		1 00.00
37.00	MARKETING - A&G	А		ADMINISTRATIVE & GENERAL	5. 00		37.00
37. 01	MARKETING - DIETARY	Α		DI ETARY	10. 00		37. 01
37. 02	MARKETING - A&P	Α	1	ADULTS & PEDIATRICS	30. 00		37. 02
37. 03	MARKETING - OPERATING ROOM	Α		OPERATING ROOM	50.00		07.00
37. 04	MARKETING - LABORATORY	A	1	LABORATORY	60.00		37.04
37. 05	MARKETING - PHYSICAL THERAPY	A	4	PHYSI CAL THERAPY	66. 00		37. 05
37. 06	MARKETING - OCCUPATIONAL	Α	-10	OCCUPATI ONAL THERAPY	67. 00	0	37. 06
37. 07	THERAPY MARKETING - OB GYN	۸	400	OB GYN	90. 03	0	37. 07
37.07	MARKETING - OB GYN	A A		PRIMARY CARE	194. 07		37.07
37.08	MARKETING - PRIMARY CARE	A		EMERGENCY	91.00		37.08
37. 10	MARKETING - LINERGENCT ROOM	A		HOSPI CE	116.00		37. 10
38. 00	BARIATRIC NP	A		CASE MANAGEMENT	76. 02		38.00
39.00	4	Ä	•	ADMI NI STRATI VE & GENERAL	5. 00		39.00
	TOTAL (£ 1: 1 +b 10)		14 007 500		0.00	ľ	50.00

-14, 827, 589

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 15-0065

Peri od: Worksheet A-8-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

5/23/2017 9:42 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 147, 354 147, 354 0 211,500 0 1.00 2.00 50.00 OPERATING ROOM 585, 900 585, 900 0 246, 400 0 2.00 3.00 53. 00 ANESTHESI OLOGY 2, 243, 290 2, 243, 290 239, 400 0 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 767, 723 271, 900 1, 310 4 00 460, 632 307.091 4 00 57. 00 CT SCAN 5.00 5, 160 5, 160 271, 900 0 5.00 6.00 60. 00 LABORATORY 358, 152 128, 152 230,000 211, 500 1,741 6.00 93, 934 7.00 65. 00 RESPIRATORY THERAPY 93, 934 211, 500 0 7.00 69. OO ELECTROCARDI OLOGY 8.00 9,000 9.000 211, 500 72 8.00 9.00 76. 02 CASE MANAGEMENT 165, 699 165, 699 211, 500 0 9.00 10.00 76. 03 PAIN MANAGEMENT 515, 422 515, 422 0 211, 500 0 10.00 90. 01 PALLIATIVE HEALTH 6, 750 6, 750 211, 500 0 11.00 11.00 0 0 90. 02 VEIN CENTER 244, 019 211, 500 12.00 244, 019 0 12.00 13.00 90. 03 OB GYN 1, 616, 452 1, 616, 452 0 237, 100 0 13.00 14.00 91. 00 EMERGENCY 1, 718, 142 1, 718, 142 211, 500 0 14.00 <u>7, 930, 90</u>6 546, 091 3, 123 200.00 8, 476, 997 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Unadjusted RCE Memberships & of Mal practi ce Li mi t Component Conti nui ng Limit Share of col Insurance Educati on 12 8. 00 9. 00 14.00 1. 00 2 00 13. 00 12.00 1.00 30.00 ADULTS & PEDIATRICS 0 0 1.00 0 50. 00 OPERATING ROOM 0 2.00 0 0 0 0 0 0 2.00 53. 00 ANESTHESI OLOGY 0 0 3 00 3 00 0 54. 00 RADI OLOGY-DI AGNOSTI C 0 4.00 171, 245 8,562 0 4.00 5.00 57. 00 CT SCAN 5.00 0 6.00 60. 00 LABORATORY 177,030 8,852 0 0 0 0 6.00 65. 00 RESPIRATORY THERAPY 0 7 00 0 7 00 0 69. 00 ELECTROCARDI OLOGY 0 8.00 7, 321 366 0 8.00 9.00 76. 02 CASE MANAGEMENT 0 9.00 0 0 76. 03 PAIN MANAGEMENT 0 0 10.00 10.00 0 0 0 90. 01 PALLIATIVE HEALTH 11.00 0 11.00 0 12.00 90. 02 VEIN CENTER 0 0 0 0 12.00 90. 03 OB GYN 0 13.00 13.00 0 14.00 91. 00 EMERGENCY 0 C 14.00 0 355, 596 200.00 200.00 17, 780 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 15. 00 1.00 2.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDIATRICS 0 0 0 147, 354 1.00 50. 00 OPERATING ROOM 2.00 0 0 0 585, 900 2.00 53. 00 ANESTHESI OLOGY 0 2, 243, 290 3 00 3 00 0 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 171, 245 135, 846 596, 478 4.00 5.00 57. 00 CT SCAN o 5, 160 5.00 6.00 60. 00 LABORATORY o 52, 970 181, 122 177,030 6.00 65. 00 RESPIRATORY THERAPY 7.00 o 0 93, 934 7 00 8.00 69. 00 ELECTROCARDI OLOGY 0 7, 321 1, 679 1, 679 8.00 76. 02 CASE MANAGEMENT o 165, 699 9.00 0 9.00 0 515, 422 76. 03 PAIN MANAGEMENT 10.00 0 10.00 0 90. 01 PALLI ATI VE HEALTH 11.00 0 0 6,750 11 00 12.00 90. 02 VEIN CENTER 0 244, 019 12.00 90. 03 OB GYN 0 13.00 0 0 1, 616, 452 13.00 91. 00 EMERGENCY 0 14.00 1, 718, 142 14.00 0 0 200.00 355, 596 190, 495 8, 121, 401 200.00

| Peri od: | Worksheet B | From 01/01/2016 | Part | | To 12/31/2016 | Date/Time Prepared: | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0065

			To	12/31/2016	Date/Time Pre 5/23/2017 9:4	
		CAPI TAL REI	LATED COSTS		372372017 7.4	2 4111
		DI DO A FLIVE	10/01 5 50/11 5	545L0V55		
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
GENERAL SERVICE COST CENTERS	0	1.00	2.00	4. 00	4A	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	4, 587, 640	4, 587, 640				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	3, 960, 989	1	3, 960, 989			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	14, 979, 798	1		15, 002, 456		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	14, 223, 373	l	439, 432	2, 015, 822	17, 118, 968	5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	2, 917, 098 318, 776	l		373, 326 12, 433	5, 157, 735 348, 267	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	1, 151, 686	l		245, 526	1, 423, 885	9.00
10. 00 01000 DI ETARY	525, 293	92, 269	18, 712	79, 111	715, 385	10.00
11. 00 01100 CAFETERI A	368, 370	l e	-	112, 575	480, 945	ł
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	3, 056, 498 478, 497	100, 642 67, 150		624, 974 116, 366	3, 857, 311 706, 463	1
15. 00 01500 PHARMACY	2, 619, 766	l		322, 614	3, 113, 723	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 205, 565	l		272, 619		
18.00 01850 PHYSICIAN PRIVATE PRACTICE	280, 977	0	- 1	74, 591	355, 568	1
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	176, 007	176, 007	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	5, 434, 366	760, 660	238, 905	1, 319, 501	7, 753, 432	30.00
31. 00 03100 NTENSI VE CARE UNI T	1, 081, 647	74, 858		272, 213	1, 538, 031	31.00
43. 00 04300 NURSERY	338, 684	1		91, 193	440, 206	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	4, 191, 320 477, 078	l		731, 067 129, 994	5, 711, 017 677, 225	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 261, 604	l		348, 215		52.00
53. 00 05300 ANESTHESI OLOGY	116, 474	l		619, 170	773, 955	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 214, 039	l		720, 845	4, 607, 461	54.00
54. 01 03630 ULTRA SOUND	276, 699	l		66, 467	374, 116	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57. 00 05700 CT SCAN	140, 403 514, 727	5, 778 15, 723		23, 358 69, 893	169, 616 612, 057	54. 02 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	328, 488	l		49, 542	393, 711	58.00
60. 00 06000 LABORATORY	2, 716, 218			415, 748	3, 263, 788	•
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	292, 478			0	299, 215	1
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	260, 927	52, 360		69, 235	429, 776	64. 00 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 006, 102 1, 022, 875			275, 298 272, 981	1, 372, 197 1, 471, 861	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	319, 833	l		85, 987	412, 262	ł
68. 00 06800 SPEECH PATHOLOGY	221, 899	l		59, 553		1
69. 00 06900 ELECTROCARDI OLOGY	218, 111	17, 615		30, 920		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPLANTABLE DEVICES CHARGED TO	8, 164, 659 2, 261, 826	l		0	8, 164, 659 2, 261, 826	1
PATIENTS	2, 201, 020	٥		O	2, 201, 020	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 469, 422		0	0	7, 469, 422	73. 00
76.00 03952 WOUND CARE (DIABETES CENTER)	217, 360			50, 063	294, 344	
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	6, 478 1, 026, 015			97, 090 332, 932		
76. 97 07697 CARDI AC REHABI LI TATI ON	446, 241	28, 136		118, 825	598, 250	1
OUTPATIENT SERVICE COST CENTERS		·	·	·	·	
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	15, 131	0		2, 744	17, 875	1
90. 01 04951 PALLI ATI VE HEALTH 90. 02 09000 VEI N CENTER	248, 948 187, 129			65, 491 108, 266	318, 466 302, 269	
90. 03 09001 0B GYN	636, 639			602, 117	1, 429, 079	
91. 00 09100 EMERGENCY	2, 851, 670	1		1, 159, 150		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	
93. 00 O4952 BEHAVI ORAL HEALTH	500, 162	15, 902	12, 877	134, 951	663, 892	93.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	1, 432, 586	21, 604	918	354, 735	1, 809, 843	101 00
SPECIAL PURPOSE COST CENTERS	1, 432, 300	21,004	710	354, 735	1,007,043	101.00
113.00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	847, 014			185, 099		
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	100, 419, 578	3, 669, 108	3, 881, 549	13, 288, 607	97, 707, 757	JI 18. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 186	0	0	15, 186	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 226, 346			825, 150		
194. 00 07950 WELLNESS	1, 199			0		194.00
194. 02 07952 EXTERNAL SVCS MARKETING	891, 688	l		53, 827 54, 000	970, 866 317, 010	
194. 03 07953 WASHINGTON CLINIC 194. 04 07954 PHYSICIAN OFFICES	206, 152 953, 035			56, 900 227, 124	317, 010 1, 244, 105	
194. 05 07955 NTEGRATED MEDICINE	312, 210	l		81, 114	441, 251	194. 05
194. 06 07956 SURGI CAL PROFESSI ONAL	721, 864	1		175, 193		

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2016 To 12/31/2016		
				To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2. 00	4. 00	4A	
194. 07 07957 PRI MARY CARE	805, 312	256, 455	9, 17	7 194, 940	1, 265, 884	194. 07
194.08 07958 EMPLOYER CLINIC	795, 181	61, 052	15	1 87, 736	944, 120	194. 08
194. 09 07959 UROLOGY PROF	216, 328	26, 576		0 11, 865	254, 769	194. 09
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	108, 548, 893	4, 587, 640	3, 960, 98	9 15, 002, 456	108, 548, 893	202.00

Peri od: Worksheet B From 01/01/2016 Part I Date/Ti me Prepared: 5/23/2017 9:42 am

				1273172010	5/23/2017 9: 4	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL 5. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	7.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	l l					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	17, 118, 968	l e				5.00
7. 00 00700 OPERATION OF PLANT	965, 714	6, 123, 449	1			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	65, 208	l '	1			8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	266, 603 133, 946	l '	1	1, 731, 088 45, 898	1, 041, 527	9. 00 10. 00
11. 00 01000 DFETART	90, 050		1	43, 676	1, 041, 327	11.00
13. 00 01300 NURSING ADMINISTRATION	722, 227	159, 574	_	50, 063	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	132, 275	l '	l ő	33, 403	0	14.00
15. 00 01500 PHARMACY	583, 001	57, 502	0	18, 040	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	282, 271	37, 456	0	11, 751	0	16.00
18.00 01850 PHYSICIAN PRIVATE PRACTICE	66, 575	l e	_	0	0	18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	32, 955	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST C		1 00/ 000	000.050	270 200	004 405	
30. 00 03000 ADULTS & PEDI ATRI CS	1, 451, 722			378, 388 37, 237	924, 195	30.00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	287, 975 82, 422			5, 138	117, 332 0	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	02, 422	10, 377	7, 704	5, 130		43.00
50. 00 05000 OPERATING ROOM	1, 069, 308	523, 111	45, 165	164, 115	0	50.00
51. 00 05100 RECOVERY ROOM	126, 801	102, 701		32, 220	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	315, 571	119, 868		37, 606	0	52.00
53. 00 05300 ANESTHESI OLOGY	144, 912	1, 743	0	547	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	862, 683	525, 279	37, 398	164, 796	0	54.00
54.01 03630 ULTRA SOUND	70, 048		1	6, 626	0	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOS			1	2, 874	0	54.02
57. 00 05700 CT SCAN	114, 599		1	7, 821	0	57.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG		17, 573	1	5, 513	0	58.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING,	611, 099 & TRANS. 56, 024	114, 740 10, 682	1	35, 997 3, 351	0	60. 00 63. 00
64. 00 06400 INTRAVENOUS THERAPY	80, 470	l '	1	26, 046	0	64.00
65. 00 06500 RESPIRATORY THERAPY	256, 925	l '	1	32, 360	0	65.00
66. 00 06600 PHYSI CAL THERAPY	275, 585	l '	1		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	77, 190	l '	1	3, 160	0	67.00
68.00 06800 SPEECH PATHOLOGY	53, 775	l '		2, 505	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	56, 744	27, 930	19, 607	8, 762	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO		0	0	0	0	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGE	O TO 423, 495	0	0	0	0	72.00
PATIENTS	1 200 545					70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03952 WOUND CARE (DIABETES CENTE	1, 398, 545	ł .		12 220	0	73. 00 76. 00
76. 00 03952 WOUND CARE (DIABETES CENTE) 76. 02 03951 CASE MANAGEMENT	R) 55, 112 24, 526		0	13, 239 13, 519	0	76.00
76. 03 03950 PALN MANAGEMENT	268, 288	l '	_		0	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON	112, 014		1		0	76. 97
OUTPATIENT SERVICE COST CENTERS		,	_			
90. 00 04950 OTHER OUTPATIENT SERVICE C	OST CENTER 3, 347	0	0	0	0	90.00
90. 01 04951 PALLI ATI VE HEALTH	59, 628	6, 385	0	2, 003	0	90. 01
90. 02 09000 VEIN CENTER	56, 596		1	1, 583	0	90. 02
90. 03 09001 0B GYN	267, 575			45, 326	0	90.03
91. 00 09100 EMERGENCY	789, 177	294, 279	38, 838	92, 324	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DIST		25 244		7 010	0	92.00
93. 00 04952 BEHAVI ORAL HEALTH	124, 304	25, 214	0	7, 910	0	93.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	338, 868	34, 254	0	10, 746		101.00
SPECIAL PURPOSE COST CENTERS	330, 606	34, 234	<u> </u>	10, 740		1101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	198, 778	46, 820	0	14, 689	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-					1, 041, 527	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP	R CANTEEN 2,843	24, 079	0	7, 554		190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICE		542, 041	1	0		192. 00
194. 00 07950 WELLNESS	224	0	0	0		194.00
194. 02 07952 EXTERNAL SVCS MARKETI NG	181, 781	39, 118	1	12, 273		194. 02
194. 03 07953 WASHI NGTON CLI NI C	59, 356	l '	1	26, 841		194. 03
194. 04 07954 PHYSI CLAN OFFI CES	232, 941	92, 566	1	29, 041		194. 04 194. 05
194. 05 07955 I NTEGRATED MEDI CI NE 194. 06 07956 SURGI CAL PROFESSI ONAL	82, 618 174, 705			22, 892 17, 099		194. 05
194. 06 07956 SURGI CAL PROFESSI UNAL 194. 07 07957 PRI MARY CARE	237, 019		1	17, 099		194.06
194. 08 07958 EMPLOYER CLINIC	176, 773	l '	1	30, 370		194.07
194. 09 07959 UROLOGY PROF	47, 702					194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
	· · · · · · · · · · · · · · · · · · ·			<u>'</u>		

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0065	Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/23/2017 9: 4	<u>2 am</u>
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
202.00 TOTAL (sum lines 118-201)	17, 118, 968	6, 123, 449	438, 97	3 1, 731, 088	1, 041, 527	202. 00

Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/23/2017 9: 42 am

Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	5/23/2017 9: 4 MEDI CAL RECORDS &	
	11. 00	N 13. 00	SUPPLY 14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 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						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	570, 995 30, 363 10, 968 13, 895 20, 218	4, 819, 538 0 206, 460	989, 580 1, 077 1, 266	3, 993, 698 O	1, 860, 530	10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
18.00 01850 PHYSICIAN PRIVATE PRACTICE	2, 991	o	137	ō	0	18. 00
19. 00 O1900 NONPHYSI CLAN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 074	0	0	0	0	19. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	79, 479 15, 363 4, 906	228, 273	6, 857 734 0	0 0 0	71, 479 10, 263 8, 363	30. 00 31. 00 43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	44, 276 6, 419 18, 732 7, 298	0 278, 333	14, 291 184 0 440	0 0 0	429, 866 39, 759 41, 130 30, 082	50.00 51.00 52.00 53.00
54. 01 03630 NICSTRESTOLLOGT 54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	7, 290 31, 471 2, 925 951	467, 603	1, 934 79 273	0	110, 428 23, 421 10, 708	54. 00 54. 01 54. 02
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 60. 00 06000 LABORATORY	3, 593 2, 469 32, 409	0	174 13 2, 431	0 0	205, 994 64, 292 301, 303	57. 00 58. 00 60. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY	0 3, 811 16, 901	0 0 0	0 176 702	0 0 0	4, 570 7, 311 36, 528	63. 00 64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	16, 839 4, 058 2, 774 1, 693	0	268 85 61 210 741, 318	0 0	25, 046 12, 059 3, 409 40, 946 50, 331	66. 00 67. 00 68. 00 69. 00 71. 00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	-1	205, 365	0 3, 993, 698	31, 563 114, 711	72.00
76. 00 03952 WOUND CARE (DIABETES CENTER) 76. 02 03951 CASE MANAGEMENT 76. 03 03950 PAIN MANAGEMENT	2, 830 2, 502 11, 508	0	214 175 231	0 0	4, 060 976 17, 907	76. 00 76. 02 76. 03
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	6, 190	0	201	0	1, 582	76. 97
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	124		4	0	216	
90. 01 04951 PALLI ATI VE HEALTH 90. 02 09000 VEI N CENTER 90. 03 09001 OB GYN	2, 556 3, 434 15, 835	0 0	49 202 1, 648	0 0 0	2, 307 11, 904 11, 592	90. 01 90. 02 90. 03
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	49, 274		1, 911	0	104, 631	92.00
93. 00 04952 BEHAVI ORAL HEALTH OTHER REI MBURSABLE COST CENTERS	3, 773		92	0	2, 192	93.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	17, 334	257, 552	544	0	15, 831	101. 00
113.00 11300 I NTEREST EXPENSE					40.770	113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	9, 764 502, 000	4, 819, 538	290 983, 636	3, 993, 698	1, 860, 530	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 WELLNESS	0 27, 675 0	O	0 767 0	0 0 0	0	190. 00 192. 00 194. 00
194. 02 07952 EXTERNAL SVCS MARKETI NG 194. 03 07953 WASHI NGTON CLI NI C	2, 947 6, 209	0	761 0	0	0	194. 02 194. 03
194.04 07954 PHYSICIAN OFFICES 194.05 07955 INTEGRATED MEDICINE	9, 114 2, 724		399 734	0		194. 04 194. 05
194. 06 07956 SURGI CAL PROFESSI ONAL	4, 151	0	80	0	0	194. 06
194. 07 07957 PRI MARY CARE 194. 08 07958 EMPLOYER CLI NI C	10, 689 5, 486		760 2, 095	0 0		194. 07 194. 08
194.09 07959 UROLOGY PROF 200.00 Cross Foot Adjustments	0		348	O		194. 09 200. 00
				·		

Health Fin	ancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2016	Worksheet B Part I	
					Γο 12/31/2016		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
201.00	Negative Cost Centers	0	0	(0	0	201.00
202.00	TOTAL (sum lines 118-201)	570, 995	4, 819, 538	989, 580	3, 993, 698	1, 860, 530	202.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	F	eriod: rom 01/01/2016		norod.
					o 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared: 2 am
	Cost Center Description	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post	Total	
		110101102			Stepdown		
		18. 00	19. 00	24.00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	16.00	19.00	24.00	25.00	26.00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 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 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						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	01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	425, 271 0	211, 036				16. 00 18. 00 19. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	J	211,030				17.00
30.00	03000 ADULTS & PEDIATRICS	0	0	13, 291, 668			
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	0	2, 375, 222 640, 287			
	ANCILLARY SERVICE COST CENTERS		_			·	
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0	8, 659, 014 985, 309			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	2, 500, 230		· ·	
53.00	05300 ANESTHESI OLOGY	0	211, 036	1, 170, 013		1, 170, 013	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	0	6, 809, 053 498, 335		6, 809, 053 498, 335	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	225, 341	0	225, 341	54. 02
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	969, 168 557, 288		969, 168 557, 288	
60.00	06000 LABORATORY	0	Ö	4, 823, 872			
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0	0	373, 842 630, 610		373, 842 630, 610	1
65.00	06500 RESPIRATORY THERAPY	0	0	1, 818, 760		1, 818, 760	1
66.00	06600 PHYSI CAL THERAPY	0	0	2, 398, 473		2, 398, 473	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	518, 887 357, 714		518, 887 357, 714	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	484, 108	0	484, 108	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	0	0	10, 485, 020 2, 922, 249		10, 485, 020 2, 922, 249	1
72.00	PATIENTS	0	O	2, 722, 247	o o	2, 722, 247	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	12, 976, 376		12, 976, 376	
76. 00 76. 02	03952 WOUND CARE (DIABETES CENTER) 03951 CASE MANAGEMENT	0	0	411, 998 215, 778		411, 998 215, 778	
	03950 PAIN MANAGEMENT	0	0	1, 873, 916			
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	776, 844	0	776, 844	76. 97
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	570	0	22, 136	0	22, 136	
90. 01 90. 02	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	11, 783 15, 830	0	403, 177 396, 865		403, 177 396, 865	
	09001 0B GYN	72, 997	0	1, 988, 526		1, 988, 526	
91.00	09100 EMERGENCY	0	0	6, 317, 441	0	6, 317, 441	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	0	0	827, 377	0	827, 377	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS					·	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	2, 484, 972	0	2, 484, 972	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	1, 345, 753			
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	101, 180	211, 036	93, 535, 622	0	93, 535, 622	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	49, 662			190. 00
	19200 PHYSICIANS'PRIVATE OFFICES 07950 WELLNESS	127, 580 0	0	5, 985, 622 1, 423			192. 00 194. 00
194. 02	07952 EXTERNAL SVCS MARKETING	13, 585	0	1, 221, 331		1, 221, 331	194. 02
	07953 WASHINGTON CLINIC	28, 623	0	523, 592 1 450 191		523, 592 1 450 191	
	07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE	42, 015 12, 556	0	1, 650, 181 635, 742		1, 650, 181 635, 742	
	07956 SURGI CAL PROFESSI ONAL	19, 135	0				

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	18. 00	19. 00	24. 00	25. 00	26.00	
194. 07 07957 PRI MARY CARE	49, 276	0	2, 097, 82	6 0	2, 097, 826	194. 07
194. 08 07958 EMPLOYER CLINIC	25, 292	0	1, 280, 93	9 0	1, 280, 939	194. 08
194. 09 07959 UROLOGY PROF	6, 029	0	364, 20	6 0	364, 206	194. 09
200.00 Cross Foot Adjustments		0		0	0	200.00
201.00 Negative Cost Centers	0	0		0	0	201.00
202.00 TOTAL (sum lines 118-201)	425, 271	211, 036	108, 548, 89	3 0	108, 548, 893	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0065

Cast Century Description						То	12/31/2016	Date/Time Pre 5/23/2017 9:4	
CASE SERVICE COST CENTERS 1.00 2.00 2A 4.00 1.00					CAPI TAL REI	LATED COSTS		10, 20, 20, 7, 7, 1	
CEMBERAL SERVICE OOST CENTERS 1.00 2.00 2A 4.00 1.00			Cost Center Description	Directly	RIDG & FLYT	MVRLE FOLLE	Subtotal	EMPL OVEE	
			oost center bescription		DEDG & TTXT	WVDLL LQOTT	Subtotal		
Company Comp								DEPARTMENT	
To Company C					1. 00	2.00	2A	4. 00	
2.00 DOZOGL CAP REL COSTS - MUNEL EDUIL P 4.00 DOZOGL CAP REL COSTS - MUNEL EDUIL P 5.00 DOZOGL ADM IN STRATT VE & CEMERAL 5.11 14,789 440,341 450,432 985,191 30,333 50,00 5.00 DOZOGL ADM IN STRATT VE & CEMERAL 5.24 24,058 2,615 31,177 371 9.00 7.00 DOZOGL ADM IN STRATT VE & CEMERAL 6.00 DOZOGL ADM IN STRATT VE & CEMERAL 7.00 D				-			=: -		
4.00 00000 DIAMIN STRATIVE & CEREALA 15,118 440,311 499,422 891,919 3,033 5,00									
5.00 DROOD AMAN IN STRATIVE A GENERAL 19, 418 449, 429 479, 670 5000 5000 500 5000		1	•	0	21. 898	760	22, 658	22, 658	
B.00 00000 LANDRY K LINEN SERVICE 0 10,081 977 17,086 19 8.00				15, 418					
0.00 00900 DUSENCEP ING									
10.00 01000 DETARY		1	•	_					
13.00 01300 NIRSING AGMIN INSTRATION 0 100, 442 75, 197 175, 839 944 13.00 15.00 01500 PHARMACY 0 67, 150 44, 450 111, 600 176 14.00 16.00 01500 PHARMACY 0 32, 262 135, 077 171, 343 487 15.00 15.00 01500 PHARMACY 0 32, 262 35, 761 29, 384 417 15.00 15.00 01500 PHARMACY 0 20, 20, 262 57, 761 29, 384 417 15.00									
14. 0.0 01400 CENTRAL SERVICES & SUPPLY 0 67, 150 44, 460 111, 600 176 14, 00 16. 0.0 01500 PHARMACY 0 23, 623 5,761 29, 384 412 16, 00 18. 0.0 01500 PHARMACY 0 23, 623 5,761 29, 384 412 16, 00 19. 0.0 01500 PHASCI CAN PRI VATE PRACTIFE 0 0 0 0 0 131 180, 00 19. 0.0 01500 OUTS & PEDIA TRIC S 0 0 0 0 0 0 19. 0.0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 11. 0.0 03100 INTENSIVE CANE UNIT 4,887 74,858 109,313 188,758 411 31, 00 13. 0.0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 0 0 10. 0 03000 OUTS & PEDIA TRIC S 0 0 0 0 0 0 0 0 0				0	_	_	- 1		
15.00 01500 PHARMACY 0 36,266 135,077 171,343 487 15.00 16.00 16.00 16.00 16.00 16.00 16.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 11.31 18.00 19				0					
16.00 01400 MEDICAL RECORDS & LIBRARY 0 23,623 5,761 29,384 412 16.00 19.00 01400 MOMPHYSI CLAN PRIVATE PRACTICE 0 0 0 0 0 0 266 19.00				0					
19.00 1900		01600	MEDICAL RECORDS & LIBRARY	0					16. 00
IMPATT INT ROUTINE SERVICE COST CENTERS 1,004,936				0					
30.00	19.00			l O	0	<u> </u>	<u> </u>	200	19.00
43.00 0.4300 NURSERY 0 10,329 0 10,329 30 0.00 0.000		03000	ADULTS & PEDIATRICS					1, 994	
MICLILARY SERVICE COST CENTERS									
50.00	43.00			0	10, 329	<u> </u>	10, 329	138	43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 75,600 0 75,600 526 52, 00 53.00 63300 MESTHESI DLOGY 0 0 0 0 331,288 341,289 672,577 1,089 54,00 54,01 03630 ULFAN SOUNDED 0 0 331,288 341,289 672,577 1,089 54,00 54,01 03630 ULFAN SOUNDED 0 0 15,778 77 5,855 35 54,02 57,70 05700 CT SCAN 0 05700 CT SCAN 0 0 0 0 0 5,778 77 5,855 35 54,02 54,02 57,00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		05000	OPERATING ROOM	167, 417					
53.00 05300 ANESTHESIOLOGY 0 1.099 37, 212 38, 311 935 53.00 54.01 03630 ULTRA SOUND 0 313, 328 341, 289 672, 577 1.089 54.00 54.01 03630 ULTRA SOUND 0 13, 320 17, 630 30, 950 100 54.01 57.00 05700 CT SCAM 0 157, 723 11, 714 27, 437 106 57, 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 11, 083 4, 598 15, 681 75 58.00 60.00 06000 MAGNETIC RESONANCE IMAGING (MRI) 0 11, 083 4, 598 15, 681 75 58.00 60.00 06000 LABORATORY 132, 046 72, 365 59, 457 263, 868 628 60.00 60.00 06000 LABORATORY 132, 046 72, 365 59, 457 263, 868 628 60.00 60.00 06000 RESPI RATIORY 14, 600 66, 53 25, 744 99, 914 105 64.00 60.00 06600 RESPI RATIORY 14, 600 66, 53 25, 744 99, 914 105 64.00 60.00 06600 RESPI RATIORY 14, 600 66, 53 25, 744 99, 917 416 65.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 363 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 363 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 353 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 363 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 363 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 363 89 6, 442 130 67.00 60.00 06600 PILYSI CAL THERAPY 0 6, 600 0 0 0 0 0 60.00 06600 PILYSI CAL THERAPY 0 6, 600 0 0 0 0 60.00 06600 PILYSI CAL THERAPY		1	•	0					
54. 00 05400 RADIOLOGY-DI AGNOSTIC 0 331, 288 341, 289 672, 577 1, 089 54. 00 154. 00 3350 ULTRA SOUND 0 0 5, 778 77 5, 855 35 54. 02 57. 00 5700 CT SCAN 0 0 15, 723 11, 714 27, 437 106 57. 00 5700 CT SCAN 0 0 11, 083 4, 598 15, 681 75 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 11, 083 4, 598 15, 681 75 58. 00 06300 LAGDRATORY PROCESSING, & TRANS. 0 6, 737 0 6, 737 0 63. 00 06300 LADORATORY PROCESSING, & TRANS. 0 6, 737 0 6, 737 0 63. 00 06500 RESPIRATORY THERAPY 4, 600 65, 053 25, 744 95, 397 416 65. 00 06500 RESPIRATORY THERAPY 0 6, 583 14, 70 176, 005 412 66. 00 06600 PHSICAL THERAPY 0 6, 583 14, 70 176, 005 412 66. 00 06600 SPECH PATHOLOGY 0 0 6, 583 14, 70 176, 005 412 66. 00 06600 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0				0					
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 5.778 177 5.855 35 64. 02				0					
57.00 05700 CT SCAN 0 15.723 11,714 27,427 106 57.00				0					
58.00 05800 MAGNETIC RESONANCE I IMAGI NC (WRI)		1	l e e e e e e e e e e e e e e e e e e e	0					
63.00 06300 06400 STORING, PROCESSING, & TRANS. 0 6,737 0 6,30 0640 00 0400 INTRAVENDUS THERAPY 4,600 65,03 25,744 99,614 105 64,00 66,00 06500 RESPIRATORY THERAPY 4,600 65,03 25,744 99,537 416 65,00 66,00 06500 PRYSI CAL THERAPY 0 6,353 89 6,442 130 67,00 67,00 06700 0CUPATI ONAL THERAPY 0 6,353 89 6,442 130 67,00 68,00 06800 SPEECH PATOLLORY 0 5,037 715 5,752 90 68,00 06800 SPEECH PATOLLORY 0 5,037 715 5,752 90 68,00 06800 SPEECH PATOLLORY 0 5,037 715 5,752 90 68,00 06800 SPEECH PATOLLORY 0 0 0 0 0 0 0 0 0				0					
64. 00		1	•	132, 046					
65.00 06500 RESPIRATORY THERAPY 4,600 65.053 25,744 95,397 416 65.00				0				-	
66.00 06600 Deleysic Cal Therappy 0 161, 835 14, 170 176, 005 412 66.00		1	•	4, 600					
68.00 06800 SPEECH PATHOLOGY 0 5,037 715 5,752 90 68.00	66.00	06600	PHYSI CAL THERAPY	0	161, 835	14, 170	176, 005	412	66.00
69 00 0900 0900 00 00 00 0				0					
171.00 07100 MPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 0 0 0 0				1. 440					
PATIENTS PATIENTS	71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 00 03952 WOUND CARE (DIABETES CENTER) 20,929 26,615 306 47,850 76 76.00 76. 02 03951 CASE MANAGEMENT 0 68,697 5,243 73,940 50.3 76. 97 07697 CARDI AC REHABILITATION 0 28,136 5,048 33,184 10.0 76. 97 07697 CARDI AC REHABILITATION 0 28,136 5,048 33,184 10.0 76. 97 07697 CARDI AC REHABILITATION 0 28,136 5,048 33,184 10.0 76. 97 07697 CARDI AC REHABILITATION 0 28,136 5,048 33,184 10.0 76. 97 07697 CARDI AC REHABILITATION 0 28,136 5,048 33,184 10.0 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 90 04950 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 76. 90 04950 OTHER OUTPATIENT SERVICE COST CENTER 0 0 4,027 0 4,027 99 90. 01 76. 90 04951 PALLITATIVE HEALTH 0 0 4,027 0 4,027 99 90. 01 76. 90 09000 VEIN CENTER 0 0 91,118 99,205 190,323 910 90.03 76. 90 09000 09000 09000 09000 09000 09000 090000 090000 76. 90 09000 09000 090000 090000 090000 090000 090000 090000 090000 76. 90 09000 09000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000 09000000 0900000000	72. 00	07200		0	0	0	0	0	72. 00
76. 00 03952 WOUND CARE (DIABETES CENTER) 20,929 26,615 306 47,850 76 76,00 76. 02 03951 CASE MANAGEMENT 0 27,177 244 27,421 147 76.00 76. 03 03950 PAIN MANAGEMENT 0 68,697 5,243 73,940 503 76. 97 07697 CARDI AC REHABI LI TATION 0 28,136 5,048 33,184 180 76.97 90. 00 04950 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0 0 0 90. 01 04951 PALLI ATI VE HEALTH 0 4,027 99 90.01 90. 02 09000 VEIN CENTER 0 3,183 3,691 6,874 164 90.02 90. 03 09001 0B GVN 0 91,118 99,205 190,323 910 90.03 91. 00 09100 BERGENCY 0 185,598 18,463 204,061 1,751 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 15,902 12,877 28,779 204 93.00 04952 BEHAVI GRAL HEALTH 0 15,902 12,877 28,779 204 93.00 04952 BEHAVI GRAL HEALTH 0 15,902 12,877 28,779 204 93.00 04952 BEHAVI GRAL HEALTH AGENCY 311 21,604 918 22,833 536 101.00 113. 00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 190,000 9000	73. 00	07300	•	0	0	0	0	0	73. 00
76. 93 03950 PAIN MANAGEMENT 0 68,697 5,243 73,940 503 76.03 76.97 07697 CARDI AC REHABILITATION 0 0 28,136 5,048 33,184 180 76.97 000 04950 07160 07160				20, 929					
76. 97				0					
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER									
90. 01		OUTPA	TIENT SERVICE COST CENTERS						
90. 02 09000 VEIN CENTER 0 3, 183 3, 691 6, 874 164 90. 02 90. 03 09001 0B GYN 0 91, 118 99, 205 190, 323 910 90. 03 91. 00 09100 EMERGENCY 0 185, 598 18, 463 204, 061 1, 751 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 93. 00 04952 BEHAVI ORAL HEALTH 0 15, 902 12, 877 28, 779 204 93. 00 04952 BEHAVI ORAL HEALTH 0 15, 902 12, 877 28, 779 204 93. 00 04952 BEHAVI ORAL HEALTH AGENCY 311 21, 604 918 22, 833 536 101. 00 10100 HOME HEALTH AGENCY 311 21, 604 918 22, 833 536 116. 00 11300 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 445, 144 3, 669, 108 3, 881, 549 7, 995, 801 20, 067 118. 00 NONREI MBURSABLE COST CENTERS 120 341, 860 60, 315 402, 295 1, 247 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 120 341, 860 60, 315 402, 295 1, 247 192. 00 194. 00 07950 WELLNESS 0 0 0 0 0 0 0 194. 00 07950 WELLNESS 120 341, 860 60, 315 402, 295 1, 247 192. 00 194. 03 07953 WASHI NGTON CLI NI C 0 53, 958 0 53, 958 86 194. 03 194. 04 07954 PHYSI CI AN OFFI CES 120 58, 381 5, 565 64, 066 343 194. 04 194. 05 07955 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06 195. 0900 0900				0					
91. 00				0					
92. 00				0					
93. 00		1	•	0	185, 598	18, 463		1, 751	
101. 00		1	,	0	15, 902	12, 877		204	
113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 116.00 1									
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 66, 937 29, 529 0 96, 466 280 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 445, 144 3, 669, 108 3, 881, 549 7, 995, 801 20, 067 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 186 0 15, 186 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 120 341, 860 60, 315 402, 295 1, 247 192. 00 194. 00 07950 WELLNESS 0 0 0 0 0 194. 00 07952 EXTERNAL SVCS MARKETI NG 0 24, 671 680 25, 351 81 194. 02 194. 03 07953 WASHI NGTON CLI NI C 0 53, 958 0 53, 958 86 194. 03 194. 04 07954 PHYSI CI AN OFFI CES 120 58, 381 5, 565 64, 066 343 194. 04 194. 05 07955 INTEGRATED MEDI CI NE 0 46, 019 1, 908 47, 927 123 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06	101.00			311	21, 604	918	22, 833	536	101.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 445, 144 3, 669, 108 3, 881, 549 7, 995, 801 20, 067 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 186 0 15, 186 0 190. 00		11300	INTEREST EXPENSE						
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 186 0 15, 186 0 190. 00									
190. 00	118.00			445, 144	3, 009, 108	3, 881, 549	7, 995, 801	20, 067	118.00
194. 00 07950 WELLNESS 0 0 0 0 194. 00 194. 02 07952 EXTERNAL SVCS MARKETING 0 24, 671 680 25, 351 81 194. 02 194. 03 07953 WASHI NGTON CLINIC 0 53, 958 0 53, 958 86 194. 03 194. 04 07954 PHYSI CI AN OFFI CES 120 58, 381 5, 565 64, 066 343 194. 04 194. 05 07955 INTEGRATED MEDI CI NE 0 46, 019 1, 908 47, 927 123 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06		19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	_					
194. 02 07952 EXTERNAL SVCS MARKETING 0 24, 671 680 25, 351 81 194. 02 194. 03 07953 WASHI NGTON CLINI C 0 53, 958 0 53, 958 86 194. 03 194. 04 07954 PHYSI CI AN OFFI CES 120 58, 381 5, 565 64, 066 343 194. 04 194. 05 07955 INTEGRATED MEDI CI NE 0 46, 019 1, 908 47, 927 123 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06				1					
194. 03 07953 WASHI NGTON CLINI C 0 53, 958 0 53, 958 86 194. 03 194. 04 07954 PHYSI CI AN OFFI CES 120 58, 381 5, 565 64, 066 343 194. 04 194. 05 07955 I NTEGRATED MEDI CI NE 0 46, 019 1, 908 47, 927 123 194. 05 194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06	194. 02	07952	EXTERNAL SVCS MARKETING				- 1		
194. 05 O7955 I NTEGRATED MEDI CI NE 0 46, 019 1, 908 47, 927 123 194. 05 194. 06 O7956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06	194. 03	07953	WASHINGTON CLINIC	0	53, 958	0	53, 958	86	194. 03
194. 06 07956 SURGI CAL PROFESSI ONAL 0 34, 374 1, 644 36, 018 265 194. 06				1				343	194. 04
				0					

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2016 To 12/31/2016		pared:
				12,01,2010	5/23/2017 9: 4	2 am
		CAPI TAL REL	LATED COSTS			
Cook Cooker Boominties	D:+1	DIDC 0 FLVT	MVDLE FOLLID	Culatatal	EMDL OVEE	
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs	1.00	2.00	2.4	4.00	
	0	1. 00	2. 00	2A	4. 00	
194.08 07958 EMPLOYER CLINIC	0	61, 052	15	1 61, 203	133	194. 08
194. 09 07959 UROLOGY PROF	0	26, 576		0 26, 576	18	194. 09
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	445, 384	4, 587, 640	3, 960, 98	9 8, 994, 013	22, 658	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 9:42 am

					5/23/2017 9: 4	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5. 50	7100	0.00	7.00	10100	
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTME						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	898, 224	1 022 224				5.00
7.00 OO7OO OPERATION OF PLANT 8.00 OO8OO LAUNDRY & LINEN SERVICE	50, 670 3, 421	1, 933, 334 8, 050	1			7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	13, 988	l	1			9.00
10. 00 01000 DI ETARY	7, 028	46, 190		1, 551	171, 925	10.00
11. 00 01100 CAFETERI A	4, 725	l	1	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	37, 894	50, 382	0	1, 691	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 940	33, 616	0	1, 128	0	14.00
15. 00 01500 PHARMACY	30, 589	l	1		0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	14, 810	l	i		0	16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	3, 493			0	0	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST C	1, 729	0	0	l O	0	19. 00
30. 00 03000 ADULTS & PEDIATRICS	76, 170	380, 792	15, 547	12, 784	152, 557	30.00
31. 00 03100 NTENSI VE CARE UNI T	15, 110	l	1		19, 368	31.00
43. 00 04300 NURSERY	4, 325	5, 171	649		0	43.00
ANCILLARY SERVICE COST CENTERS			•	'		
50. 00 05000 OPERATING ROOM	56, 105	165, 160	2, 937	5, 544	0	50.00
51.00 05100 RECOVERY ROOM	6, 653	32, 425		.,	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	16, 558	1	1		0	52.00
53. 00 05300 ANESTHESI OLOGY	7, 603	550		18	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	45, 264	165, 845	1	· ' !	0	54.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOS'	3, 675 TLC 1, 666	1	1	224 97	0	54. 01 54. 02
57. 00 05700 CT SCAN	6, 013	7, 871	0	264	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING		1	_	l .	0	58.00
60. 00 06000 LABORATORY	32, 063	l	1	l .	0	60.00
63.00 06300 BLOOD STORING, PROCESSING,			1	l '	0	63.00
64.00 06400 INTRAVENOUS THERAPY	4, 222			880	0	64.00
65. 00 06500 RESPIRATORY THERAPY	13, 480	32, 566	0	1, 093	0	65.00
66. 00 06600 PHYSI CAL THERAPY	14, 460	1	1		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 050	l	1	107	0	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 821	2, 521		85	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO	2, 977	8, 818 0	1	l l	0	69. 00 71. 00
72. 00 07200 IMPLANTABLE DEVICES CHARGE		l e		· ·	0	71.00
PATIENTS	22,220	٥			O	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 380	О	0	O	0	73.00
76.00 03952 WOUND CARE (DIABETES CENTE	R) 2, 892	13, 323	0	447	0	76.00
76. 02 03951 CASE MANAGEMENT	1, 287	13, 605	0	457	0	76. 02
76. 03 03950 PAI N MANAGEMENT	14, 077	34, 390	1		0	76. 03
76. 97 O7697 CARDI AC REHABI LI TATI ON	5, 877	14, 085	0	473	0	76. 97
90. 00 O4950 OTHER OUTPATIENT SERVICE CO	OST CENTED 174	0	0	ol	0	00.00
90. 01 04950 OTHER OUTPATTENT SERVICE C	OST CENTER 176 3, 129			68	0	90. 00 90. 01
90. 02 09000 VEI N CENTER	2, 969			53	0	90.01
90. 03 09001 OB GYN	14, 039			1, 531	0	90. 03
91. 00 09100 EMERGENCY	41, 407	92, 912			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DIST	NCT PART)					92.00
93. 00 04952 BEHAVI ORAL HEALTH	6, 522	7, 961	0	267	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY	17, 780	10, 815	0	363	0	101. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE			1			113. 00
116. 00 11600 HOSPI CE	10, 430	14, 782	1	496	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-			1		171, 925	
NONREI MBURSABLE COST CENTERS	117) 171,720	1, 475, 511	20, 340	+0, 700	171, 723	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN 149	7, 602	0	255	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CE			1			192.00
194. 00 07950 WELLNESS	12		0	0	0	194. 00
194. 02 07952 EXTERNAL SVCS MARKETING	9, 538	12, 351	0			194. 02
194. 03 07953 WASHI NGTON CLI NI C	3, 114	27, 011	0			194. 03
194. 04 07954 PHYSI CI AN OFFI CES	12, 222	29, 226	1	981		194.04
194. 05 07955 I NTEGRATED MEDI CI NE	4, 335					194.05
194. 06 07956 SURGI CAL PROFESSI ONAL 194. 07 07957 PRI MARY CARE	9, 167 12, 436	17, 208 128, 383		0.0		194. 06 194. 07
194. 07 07957 PRI MARY CARE 194. 08 07958 EMPLOYER CLINIC	9, 275		1	l ' l		194.07
194. 09 07959 UROLOGY PROF	2, 503		1			194. 06
200.00 Cross Foot Adjustments	2, 303	15, 304		'47	O	200.00
201.00 Negative Cost Centers	О	О	0	o	0	201. 00
	· · · · · · · · · · · · · · · · · · ·			<u>'</u>		·

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0065	Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/23/2017 9: 4	2 am
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE	E		
	5. 00	7. 00	8. 00	9. 00	10.00	
202.00 TOTAL (sum lines 118-201)	898, 224	1, 933, 334	28, 54	8 58, 480	171, 925	202. 00

			10) 12/31/2010	Date/lime Pre 5/23/2017 9:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O N	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	4 005					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	4, 895 260	267, 010				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	94	207, 010	153, 554			14.00
15. 00 01500 PHARMACY	119	11, 438	167	232, 907		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	173	0	196	0	57, 198	16.00
18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	26	0	21	0	0	18.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS I NPATIENT ROUTINE SERVICE COST CENTERS	18	0	0	0]	0	19. 00
30. 00 03000 ADULTS & PEDIATRICS	680	65, 428	1, 064	0	2, 200	30.00
31. 00 03100 INTENSIVE CARE UNIT	132	12, 647	114	0	316	31.00
43. 00 04300 NURSERY	42	4, 038	0	0	257	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	200	27 447	2 210	ما	10 171	FO 00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	380 55	36, 447 0	2, 218 29	0	13, 171 1, 223	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	161	15, 420	0	ő	1, 266	52.00
53. 00 05300 ANESTHESI OLOGY	63	0	68	0	926	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	270	25, 906	300	0	3, 398	54.00
54. 01 03630 ULTRA SOUND	25	0	12	0	721	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57. 00 05700 CT SCAN	8 31	0	42 27	0	330 6, 339	54. 02 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21	0	2	0	1, 978	58.00
60. 00 06000 LABORATORY	278	25, 601	377	0	9, 272	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	141	63.00
64. 00 06400 I NTRAVENOUS THERAPY	33	0	27	0	225	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	145 144	0 13, 861	109 42	0	1, 124 771	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	35	13, 601	13	0	371	67.00
68. 00 06800 SPEECH PATHOLOGY	24	0	10	Ö	105	68.00
69. 00 06900 ELECTROCARDI OLOGY	15	1, 394	33	0	1, 260	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	115, 031	0	1, 549	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	31, 867	0	971	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	o	232, 907	3, 530	73. 00
76.00 03952 WOUND CARE (DIABETES CENTER)	24	0	33	0	125	76.00
76. 02 03951 CASE MANAGEMENT	21	0	27	0	30	76. 02
76. 03 03950 PALN MANAGEMENT	99	0	36	0	551	76.03
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	53	0	31	0	49	76. 97
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER	1	0	1	0	7	90.00
90. 01 04951 PALLI ATI VE HEALTH	22	0	8	0	71	90. 01
90. 02 09000 VEIN CENTER	29	0	31	0	366	90. 02
90. 03 09001 0B GYN	136	0	256	0	357	90.03
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	422	40, 561	297	U	3, 220	91. 00 92. 00
93. 00 04952 BEHAVI ORAL HEALTH	32	0	14	0	67	93.00
OTHER REIMBURSABLE COST CENTERS	02	<u> </u>	• • •	<u> </u>	<u> </u>	70.00
101.00 10100 HOME HEALTH AGENCY	149	14, 269	84	0	487	101.00
SPECIAL PURPOSE COST CENTERS	T T					
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE	84	0	45	0	121	113. 00 116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	4, 304	267, 010	152, 632	232, 907	57, 198	
NONREI MBURSABLE COST CENTERS	1,700.1	207,010	1027 002	202, 707	3,71,70	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	237	0	119	0		192.00
194.00 07950 WELLNESS 194.02 07952 EXTERNAL SVCS MARKETING	0 25	0	0	0		194. 00 194. 02
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON CLINIC	53	0	118 0	n		194. 02
194. 04 07954 PHYSI CI AN OFFI CES	78	Ö	62	Ö		194. 04
194. 05 07955 I NTEGRATED MEDICINE	23	0	114	O	0	194. 05
194. 06 07956 SURGI CAL PROFESSI ONAL	36	0	12	0		194.06
194. 07 07957 PRIMARY CARE	92	0	118	0		194. 07
194. 08 07958 EMPLOYER CLINIC 194. 09 07959 UROLOGY PROF	47 O	O	325 54	O O		194. 08 194. 09
200.00 Cross Foot Adjustments			34			200.00
1 1 9 1 1	, <u>I</u>				·	

Health Fina	ncial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
					From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	pared.
						5/23/2017 9: 4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
201. 00	Negative Cost Centers	0	0	(0	0	201.00
202. 00	TOTAL (sum lines 118-201)	4, 895	267, 010	153, 554	4 232, 907	57, 198	202. 00

Provider CCN: 15-0065 ALLOCATION OF CAPITAL RELATED COSTS Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 5/23/2017 9:42 am OTHER GENERAL SERVI CE Cost Center Description PHYSI CI AN NONPHYSI CI AN Subtotal Intern & Total PRI VATE **ANESTHETLSTS** Residents PRACTI CE Cost & Post Stepdown Adjustments 18. 00 19. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01850 PHYSICIAN PRIVATE PRACTICE 18.00 18.00 3.653 01900 NONPHYSICIAN ANESTHETISTS 2, 013 19.00 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 1, 714, 152 1, 714, 152 30.00 03100 INTENSIVE CARE UNIT 0 276, 975 31 00 0 31 00 276, 975 04300 NURSERY 25, 123 25, 123 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 239, 114 0 1, 239, 114 50.00 05100 RECOVERY ROOM 0000000000000000000 111, 822 0 111, 822 51 00 51 00 05200 DELIVERY ROOM & LABOR ROOM o 52.00 148, 879 148, 879 52.00 05300 ANESTHESI OLOGY 48, 474 0 53.00 48, 474 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 922, 648 922, 648 54.00 54.00 03630 ULTRA SOUND 42.375 42, 375 54.01 54 01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 10, 925 10, 925 54.02 57 00 05700 CT SCAN 48,088 48,088 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 27, 359 0 27, 359 58.00 06000 LABORATORY 369, 529 369, 529 60 00 60 00 06300 BLOOD STORING, PROCESSING, & TRANS. 13, 302 13, 302 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 131, 318 0 0 131, 318 64.00 06500 RESPIRATORY THERAPY 144.330 65.00 144, 330 65.00 06600 PHYSI CAL THERAPY 66.00 290, 833 290, 833 66.00 67.00 06700 OCCUPATIONAL THERAPY 14, 328 0 0 14, 328 67.00 68.00 06800 SPEECH PATHOLOGY 11, 408 11, 408 68.00 06900 ELECTROCARDI OLOGY 69 00 71.583 71.583 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 196, 806 196, 806 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 55,058 0 55,058 72.00 PATI ENTS 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 309, 817 309, 817 73 00 76.00 03952 WOUND CARE (DIABETES CENTER) 64,770 0 64,770 76.00 03951 CASE MANAGEMENT 0 42, 995 0 42, 995 76.02 76.02 03950 PAIN MANAGEMENT 0 ol 76.03 124, 750 124, 750 76.03 07697 CARDIAC REHABILITATION 53, 932 76.97 0 53, 932 0 76.97 OUTPATIENT SERVICE COST CENTERS 04950 OTHER OUTPATIENT SERVICE COST CENTER 194 0 194 90.00 04951 PALLIATIVE HEALTH 101 9. 541 0 9. 541 90 01 90 01 90.02 09000 VEIN CENTER 136 12, 215 0 12, 215 90.02 90.03 09001 OB GYN 253, 793 0 253, 793 627 90.03 0 91.00 09100 EMERGENCY 0 390, 276 390, 276 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 0 92 00 93.00 04952 BEHAVI ORAL HEALTH 43,846 43, 846 93.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 67, 316 101. 00 67, 316 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 123, 007 116. 00 0 123,007 0 SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 118.00 869 7, 410, 881 7, 410, 881 118. 00 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 23, 192 190. 00 23, 192 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,096 619, 884 0 619, 884 192.00 194. 00 07950 WELLNESS 12 194.00 0 0 12 194. 02 07952 EXTERNAL SVCS MARKETING 47, 996 0 117 47, 996 194. 02 194. 03 07953 WASHINGTON CLINIC 246 85, 375 0 85, 375 194. 03 194. 04 07954 PHYSICIAN OFFICES 107, 339 o 107, 339 194. 04 361 76, 441 194. 05 194.05 07955 INTEGRATED MEDICINE o 76, 441 108 194. 06 07956 SURGI CAL PROFESSI ONAL 164 63, 448 63, 448 194. 06

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2016	Worksheet B Part II	
				To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
	OTHER GENERAL					
Cost Center Description	SERVI CE PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total	
	PRI VATE PRACTI CE	ANESTHETI STS		Residents Cost & Post		
				Stepdown Adjustments		
	18. 00	19. 00	24.00	25. 00	26.00	
194. 07 07957 PRI MARY CARE	423		411, 68	9 0	411, 689	194. 07
194.08 07958 EMPLOYER CLINIC	217		102, 78	9 0	102, 789	194. 08
194. 09 07959 UROLOGY PROF	52		42, 95	4 0	42, 954	194. 09
200.00 Cross Foot Adjustments		2, 013	2, 01	3 0	2, 013	200. 00
201.00 Negative Cost Centers	0	0		0	0	201.00
202.00 TOTAL (sum lines 118-201)	3, 653	2, 013	8, 994, 01	3 0	8, 994, 013	202.00

	Financial Systems	SCHNECK MEDIC				u of Form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provider CO	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre	
		0.451.741.551	1750 00070			5/23/2017 9: 4	2 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2. 00	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	358, 882					1.00
2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 18. 00 19. 00	00200 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 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	1, 713 34, 447 20, 606 1, 258 1, 882 7, 218 0 7, 873 5, 253 2, 837 1, 848 0	7, 943, 163 1, 525 881, 216 3, 216, 376 1, 960 5, 243 37, 525 0 150, 796 89, 137 270, 876 11, 553 0	286, 623 407, 864 2, 264, 318 421, 599 1, 168, 848 987, 716 270, 246 637, 684	-17, 118, 968 0 0 0 0 0 0 0 0 0	5, 157, 735 348, 267 1, 423, 885 715, 385 480, 945 3, 857, 311 706, 463 3, 113, 723 1, 507, 568 355, 568 176, 007	2.00 4.00 5.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 18.00
30.00	03000 ADULTS & PEDIATRICS	59, 505	479, 088	4, 780, 629			
31.00	03100 INTENSIVE CARE UNIT	5, 856	219, 210	986, 243			1
43. 00	04300 NURSERY	808	0	330, 396	0	440, 206	43.00
50. 00 51. 00 52. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	25, 809 5, 067 5, 914	919, 875 10, 791 0	2, 648, 697 470, 974 1, 261, 604	0	677, 225	51.00
53.00	05300 ANESTHESI OLOGY	86	74, 624	2, 243, 290		773, 955	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 916	684, 404	2, 611, 662			1
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 042 452	35, 354 155	240, 813 84, 627		374, 116 169, 616	1
57. 00	05700 CT SCAN	1, 230	23, 490	253, 225		612, 057	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	867	9, 221	179, 495		393, 711	1
60.00	06000 LABORATORY	5, 661	119, 232 0	1, 506, 278			
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	527 4, 096	94, 760	250, 844		299, 215 429, 776	
65.00	06500 RESPI RATORY THERAPY	5, 089	51, 626	997, 419		1, 372, 197	1
66.00	06600 PHYSI CAL THERAPY	12, 660	28, 415	989, 027		1, 471, 861	
67.00	06700 OCCUPATI ONAL THERAPY	497	179	311, 535		412, 262	•
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	394 1, 378	1, 433 73, 020	215, 764 112, 024		287, 204 303, 059	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 370	73,020	112, 024			1
	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	0			
	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	7, 469, 422	•
76. 00 76. 02	03952 WOUND CARE (DIABETES CENTER) 03951 CASE MANAGEMENT	2, 082 2, 126	613 490	181, 381 351, 763		294, 344 130, 989	•
76. 02	03950 PAIN MANAGEMENT	5, 374	10, 515	1, 206, 231			1
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 201	10, 124	430, 510	0	598, 250	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		0	0.040		17 075	00.00
90. 00 90. 01	04950 OTHER OUTPATIENT SERVICE COST CENTER 04951 PALLIATIVE HEALTH	0 315	0	9, 940 237, 277			1
90. 02	09000 VEIN CENTER	249	7, 402	392, 254		302, 269	90. 02
90. 03	09001 OB GYN	7, 128	198, 941	2, 181, 505			
91.00	09100 EMERGENCY	14, 519	37, 025	4, 199, 666	0	4, 214, 881	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	1, 244	25, 822	488, 936	0	663, 892	92. 00 93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	1, 244	25, 022	400, 730	0	003, 072	73.00
101.00	10100 HOME HEALTH AGENCY	1, 690	1, 840	1, 285, 226	0	1, 809, 843	101.00
440.00	SPECIAL PURPOSE COST CENTERS	T			Ī		140.00
	11300 INTEREST EXPENSE 11600 HOSPICE	2, 310	0	670, 624	0	1, 061, 642	113.00
118.00		287, 027	7, 783, 856				
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	100.050	2 000 547			190.00
	19200 PHYSICIANS'PRIVATE OFFICES 07950 WELLNESS	26, 743 0	120, 953 0	2, 989, 567 0			194.00
	07952 EXTERNAL SVCS MARKETING	1, 930	1, 364	195, 019	_		•
	07953 WASHINGTON CLINIC	4, 221	0	206, 152		317, 010	
	07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE	4, 567 3, 600	11, 160 3, 827	822, 885 293, 882		1, 244, 105 441, 251	
	07955 INTEGRATED MEDICINE 07956 SURGI CAL PROFESSI ONAL	2, 689	3, 627 3, 297				
	· · · · ·	, , , , , , , ,		.,	-		•

Health Finar	cial Systems	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1		
					From 01/01/2016 To 12/31/2016			
		CAPI TAL REL	ATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliatio n	ADMINISTRATIV E & GENERAL		
		reel)	VALUE)	(GROSS SALARI ES)		(ACCUM. COST)		
		1. 00	2.00	4. 00	5A	5. 00		
194. 07 07957	PRIMARY CARE	20, 062	18, 404	706, 280	0	1, 265, 884	194. 07	
194. 08 07958	EMPLOYER CLINIC	4, 776	302	317, 87 ⁻	1 0	944, 120	194. 08	
194. 09 07959	UROLOGY PROF	2, 079	0	42, 98	6 0	254, 769	194. 09	
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)	4, 587, 640	3, 960, 989	15, 002, 45	6	17, 118, 968		
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 783143	0. 498666	0. 276010	o	0. 187236	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			22, 658	8	898, 224	204. 00	
205 00	Unit and multiplian (What D. Dant	1		0 00044	-	0 000004	205 00	

0.000417

0. 009824 205. 00

Unit cost multiplier (Wkst. B, Part

205.00

	Financial Systems	SCHNECK MEDI				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre	
				'	0 12/31/2010	5/23/2017 9: 4	
	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) 7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 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	302, 116	404 400				7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	1, 258	481, 690	272 222			8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 882 7, 218	2, 694	272, 233 7, 218			9.00
11. 00	01100 CAFETERI A	7,210	0	7,210		1, 232, 956	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	7, 873	0	7, 873	_	65, 564	1
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 253	0	5, 253		23, 684	
15.00	01500 PHARMACY	2, 837	0	2, 837	0	30, 004	15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 848	0	1, 848		43, 656	1
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE	0	0	C		6, 458	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	4, 479	19.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	59, 505	262, 323	59, 505	30, 294	171, 627	30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 856	23, 396			33, 174	1
43. 00	04300 NURSERY	808	10, 956			10, 593	1
	ANCILLARY SERVICE COST CENTERS	1	·			·	1
50.00	05000 OPERATING ROOM	25, 809	49, 560	25, 809		95, 605	•
51.00	05100 RECOVERY ROOM	5, 067	0	5, 067		13, 860	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 914	3, 918			40, 449	•
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	86	U 41 027	86		15, 758	•
54. 00	03630 ULTRA SOUND	25, 916 1, 042	41, 037	25, 916 1, 042		67, 955 6, 315	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	452	0	452	_	2, 054	1
57. 00	05700 CT SCAN	1, 230	0	1, 230		7, 758	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	867	0	867		5, 332	1
60.00	06000 LABORATORY	5, 661	0	5, 661	0	69, 980	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	527	0	527		0	
64.00	06400 I NTRAVENOUS THERAPY	4, 096	0	4, 096		8, 230	1
65.00	06500 RESPI RATORY THERAPY	5, 089	0	5, 089		36, 495	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 0CCUPATI ONAL THERAPY	12, 660 497	23, 674	12, 660 497		36, 360 8, 762	1
68. 00	06800 SPEECH PATHOLOGY	394	0	394		5, 702 5, 990	1
69. 00	06900 ELECTROCARDI OLOGY	1, 378	21, 515			3, 656	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	o	0	1
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	C	o	0	72.00
	PATI ENTS						
	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER)	2, 082	0	2 000			73.00
	03951 CASE MANAGEMENT	2, 126	_	2, 082 2, 126		-,	76. 00 76. 02
	03950 PAIN MANAGEMENT	5, 374	0	1		24, 849	1
	07697 CARDI AC REHABI LI TATI ON	2, 201	0				
	OUTPATIENT SERVICE COST CENTERS						
	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C		267	
90. 01	04951 PALLI ATI VE HEALTH	315				· ·	
90. 02	09000 VEIN CENTER 09001 0B GYN	249 7, 128		249 7, 128		7, 415 34, 192	1
90.03	09100 EMERGENCY	14, 519	42, 617			106, 397	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 517	42,017	14, 517		100, 377	92.00
	04952 BEHAVI ORAL HEALTH	1, 244	0	1, 244	o	8, 148	93.00
	OTHER REIMBURSABLE COST CENTERS						
101. 00	10100 HOME HEALTH AGENCY	1, 690	0	1, 690	0	37, 429	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						112 00
	11600 HOSPI CE	2, 310	0	2, 310	o	21 083	113. 00 116. 00
118. 00		230, 261	481, 690				
	NONREI MBURSABLE COST CENTERS		·				1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	0	1, 188			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	26, 743	0	C			192.00
	07950 WELLNESS 07952 EXTERNAL SVCS MARKETING	1 020	0	1 020	1 -1		194.00
	07952 WASHINGTON CLINIC	1, 930 4, 221	0	1, 930 4, 221			194. 02 194. 03
	07954 PHYSICIAN OFFICES	4, 221	n	4, 567			194. 03
	07955 I NTEGRATED MEDICINE	3, 600	0	3, 600			194. 05
194. 06	07956 SURGI CAL PROFESSI ONAL	2, 689	0	2, 689		8, 963	194. 06
	07957 PRI MARY CARE	20, 062	0	20, 062			194. 07
	07958 EMPLOYER CLINIC	4, 776	0	4, 776			194. 08
194. 09	07959 UROLOGY PROF	2, 079	0	2, 079) 0	0	194. 09

Health Fin	ancial Systems	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOC	TATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVI CE)	
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	6, 123, 449	438, 973	1, 731, 08	8 1, 041, 527	570, 995	202. 00
202.00	Part I)	20 2/052/	0.011010	/ 25004	20 507520	0.4/0111	202 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	20. 268536					
204. 00	Cost to be allocated (per Wkst. B, Part II)	1, 933, 334	28, 548	58, 48	0 171, 925	4, 895	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	6. 399310	0. 059266	0. 21481	5. 035882	0. 003970	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems SCHNECK MEDICAL CENTER COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0065 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 9:42 am OTHER GENERAL SERVI CE Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL PHYSI CI AN ADMI NI STRATI O SERVICES & (COSTED RECORDS & PRI VATE SUPPLY REQUIS.) LI BRARY PRACTI CE Ν (DI RECT (COSTED (GROSS (TIME NRSING HRS) REQUIS.) CHARGES) SPENT) 13. 00 14. 00 15.00 16. 00 18.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 700, 405 13.00 01400 CENTRAL SERVICES & SUPPLY 10, 898, 946 14 00 14 00 Ω 15.00 01500 PHARMACY 30,004 11,867 100 15.00 01600 MEDICAL RECORDS & LIBRARY 13, 945 296, 642, 858 16.00 0 16.00 01850 PHYSICIAN PRIVATE PRACTICE 18.00 199, 197 18.00 0 1,508 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 Ω 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 171, 627 75, 518 11, 396, 579 0 30.00 03100 INTENSIVE CARE UNIT 0 1, 636, 313 8,089 31 00 33, 174 0 31.00 04300 NURSERY 43.00 10, 593 0 1, 333, 366 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 95, 605 157, 399 0 68, 539, 416 0 50.00 05100 RECOVERY ROOM 0 6, 339, 196 51.00 51 00 2,030 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 40, 449 6, 557, 780 0 52.00 05300 ANESTHESI OLOGY 4,841 0 4, 796, 294 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 21, 297 17, 606, 466 54.00 67.955 0 54.00 03630 ULTRA SOUND 0 3, 734, 207 54.01 867 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 3,011 0 1, 707, 298 0 54.02 0 32, 843, 409 57 00 05700 CT SCAN 0 1, 913 57.00 10, 250, 711 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 140 0 0 58.00 0 0 06000 LABORATORY 60 00 67.156 26, 776 48, 039, 335 0 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 728, 590 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 1, 943 1, 165, 651 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 7,727 5, 824, 026 65.00 0 0 06600 PHYSI CAL THERAPY 66.00 36, 360 2, 957 3, 993, 289 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 939 1, 922, 631 0 67.00 68.00 06800 SPEECH PATHOLOGY 543, 578 68.00 0 676 06900 ELECTROCARDI OLOGY 2, 315 0 6, 528, 372 69.00 69 00 3,656 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 8, 164, 659 0 8,024,704 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 2, 261, 826 5, 032, 392 0 72.00 PATI ENTS 07300 DRUGS CHARGED TO PATIENTS 100 18, 289, 381 73 00 0 Ω 73 00 76.00 03952 WOUND CARE (DIABETES CENTER) 0 2, 361 0 647, 332 0 76.00 03951 CASE MANAGEMENT 0 1, 924 0 155, 570 0 76.02 76.02 0 76.03 03950 PAIN MANAGEMENT 2, 545 0 2, 855, 113 0 76.03 07697 CARDIAC REHABILITATION O 76.97 2, 211 252, 184 Ω 76.97 OUTPATIENT SERVICE COST CENTERS 04950 OTHER OUTPATIENT SERVICE COST CENTER 0 39 34, 448 267 90.00 04951 PALLIATIVE HEALTH 0 0 90 01 540 367, 812 5, 519 90 01 90.02 09000 VEIN CENTER 0 2, 223 0 1.897.921 7, 415 90.02 09001 OB GYN 0 1, 848, 264 34, 192 90.03 90.03 0 18, 146 91.00 09100 EMERGENCY 106, 397 21.052 0 16, 682, 286 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 93.00 04952 BEHAVI ORAL HEALTH 1,013 0 349, 525 0 93.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 101. 00 37, 429 5, 994 2, 524, 018 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2, 195, 401 3, 194 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 700, 405 10, 833, 485 100 296, 642, 858 47, 393 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 8, 446 0 59, 758 192.00 194. 00 07950 WELLNESS 0 0 0 0 194, 00 194. 02 07952 EXTERNAL SVCS MARKETING 0 8, 377 0 6, 363 194. 02 0 194. 03 07953 WASHINGTON CLINIC 0 0 13, 407 194. 03 194. 04 07954 PHYSICIAN OFFICES 4, 396 0 o 19, 680 194. 04

0

8, 085

882

0

0

o

5, 881 194. 05

8, 963 194. 06

194.05 07955 INTEGRATED MEDICINE

194. 06 07956 SURGI CAL PROFESSI ONAL

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0065	Period: Worksheet B-1

				Т	o 12/31/2016	Date/Time Pre 5/23/2017 9:4	
						OTHER GENERAL	
						SERVI CE	
Cos	st Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PHYSI CI AN	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	PRI VATE	
		N	SUPPLY	REQUIS.)	LI BRARY	PRACTI CE	
		(DI RECT	(COSTED		(GROSS	(TIME	
		NRSI NG HRS)	REQUI S.)		CHARGES)	SPENT)	
		13. 00	14. 00	15. 00	16. 00	18. 00	
194. 07 07957 PR	MARY CARE	0	8, 367	0	0	23, 081	194. 07
194. 08 07958 EM	IPLOYER CLINIC	0	23, 074	0	0	11, 847	194. 08
194. 09 07959 UR	OLOGY PROF	0	3, 834	0	0	2, 824	194. 09
200. 00 Cr	ross Foot Adjustments						200. 00
201. 00 Ne	egative Cost Centers						201.00
	ost to be allocated (per Wkst. B,	4, 819, 538	989, 580	3, 993, 698	1, 860, 530	425, 271	202. 00
	irt I)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.000704		0.004070	0 404007	
1 1	it cost multiplier (Wkst. B, Part I)	6. 881073		39, 936. 980000			
	est to be allocated (per Wkst. B,	267, 010	153, 554	232, 907	57, 198	3, 653	204. 00
	rt II)						
	it cost multiplier (Wkst. B, Part	0. 381222	0. 014089	2, 329. 070000	0. 000193	0. 018339	205. 00
)						

Health FinancialSystemsSCHNECK MEDICAL CENTERIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-0065Period:Worksheet B-1

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 9:42 am Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16,00 01850 PHYSICIAN PRIVATE PRACTICE 18.00 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 100 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53 00 05300 ANESTHESI OLOGY 100 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 54.01 03630 ULTRA SOUND 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 00000000000 54.02 57.00 05700 CT SCAN 57.00 58. 00 | 05800 | MAGNETIC RESONANCE I MAGING (MRI) 58.00 06000 LABORATORY 60.00 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63 00 63 00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67 00 06700 OCCUPATI ONAL THERAPY 67 00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPLANTABLE DEVICES CHARGED TO 72.00 72.00 PATI ENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 76.00 03952 WOUND CARE (DIABETES CENTER) 76.00 03951 CASE MANAGEMENT 76.02 76.02 0 76.03 03950 PAIN MANAGEMENT 76.03 76.97 07697 CARDIAC REHABILITATION 0 76.97 OUTPATIENT SERVICE COST CENTERS 04950 OTHER OUTPATIENT SERVICE COST CENTER 90 00 0 90 00 90.01 04951 PALLI ATI VE HEALTH 0 90.01 09000 VEIN CENTER 90.02 0 90.02 09001 OB GYN 90.03 90.03 09100 EMERGENCY 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 04952 BEHAVI ORAL HEALTH 93.00 0 93.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 100 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 WELLNESS 194.00 0000000 194. 02 07952 EXTERNAL SVCS MARKETING 194. 02 194. 03 07953 WASHINGTON CLINIC 194 03 194. 04 07954 PHYSICIAN OFFICES 194.04 194.05 07955 INTEGRATED MEDICINE 194.05 194. 06 07956 SURGI CAL PROFESSI ONAL 194.06 194. 07 07957 PRI MARY CARE 194.07 194. 08 07958 EMPLOYER CLINIC 194.08 194. 09 194. 09 07959 UROLOGY PROF

Health Financial Systems		SCHNECK MEDIC	CAL CENTER	In Lieu of Form CMS-2552-10		
COST AL	LOCATION - STATISTICAL BASIS		Provider CCN: 15-0065	Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prepared: 5/23/2017 9:42 am	
	Cost Center Description	NONPHYSI CI AN				
		ANESTHETI STS				
		(ASSI GNED				
		TIME)				
		19. 00				
200.00	Cross Foot Adjustments				200.00	
201.00	Negative Cost Centers				201.00	
202.00	Cost to be allocated (per Wkst. B,	211, 036			202. 00	
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	2, 110. 360000			203. 00	
204.00	Cost to be allocated (per Wkst. B,	2, 013			204. 00	
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	20. 130000			205. 00	
	11)					

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

					To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	13, 291, 668		13, 291, 66	8 0	13, 291, 668	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 375, 222		2, 375, 22	2 0	2, 375, 222	31.00
43.00	04300 NURSERY	640, 287		640, 28	7 0	640, 287	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 659, 014		8, 659, 01	4 0	8, 659, 014	50.00
	05100 RECOVERY ROOM	985, 309		985, 30	9 0	985, 309	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 500, 230		2, 500, 23	0	2, 500, 230	52.00
53.00	05300 ANESTHESI OLOGY	1, 170, 013		1, 170, 01	3 0	1, 170, 013	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 809, 053		6, 809, 05	3 135, 846	6, 944, 899	54.00
54. 01	03630 ULTRA SOUND	498, 335		498, 33	5 0	498, 335	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	225, 341		225, 34	1 0	225, 341	54.02
57.00	05700 CT SCAN	969, 168		969, 16	8 0	969, 168	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	557, 288		557, 28	8 0	557, 288	58. 00
60.00	06000 LABORATORY	4, 823, 872		4, 823, 87	2 52, 970	4, 876, 842	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	373, 842		373, 84	2 0	373, 842	63.00
64. 00	06400 INTRAVENOUS THERAPY	630, 610		630, 61	o o	630, 610	64.00
65.00	06500 RESPI RATORY THERAPY	1, 818, 760	0	1, 818, 76	o o	1, 818, 760	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 398, 473	0	2, 398, 47	3 0	2, 398, 473	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	518, 887	0	518, 88	7 ol	518, 887	67. 00
68. 00	06800 SPEECH PATHOLOGY	357, 714	0	357, 71	4 0	357, 714	68. 00
69. 00	06900 ELECTROCARDI OLOGY	484, 108		484, 10	1, 679	485, 787	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 485, 020		10, 485, 02	o	10, 485, 020	71.00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO	2, 922, 249		2, 922, 24	9 0	2, 922, 249	72.00
	PATI ENTS						
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 976, 376		12, 976, 37	6 0	12, 976, 376	73. 00
76. 00	03952 WOUND CARE (DIABETES CENTER)	411, 998		411, 99	8 0	411, 998	76. 00
76. 02	03951 CASE MANAGEMENT	215, 778		215, 77	8 0	215, 778	76. 02
76. 03	03950 PAIN MANAGEMENT	1, 873, 916		1, 873, 91	6 0	1, 873, 916	76. 03
76. 97	07697 CARDIAC REHABILITATION	776, 844		776, 84	4 0	776, 844	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	04950 OTHER OUTPATIENT SERVICE COST CENTER	22, 136		22, 13		22, 136	90.00
	04951 PALLI ATI VE HEALTH	403, 177		403, 17		403, 177	90. 01
	09000 VEIN CENTER	396, 865		396, 86		396, 865	
	09001 OB GYN	1, 988, 526		1, 988, 52	6 0	1, 988, 526	
	09100 EMERGENCY	6, 317, 441		6, 317, 44		6, 317, 441	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 297, 710		2, 297, 71	0	2, 297, 710	92.00
	04952 BEHAVI ORAL HEALTH	827, 377		827, 37	7 0	827, 377	93.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	2, 484, 972		2, 484, 97	2	2, 484, 972	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE	1 045					113.00
	11600 HOSPI CE	1, 345, 753	_	1, 345, 75		1, 345, 753	
200.00	Subtotal (see instructions)	95, 833, 332	0				
201.00	Less Observation Beds	2, 297, 710	_	2, 297, 71		2, 297, 710	
202. 00	Total (see instructions)	93, 535, 622	0	93, 535, 62	2 190, 495	93, 726, 117	J202. 00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0065	Peri od: From 01/01/2016	Worksheet C
		From 01/01/2016	

					To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
	LARDATI ENT. DOUTLAGE CERVILOE COCT. OFFITERS	6. 00	7. 00	8. 00	9. 00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.704.200		0.704.00			30.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	9, 794, 299 1, 636, 313		9, 794, 29			30.00
43. 00	04300 NURSERY	1, 333, 366		1, 636, 31 1, 333, 36			43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 333, 300		1, 333, 30	o _l		43.00
50. 00	05000 OPERATI NG ROOM	13, 228, 951	55, 310, 465	68, 539, 41	6 0. 126336	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	933, 716	5, 405, 480			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 220, 383	337, 397			0. 000000	
53. 00	05300 ANESTHESI OLOGY	998, 518	3, 797, 776			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	898, 378	16, 708, 088			0. 000000	
54. 01	03630 ULTRA SOUND	259, 863	3, 474, 344			0.000000	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	72, 833	1, 634, 465	1, 707, 29	0. 131987	0.000000	54. 02
57.00	05700 CT SCAN	2, 710, 580	30, 132, 829			0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	624, 942	9, 625, 769			0.000000	58.00
60.00	06000 LABORATORY	8, 242, 006	39, 797, 329	48, 039, 33	0. 100415	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	392, 513	336, 077	728, 59	0. 513103	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	194, 778	970, 873	1, 165, 65	0. 540994	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	3, 719, 748	2, 104, 278	5, 824, 02	6 0. 312286	0.000000	65.00
66. 00	06600 PHYSI CAL THERAPY	569, 286	3, 424, 003	3, 993, 28	9 0. 600626	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	411, 071	1, 511, 560	1, 922, 63	0. 269884	0.000000	
68. 00	06800 SPEECH PATHOLOGY	58, 763	484, 815			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	832, 190	5, 696, 182			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 295, 730	5, 728, 974			0. 000000	
72. 00	O7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2, 173, 137	2, 859, 255	5, 032, 39	0. 580688	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 382, 425	13, 906, 956			0. 000000	
76.00	03952 WOUND CARE (DIABETES CENTER)	32, 305	615, 027			0. 000000	
76. 02	03951 CASE MANAGEMENT	5, 764	149, 806			0. 000000	1
76. 03	03950 PAIN MANAGEMENT	341	2, 854, 772			0. 000000	1
76. 97	07697 CARDI AC REHABI LI TATI ON	246	251, 938	252, 18	4 3. 080465	0. 000000	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		24 440	04.44	0 (40500	0.00000	00.00
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	101 000	34, 448			0.000000	1
90. 01 90. 02	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	101, 000	266, 812 1, 897, 921			0. 000000 0. 000000	
90. 02	09000 VETN CENTER	0	1, 848, 264			0. 000000	
90.03	09100 EMERGENCY	1, 275, 740	15, 406, 546			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	79, 425	1, 522, 855			0. 000000	1
93. 00	04952 BEHAVI ORAL HEALTH	77, 423	349, 525			0. 000000	1
73.00	OTHER REIMBURSABLE COST CENTERS	0	347, 323	347, 32	2. 307 147	0.000000	73.00
101 00	10100 HOME HEALTH AGENCY	0	2, 524, 018	2, 524, 01	8		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	2, 02 1, 010	2,021,01	<u> </u>		101.00
113 00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	2, 195, 401	2, 195, 40	1		116.00
200.00		63, 478, 610	233, 164, 248				200.00
201.00		,, 0	22, 22, 210	,, 00			201.00
202.00	1 · · · · · · · · · · · · · · · · · · ·	63, 478, 610	233, 164, 248	296, 642, 85	8		202.00
				•			•

Heal th Financial Systems SCHNECK MEDICAL CENTER In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065
Period: From 01/01/2016
To 12/31/2016
Part I
To 12/31/2016
To 2/31/2017
9: 42 am

					5/23/2017 9: 42	am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT				l l	31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 126336			!	50.00
51.00	05100 RECOVERY ROOM	0. 155431			!	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 381262			!	52.00
53.00	05300 ANESTHESI OLOGY	0. 243941			!	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 394452				54.00
54.01	03630 ULTRA SOUND	0. 133451				54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 131987			!	54.02
57.00	05700 CT SCAN	0. 029509			!	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 054366			!	58.00
60.00	06000 LABORATORY	0. 101518				60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 513103			1	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 540994			1	64.00
65.00	06500 RESPIRATORY THERAPY	0. 312286				65.00
66.00		0. 600626			1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 269884				67. 00
	06800 SPEECH PATHOLOGY	0. 658073				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 074412				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 306593				71.00
	07200 IMPLANTABLE DEVICES CHARGED TO	0. 580688			· · · · · · · · · · · · · · · · · · ·	72.00
	PATIENTS					
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 709503				73.00
	03952 WOUND CARE (DIABETES CENTER)	0. 636455				76.00
	03951 CASE MANAGEMENT	1. 387015				76. 02
		0. 656337				76. 03
	07697 CARDI AC REHABI LI TATI ON	3. 080465			l l	76. 97
	OUTPATIENT SERVICE COST CENTERS	3. 333 .33				
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0. 642592				90.00
	04951 PALLI ATI VE HEALTH	1. 096150				90. 01
	09000 VEIN CENTER	0. 209105			ı	90. 02
	09001 OB GYN	1. 075889			· · · · · · · · · · · · · · · · · · ·	90. 03
	09100 EMERGENCY	0. 378692			· · · · · · · · · · · · · · · · · · ·	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 434025			· · · · · · · · · · · · · · · · · · ·	92.00
	04952 BEHAVI ORAL HEALTH	2. 367147				93.00
, 0. 00	OTHER REIMBURSABLE COST CENTERS	2.007147				, 5. 50
101 00	10100 HOME HEALTH AGENCY				11	01.00
101.00	SPECIAL PURPOSE COST CENTERS				11	51.00
113 00	11300 INTEREST EXPENSE				1	13.00
	11600 HOSPI CE					16.00
200.00						200.00
200.00	1 ,					01.00
202.00	l i					02.00
202.00	Total (366 Histi deti olis)	1			J21	.02.00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0065	Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

				To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared: 2 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	13, 291, 668		13, 291, 66	8 0	13, 291, 668	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 375, 222		2, 375, 22		2, 375, 222	
43. 00 04300 NURSERY	640, 287		640, 28		640, 287	
ANCILLARY SERVICE COST CENTERS	2.07.20.		2.27.23	-	2.0, 20.	1
50. 00 05000 OPERATING ROOM	8, 659, 014		8, 659, 01	4 0	8, 659, 014	50.00
51.00 05100 RECOVERY ROOM	985, 309		985, 30	9 0	985, 309	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 500, 230		2, 500, 23	0 0	2, 500, 230	52.00
53. 00 05300 ANESTHESI OLOGY	1, 170, 013		1, 170, 01	3 0	1, 170, 013	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 809, 053		6, 809, 05		6, 944, 899	1
54.01 03630 ULTRA SOUND	498, 335		498, 33		498, 335	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	225, 341		225, 34		225, 341	1
57. 00 05700 CT SCAN	969, 168		969, 16		969, 168	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	557, 288		557, 28		557, 288	1
60. 00 06000 LABORATORY	4, 823, 872		4, 823, 87		4, 876, 842	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	373, 842		373, 84		373, 842	1
64. 00 06400 I NTRAVENOUS THERAPY	630, 610		630, 61		630, 610	1
65. 00 06500 RESPIRATORY THERAPY	1, 818, 760	0			1, 818, 760	1
66. 00 06600 PHYSI CAL THERAPY	2, 398, 473	0			2, 398, 473	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	518, 887	0	,		518, 887	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	357, 714 484, 108	U	357, 71 484, 10		357, 714 485, 787	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 485, 020		10, 485, 02		10, 485, 020	1
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	2, 922, 249		2, 922, 24		2, 922, 249	
PATIENTS	2, 722, 247		2, 722, 24	9	2, 722, 247	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 976, 376		12, 976, 37	6 0	12, 976, 376	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	411, 998		411, 99	8 0	411, 998	76.00
76.02 03951 CASE MANAGEMENT	215, 778		215, 77	8 0	215, 778	76. 02
76.03 03950 PAIN MANAGEMENT	1, 873, 916		1, 873, 91	6 0	1, 873, 916	76. 03
76. 97 O7697 CARDI AC REHABI LI TATI ON	776, 844		776, 84	4 0	776, 844	76. 97
OUTPATIENT SERVICE COST CENTERS						
90.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	22, 136		22, 13		22, 136	1
90. 01 04951 PALLI ATI VE HEALTH	403, 177		403, 17		403, 177	1
90. 02 09000 VEI N CENTER	396, 865		396, 86		396, 865	1
90. 03 09001 0B GYN	1, 988, 526		1, 988, 52		1, 988, 526	
91. 00 09100 EMERGENCY	6, 317, 441		6, 317, 44		6, 317, 441	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 297, 710		2, 297, 71		2, 297, 710	
93. 00 O4952 BEHAVI ORAL HEALTH OTHER REIMBURSABLE COST CENTERS	827, 377		827, 37	7 0	827, 377	93.00
101.00 10100 HOME HEALTH AGENCY	2, 484, 972		2, 484, 97	2	2, 484, 972	101 00
SPECIAL PURPOSE COST CENTERS	2, 404, 972		2, 404, 97	۷	2, 404, 972	101.00
113. 00 11300 NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	1, 345, 753		1, 345, 75	3	1, 345, 753	
200.00 Subtotal (see instructions)	95, 833, 332	0			96, 023, 827	
201.00 Less Observation Beds	2, 297, 710		2, 297, 71	•	2, 297, 710	1
202.00 Total (see instructions)	93, 535, 622				93, 726, 117	
		'	•	,	,	•

					Fo 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared:
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Rati o	I npati ent	
			7.00	0.00	0.00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	9, 794, 299		9, 794, 299			30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 636, 313		1, 636, 313			31.00
43. 00	04300 NURSERY	1, 333, 366		1, 333, 366			43.00
	ANCILLARY SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		
50.00	05000 OPERATING ROOM	13, 228, 951	55, 310, 465	68, 539, 416	0. 126336	0.000000	50.00
51.00	05100 RECOVERY ROOM	933, 716	5, 405, 480	6, 339, 196	0. 155431	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 220, 383	337, 397			0.000000	
53.00	05300 ANESTHESI OLOGY	998, 518	3, 797, 776			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	898, 378	16, 708, 088			0. 000000	
54. 01	03630 ULTRA SOUND	259, 863	3, 474, 344			0.000000	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	72, 833	1, 634, 465			0.000000	
57. 00 58. 00	05700 CT SCAN	2, 710, 580	30, 132, 829			0. 000000 0. 000000	
60.00	05800 MAGNETIC RESONANCE MAGING (MRI) 06000 LABORATORY	624, 942 8, 242, 006	9, 625, 769 39, 797, 329			0.000000	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	392, 513	336, 077			0.000000	
64. 00	06400 I NTRAVENOUS THERAPY	194, 778	970, 873			0. 000000	
65.00	06500 RESPI RATORY THERAPY	3, 719, 748	2, 104, 278			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	569, 286	3, 424, 003			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	411, 071	1, 511, 560			0.000000	
68.00	06800 SPEECH PATHOLOGY	58, 763	484, 815			0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	832, 190	5, 696, 182	6, 528, 372	0. 074154	0.000000	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 295, 730	5, 728, 974			0.000000	
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2, 173, 137	2, 859, 255	5, 032, 392	0. 580688	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 382, 425	13, 906, 956	18, 289, 381	0. 709503	0. 000000	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	32, 305	615, 027			0.000000	
76.02	03951 CASE MANAGEMENT	5, 764	149, 806	155, 570	1. 387015	0.000000	76. 02
76. 03	03950 PAIN MANAGEMENT	341	2, 854, 772			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	246	251, 938	252, 184	3. 080465	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1 04 446	0 (10500	0.00000	
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	34, 448			0.000000	
90. 01 90. 02	04951 PALLIATIVE HEALTH 09000 VEIN CENTER	101, 000	266, 812			0.000000	
90. 02	09000 VETN CENTER	0	1, 897, 921 1, 848, 264			0. 000000 0. 000000	
91.00	09100 EMERGENCY	1, 275, 740	15, 406, 546			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	79, 425	1, 522, 855			0. 000000	
93. 00	04952 BEHAVI ORAL HEALTH	0	349, 525			0. 000000	
70.00	OTHER REIMBURSABLE COST CENTERS	91	0177020	0177020	21007117	0.00000	70.00
101.00	10100 HOME HEALTH AGENCY	0	2, 524, 018	2, 524, 018	3		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 H0SPI CE	0	2, 195, 401				116. 00
200.00	. ,	63, 478, 610	233, 164, 248	296, 642, 858	3		200.00
201.00		(2.470.410	222 4/4 242	20/ /40 05			201.00
202.00	Total (see instructions)	63, 478, 610	233, 164, 248	296, 642, 858	키	Į .	202. 00

Heal th Financial Systems SCHNECK MEDICAL CENTER In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065
Period:
From 01/01/2016
To 12/31/2016
Part I
Date/Time Prepared:
5/23/2017 9: 42 am

INPATIENT ROUTI NE SERVICE COST CENTERS 11.00						5/23/2017 9: 4	<u>42 am</u>
INPATI ENT ROUTINE SERVICE COST CENTERS				Title XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	PPS Inpatient				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS			11. 00				
31.00 03100 INTENSI VE CARE UNIT							
A3.00 04300 NURSERY	30.00						30.00
ANCILLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT					31.00
SO. 00 05000 OPERATI NG ROOM 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	43.00						43.00
51:00 05100 RECOVERY ROOM 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		ANCILLARY SERVICE COST CENTERS					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	50.00	05000 OPERATING ROOM	0. 000000				50.00
53.00 05300 AMESTHESI OLOGY 0.000000 1	51.00	05100 RECOVERY ROOM	0. 000000				51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 01 03630 ULTRA SOUND	53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54. 02	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
57. 00 05700 CT SCAN 0.000000 58.00 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 60.00 0.000000 60.0000000 60.000000 60.0000000 60.0000000000	54.01	03630 ULTRA SOUND	0. 000000				54. 01
57. 00 05700 CT SCAN 0.000000 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	54.02		1				54.02
58. 00	57.00		1				57.00
60.00 06000 LABORATORY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	58. 00		•				58.00
63. 00			•				60.00
64. 00		1					63.00
65. 00		1					64.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67:00 0CCUPATI ONAL THERAPY 0. 000000 68:00 06700 0CCUPATI ONAL THERAPY 0. 000000 68:00 06800 SPEECH PATHOLOGY 0. 000000 69:00 06900 ELECTROCARDI OLOGY 0. 000000 69:00 07:10 000000 100 000000 100 000000 100 000000			•				65.00
67. 00		1	•				66.00
68. 00			•				67.00
69. 00							68.00
71. 00							69.00
72. 00		l l	1				71.00
PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 76. 00 03952 WOUND CARE (DI ABETES CENTER) 0. 000000 76. 02 03951 CASE MANAGEMENT 0. 000000 76. 03 03950 PALN MANAGEMENT 0. 000000 76. 97 07697 CARDIAC REHABILITATION 0. 000000 0UTPATIENT SERVICE COST CENTERS 90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER 0. 000000 90. 01 04951 PALLIATIVE HEALTH 0. 000000 90. 02 09000 VEIN CENTER 0. 000000 90. 03 09001 0B GYN 0. 000000 91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000			1				72.00
73. 00	72.00		0.000000				12.00
76. 00	73 00		0.000000				73.00
76. 02			1				76.00
76. 03			1				76.00
76. 97 07697 CARDI AC REHABILITATION 0.000000 90.000000 90.000000 90.000000 90.000000 90.000000 90.000000 90.000000 90.0000000 90.0000000 90.0000000 90.00000000 90.0000000000		1	1				76. 02
OUTPATIENT SERVICE COST CENTERS O. 000000 O. 0000000 O. 00000000 O. 00000000 O. 0000000 O. 0000000 O. 0000000 O. 00000000 O. 000000000 O. 000000000 O. 00000000 O. 000000000 O. 0000000000			1				76. 03
90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER 0. 0000000 90. 01 04951 PALLIATIVE HEALTH 0. 000000 90. 02 09000 VEIN CENTER 0. 000000 90. 03 09001 0B GYN 0. 000000 0. 000000 91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	70.97		0.000000				10.97
90. 01 04951 PALLI ATI VE HEALTH 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	00 00		0.000000				- 00 00
90. 02 09000 VEIN CENTER 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			•				90.00
90. 03 09001 0B GYN		1	1				90.01
91. 00 09100 EMERGENCY							90.02
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 0000000		1					90.03
		1					91.00
			1				92.00
	93.00		0. 000000				93.00
OTHER REIMBURSABLE COST CENTERS	101 5						104 05
	101.00						101.00
SPECIAL PURPOSE COST CENTERS	440 5						140 05
							113.00
		1					116.00
		,					200.00
		1					201.00
202.00 Total (see instructions)	202.00) Iotal (see instructions)					202.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2016		
				Го 12/31/2016	Date/Time Pre 5/23/2017 9:4	
		Title	XVIII	Hospi tal	PPS	2 4111
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 714, 152	4, 750	1, 709, 40	11, 024	155. 06	30.00
31.00 INTENSIVE CARE UNIT	276, 975		276, 97	5 1, 157	239. 39	31.00
43. 00 NURSERY	25, 123		25, 12	1, 641	15. 31	43.00
200.00 Total (lines 30-199)	2, 016, 250		2, 011, 50	13, 822		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				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 665	568, 295				30.00
31.00 INTENSIVE CARE UNIT	522	124, 962				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	4, 187	693, 257				200. 00

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 15-0065	Peri od:	Worksheet D

Related Cost (from Wkst. to Charges (column 3 x column 4)	
(from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) (col. 2) col. 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 239, 114 68, 539, 416 0.018079 5, 571, 339 100, 724	
B, Part II, col. 8) col. 2) col. 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 239, 114 68, 539, 416 0.018079 5, 571, 339 100, 724	
COI . 26) .	
1. 00 2. 00 3. 00 4. 00 5. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 1, 239, 114 68, 539, 416 0. 018079 5, 571, 339 100, 724	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 1, 239, 114 68, 539, 416 0. 018079 5, 571, 339 100, 724	
50. 00 05000 OPERATI NG ROOM 1, 239, 114 68, 539, 416 0. 018079 5, 571, 339 100, 724	
	50.00
	51. 00
	52.00
	53.00
	54.00
	54. 01
	54. 02
	57. 00
	58. 00
	60.00
	63. 00
	64. 00
65. 00 06500 RESPI RATORY THERAPY 144, 330 5, 824, 026 0. 024782 1, 583, 900 39, 252	65. 00
66. 00 06600 PHYSI CAL THERAPY 290, 833 3, 993, 289 0. 072830 307, 712 22, 411	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 14, 328 1, 922, 631 0. 007452 222, 179 1, 656	67. 00
68. 00 06800 SPEECH PATHOLOGY 11, 408 543, 578 0. 020987 37, 861 795	68. 00
69. 00 06900 ELECTROCARDI OLOGY 71, 583 6, 528, 372 0. 010965 502, 204 5, 507	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 196,806 8,024,704 0.024525 1,112,109 27,274	71. 00
72. 00 07200 IMPLANTABLE DEVI CES CHARGED TO 55, 058 5, 032, 392 0. 010941 906, 847 9, 922	72.00
PATIENTS	
	73. 00
	76. 00
76. 02 03951 CASE MANAGEMENT 42, 995 155, 570 0. 276371 0 0	76. 02
	76. 03
	76. 97
OUTPATIENT SERVICE COST CENTERS	
	90.00
	90. 01
	90. 02
	90. 03
	91. 00
	92.00
	93. 00
200. 00 Total (Lines 50-199) 5, 500, 630 279, 159, 461 20, 941, 284 354, 961 2	JO. 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2016		narad.
				To 12/31/2016	Date/Time Pre 5/23/2017 9:4	epareu: .2 am
		Title	XVIII	Hospi tal	PPS	2 (111)
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adj ustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	Program		
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
	6. 00	7.00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	11, 024	0.00	3, 66	5 0		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 157	0.00	52	2 0		31.00
43. 00 04300 NURSERY	1, 641	0.00		0 0		43.00
200.00 Total (lines 30-199)	13, 822		4, 18	7 0		200. 00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS Provider CCN: 15-0065	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2016 Part IV

					То	12/31/2016	Date/Time Pre 5/23/2017 9:4	
			Title	XVIII		Hospi tal	PPS	2 4111
	Cost Center Description	Non Physician	Nursi ng	Allied Healt	h	All Other	Total Cost	
		Anesthetist	School			Medi cal	(sum of col 1	
		Cost				Educati on	through col.	
						Cost	4)	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00		0	0		0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	03630 ULTRA SOUND	0	0		0	0	0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0	0	0	54.02
		0	0		0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58. 00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	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		0	0		0	0	0	67.00
		0	0		0	0	0	68. 00
69. 00		0	0		0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71. 00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0	0	0	72.00
	PATI ENTS		_		_	_	_	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	03952 WOUND CARE (DIABETES CENTER)	0	0		0	0	0	76. 00
	03951 CASE MANAGEMENT	0	0		0	0	0	76. 02
	03950 PAIN MANAGEMENT	0	0		0	0	0	76. 03
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	0				٥١	0	00 00
	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	90.00
	04951 PALLI ATI VE HEALTH	0	0		0	U	0	90. 01
90. 02	09000 VEIN CENTER	0	0		0	0	0	90. 02
90. 03	09001 OB GYN	0	0		0	O O	0	90.03
	09100 EMERGENCY		0		0	O O	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	O O	0	92. 00 93. 00
	04952 BEHAVI ORAL HEALTH		0		0	O O	0	
200.00	Total (lines 50-199)	ا	0		0	0	0	200. 00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0065	Peri od: Worksheet D From 01/01/2016 Part IV To 12/31/2016 Date/Time Prepared:			

			Т	o 12/31/2016	Date/Time Prepared: 5/23/2017 9:42 am		
				XVIII	Hospi tal	PPS	
Cost Ce	nter Description	Total		Ratio of Cost		I npati ent	
		Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
		4)			col. 7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	RVI CE COST CENTERS	1 0	(0.500.44)			5 574 000	
50. 00 05000 OPERATI		0	68, 539, 416				
51. 00 05100 RECOVER		0	6, 339, 196			385, 005	51.00
	Y ROOM & LABOR ROOM	0	6, 557, 780				52.00
53. 00 05300 ANESTHE		0	4, 796, 294			381, 691	53.00
54. 00 05400 RADI 0L0		0	17, 606, 466			495, 953	54.00
54. 01 03630 ULTRA S		0	3, 734, 207				54. 01
	MEDICINE - DIAGNOSTIC	0	1, 707, 298			51, 149	54.02
57. 00 05700 CT SCAN		0	32, 843, 409			1, 646, 124	57.00
	C RESONANCE IMAGING (MRI)	0	10, 250, 711			350, 609	58.00
60. 00 06000 LABORAT		0	48, 039, 335			4, 301, 585	60.00
	TORING, PROCESSING, & TRANS.	0	728, 590			206, 126	63.00
64. 00 06400 I NTRAVE		0	1, 165, 651			94, 440	64.00
65. 00 06500 RESPI RA		0	5, 824, 026			1, 583, 900	
66. 00 06600 PHYSI CA		0	3, 993, 289			307, 712	66.00
	I ONAL THERAPY	0	1, 922, 631			222, 179	67.00
68. 00 06800 SPEECH		0	543, 578			37, 861	68. 00
69. 00 06900 ELECTRO		0	6, 528, 372			502, 204	69.00
	SUPPLIES CHARGED TO PATIENTS	0	8, 024, 704			1, 112, 109	71.00
72. 00 07200 I MPLANT	ABLE DEVICES CHARGED TO	0	5, 032, 392	0. 000000	0. 000000	906, 847	72.00
73. 00 07300 DRUGS C		0	18, 289, 381	0. 000000	0. 000000	1, 955, 748	73.00
	ARE (DIABETES CENTER)	0	647, 332			15, 604	76.00
76. 02 03951 CASE MA		0	155, 570			0	76. 02
76.03 03950 PAIN MA		o	2, 855, 113			0	76. 03
76. 97 07697 CARDI AC		o	252, 184			246	76. 97
	RVICE COST CENTERS	<u>'</u>	·		'		
90. 00 04950 OTHER 0	UTPATIENT SERVICE COST CENTER	0	34, 448	0.000000	0.000000	0	90.00
90. 01 04951 PALLI AT	I VE HEALTH	o	367, 812	0. 000000	0. 000000	443	90. 01
90. 02 09000 VEIN CE	NTER	o	1, 897, 921	0. 000000	0. 000000	0	90. 02
90. 03 09001 OB GYN		o	1, 848, 264	0. 000000	0. 000000	0	90. 03
91. 00 09100 EMERGEN	CY	0	16, 682, 286	0. 000000	0. 000000	655, 477	91.00
92. 00 09200 OBSERVA	TION BEDS (NON-DISTINCT PART)	o	1, 602, 280		0. 000000	44, 354	92.00
93. 00 04952 BEHAVI 0	RAL HEALTH	0	349, 525	0. 000000	0. 000000	0	93.00
200.00 Total (lines 50-199)	0	279, 159, 461			20, 941, 284	200. 00

Health Financial Systems	SCHNECK MEDICAL CEN	ITER	In Lieu	Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ATTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS Prov		From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/23/2017 9:42 am		

					10	12/31/2016	Date/IIMe Pro 5/23/2017 9:4	eparea: 42 am
				XVIII		Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
		Program	Program	Program				
		Pass-Through	Charges	Pass-Through	h			
		Costs (col. 8		Costs (col.	9			
		x col. 10)		x col. 12)				
		11. 00	12. 00	13.00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	11, 934, 947		0			50.00
51.00	05100 RECOVERY ROOM	0	1, 149, 895		0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0			52.00
53.00	05300 ANESTHESI OLOGY	0	702, 988		0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 693, 158		0			54.00
54. 01	03630 ULTRA SOUND	0	807, 315		0			54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	594, 699		0			54. 02
57.00	05700 CT SCAN	0	7, 001, 233		0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 505, 169		0			58.00
60.00	06000 LABORATORY	0	5, 711, 004		0			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	111, 077		0			63.00
64.00	06400 I NTRAVENOUS THERAPY	0	252, 718		0			64.00
65.00	06500 RESPIRATORY THERAPY	0	285, 904		0			65.00
66.00	06600 PHYSI CAL THERAPY	O	15, 574		0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	O	89, 479		0			67.00
68.00	06800 SPEECH PATHOLOGY	O	2, 191		0			68.00
69.00	06900 ELECTROCARDI OLOGY	O	1, 580, 342		0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	1, 172, 710		0			71.00
72.00		O	586, 558		0			72.00
	PATI ENTS		•					
73.00	07300 DRUGS CHARGED TO PATIENTS	O	4, 626, 692		0			73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	O	315, 794		0			76.00
76. 02	03951 CASE MANAGEMENT	O	0		0			76. 02
76. 03	03950 PAIN MANAGEMENT	O	0		0			76. 03
76. 97	07697 CARDI AC REHABI LI TATI ON	O	108, 855		0			76. 97
	OUTPATIENT SERVICE COST CENTERS							
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	50, 898		0			90.00
90. 01	04951 PALLI ATI VE HEALTH	o	288, 971		0			90. 01
90. 02	09000 VEIN CENTER	o	0	1	0			90. 02
90. 03	09001 OB GYN	O	0		0			90.03
	09100 EMERGENCY	O	2, 380, 207		0			91.00
92.00	1 1	O	359, 868		0			92.00
	04952 BEHAVI ORAL HEALTH	O	92, 864		0			93.00
200.00		0	45, 421, 110	l .	0			200.00
		1		•				•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0065 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/23/2017 9:42 am Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 126336 11, 934, 947 1, 507, 813 50.00 05100 RECOVERY ROOM 0 51.00 0.155431 1, 149, 895 0 51.00 178, 729 05200 DELIVERY ROOM & LABOR ROOM 52.00 0. 381262 0 Λ 52.00 702, 988 53.00 05300 ANESTHESI OLOGY 0. 243941 0 0 171, 488 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.386736 2, 693, 158 0 0 1,041,541 54.00 807, 315 54.01 03630 ULTRA SOUND 0.133451 0 0 107, 737 54 01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.131987 594, 699 0 233 78, 493 54.02 57.00 05700 CT SCAN 0.029509 7,001,233 0 466 206, 599 57.00 2, 505, 169 136, 196 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 75 58.00 0.054366 58.00 06000 LABORATORY 60.00 0.100415 5, 711, 004 1, 200 0 573, 470 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.513103 111,077 0 0 56, 994 63.00 06400 INTRAVENOUS THERAPY 0 64.00 0.540994 252, 718 0 136, 719 64.00 0 06500 RESPIRATORY THERAPY 89, 284 65 00 0.312286 285 904 0 65 00 66.00 06600 PHYSI CAL THERAPY 0.600626 15, 574 0 0 9, 354 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 269884 89, 479 0 0 24, 149 67.00 68.00 06800 SPEECH PATHOLOGY 0.658073 2, 191 0 0 1, 442 68.00 06900 ELECTROCARDI OLOGY 1, 580, 342 0 0 074154 117, 189 69 00 69 00 241 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 306593 1, 172, 710 0 0 1, 532, 255 71.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 72.00 0.580688 586, 558 340, 607 72.00 PATI ENTS 07300 DRUGS CHARGED TO PATIENTS 14, 770 73.00 0.709503 4, 626, 692 0 3, 282, 652 73.00 03952 WOUND CARE (DIABETES CENTER) 0 76.00 0. 636455 315, 794 0 200, 989 76.00 03951 CASE MANAGEMENT 1.387015 0 0 76.02 76.02 0 03950 PAIN MANAGEMENT 76.03 0.656337 0 0 76.03 0 76. 97 07697 CARDIAC REHABILITATION 3.080465 0 335, 324 108, 855 0 76.97 OUTPATIENT SERVICE COST CENTERS 32, 707 04950 OTHER OUTPATIENT SERVICE COST CENTER 0.642592 90.00 90.00 50.898 0 0 90.01 04951 PALLI ATI VE HEALTH 1.096150 288, 971 316, 756 90.01 09000 VEIN CENTER 0 209105 0 0 90.02 Ω 90 02 0 90.03 09001 OB GYN 1.075889 0 0 90.03 09100 EMERGENCY 0 o 91.00 0.378692 2, 380, 207 901, 365 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 516,060 92.00 1. 434025 359, 868 0 0 92.00 93. 00 | 04952 | BEHAVI ORAL HEALTH 2. 367147 92,864 0 0 219, 823 93.00 Subtotal (see instructions) 200.00 45, 421, 110 1, 200 15, 785 12, 115, 735 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

45, 421, 110

1, 200

15, 785

12, 115, 735 202. 00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, C	OTHER HEALTH SERVICES AND VACCINE COST Provider C	CN: 15-0065

			7	Го 12/31/2016	Date/Time Prepared: 5/23/2017 9:42 am
		Title	XVIII	Hospi tal	PPS
	Cos	sts			
Cost Center Description	Cost	Cost			
· ·	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0			50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
54. 01 03630 ULTRA SOUND	0	0			54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	31			54. 02
57.00 05700 CT SCAN	0	14			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4			58.00
60. 00 06000 LABORATORY	120	0			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0			64.00
65. 00 06500 RESPIRATORY THERAPY	0	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	18			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	•		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0			72.00
PATI ENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 479			73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	0			76.00
76. 02 03951 CASE MANAGEMENT	0	0			76. 02
76. 03 03950 PAIN MANAGEMENT	0	0			76. 03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76. 97
OUTPATIENT SERVICE COST CENTERS					
90.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0			90.00
90. 01 04951 PALLI ATI VE HEALTH	0	0			90. 01
90. 02 09000 VEIN CENTER	0	0			90.02
90. 03 09001 OB GYN	0	0			90.03
91. 00 09100 EMERGENCY	0	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	o			92.00
93. 00 04952 BEHAVI ORAL HEALTH	0	0			93.00
200.00 Subtotal (see instructions)	120	10, 546			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					[-0.1.00
202.00 Net Charges (line 200 +/- line 201)	120	10, 546			202.00

 Heal th Financial
 Systems
 SCHNECK MEDI

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 SCHNECK MEDICAL CENTER Provi der CCN: 15-0065 Peri od: From 01/01/2016 To 12/31/2016 Cost Title XIX Hospi tal

Cost Center Description					Charges		Costs	
Service Service Service Service Subject To Su		Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
MORKSNECT C, Part 1, col. 9		·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
Part I			From	Services (see	Servi ces	Services Not		
9 (see inst.)			Worksheet C,	inst.)	Subject To	Subject To		
9 (see inst.)			Part I, col.	ŕ	Ded. & Coins.	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS 0			9			(see inst.)		
50.00 05000 05000 05000 05000 0			1. 00	2.00	3.00	4. 00	5. 00	
51.00 05100 RECOVERY ROOM 0.155431 0 0 139, 923 0 51.00	ANCII	LARY SERVICE COST CENTERS	•		•			
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52.00 052.00 052.00 052.00 052.00 052.00 053.00 053.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 053.00 055.00 05	51.00 0510	RECOVERY ROOM	0. 155431	l o	0	139, 923	0	51.00
53.00 05300 05300 05400 200.00 0 152, 856 0 53.00 054.00 05400 240.00	52. 00 0520	DELIVERY ROOM & LABOR ROOM	0. 381262	l o	0	23, 621	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 386736 0 0 218.787 0 54. 00 54. 01 03630 ULTRA SOUND 0. 133451 0 0 76.757 0 54. 00 54. 02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 131987 0 0 24. 212 0 54. 02 57. 00 05700 CT SCAN 0. 029509 0 0 180, 634 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0. 054366 0 0 184, 956 0 58. 00 60. 00 06000 LABORATORY 0. 100415 0 0 452, 765 0 60. 00 61. 00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 0. 513103 0 0 5. 557 0 63. 00 62. 00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 0. 513103 0 0 5. 557 0 64. 00 63. 00 06400 INTRAVENOUS THERAPY 0. 540994 0 0 20, 929 0 64. 00 64. 00 06600 PRIST ICAL THERAPY 0. 312286 0 0 55, 001 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 0. 312286 0 0 53, 620 0 66. 00 66. 00 06600 OCUPATI IONAL THERAPY 0. 269884 0 0 38, 546 0 67. 00 67. 00 06700 0CCUPATI IONAL THERAPY 0. 269884 0 0 38, 546 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 058073 0 0 17, 657 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 074154 0 0 103, 653 0 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 1. 306593 0 204, 925 0 71. 00 72. 00 07200 IMPLANTABLE DEVI CES CHARGED TO 0. 580688 0 0 195, 052 0 73. 00 76. 00 03952 MOUND CARE (DI ABETES CENTER) 0. 636455 0 0 195, 052 0 76. 00 76. 00 03951 CASE MANAGEMENT 1. 387015 0 0 149, 237 0 76. 00 76. 00 03952 CASE MANAGEMENT 1. 387015 0 0 149, 237 0 76. 00 76. 00 03951 CASE MANAGEMENT 1. 387015 0 0 1, 235 0 76. 00 04950 OTHER OUTPATI ENT SERVI CE COST CENTER 0. 642592 0 0 1, 295 0 90. 01 04951 PALLI TATI VE HEALTH 1. 1096150 0 0 5, 785 0 90. 00 90. 01 04951 PALLI TATI VE HEALTH 1. 1096150 0 0 5, 785 0 90. 00				0	0		0	
54. 01 03630 ULTRA SOUND 0. 133451 0 0 76,757 0 54. 01				0	0			1
54. Q2 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 131987 0 0 24, 212 0 54. 02 57. 00 05700 CT SCAN 0. 029509 0 0 180, 634 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0. 054366 0 0 184, 956 0 58. 00 60. 00 06000 LABORATORY 0. 100415 0 0 452, 765 0 60. 00 63. 00 06300 BLOOD STORI NG PROCESSI NG 8 TRANS 0. 513103 0 0 5, 557 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0. 540994 0 0 20, 929 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0. 540994 0 0 55, 001 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 600626 0 0 53, 620 0 66. 00 67. 00 06600 PHYSI CAL THERAPY 0. 269884 0 0 38, 546 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 658073 0 0 17, 657 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 074154 0 0 103, 653 0 69. 00 69. 00 06900 LECTROCARDI OLOGY 0. 074154 0 0 103, 653 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1. 306593 0 0 204, 925 0 71. 00 72. 00 07200 IMPLANTABLE DEVI CES CHARGED TO 0. 580688 0 0 0 204, 925 0 71. 00 76. 00 03952 WOUND CARE (DI ABETES CENTER) 0. 636455 0 0 15, 527 0 76. 00 76. 00 03952 WOUND CARE (DI ABETES CENTER) 0. 636455 0 0 1, 235 0 76. 00 76. 00 07497 CARDI AC REHABI LI TATI ON 0. 656337 0 0 1, 235 0 76. 00 76. 00 074951 PALI TATI EN PERVICE COST CENTER 0. 209105 0 0 1, 235 0 76. 00 76. 00 074951 PALI TATI EN TERVI CE COST CENTER 0. 209105 0 0 1, 365 0 90. 00 76. 00 074951 PALI TATI EN TERVI CE COST CENTER 0. 209105 0 0 1, 366 0 0 1, 366 0 76. 00 074951 PALI TATI EN TERVI CE COST CENTER 0. 209105 0 0 0 1, 366 0 0 0 76. 00 074951 PALI TATI EN TERVI CE COST CENTER 0. 209105 0 0 0 0 0 0 0 76. 00				0	0	,		
57. 00 05700 CT SCAN 0.029509 0 0 180, 634 0 57. 00 88. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.054366 0 0.184, 956 0.58. 00 60. 00 06000 LABORATORY 0.100415 0 0.452, 765 0.60. 00 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.513103 0 0 5, 557 0.63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.540994 0 0 0.0999 0.64. 00 65. 00 06500 RESPIRATORY THERAPY 0.312286 0 0 55, 001 0.65. 00 66. 00 06600 PHYSICAL THERAPY 0.500626 0 0 33, 630 0.60. 00 67. 00 06700 0CCUPALT IONAL THERAPY 0.269884 0 0 38, 546 0.67. 00 68. 00 06800 SPECH PATHOLOGY 0.658073 0 0 17, 657 0.68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.74154 0 0 103, 653 0.69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.306593 0 0 204, 925 0.71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0.580688 0 0 0 0 0 72. 00 PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 1.387015 0 0 0 15, 527 0.76. 00 76. 00 03952 WOUND CARE (DIABETES CENTER) 0.636455 0 0 15, 527 0.76. 00 76. 02 03951 CASE MANAGEMENT 1.387015 0 0 149, 237 0.76. 02 76. 03 03950 PAIN MANAGEMENT 0.566337 0 0 149, 237 0.76. 03 76. 07 07697 CARDI LAG REHABILITATION 3.080465 0 0 1, 235 0 90. 01 04950 OTHER OUTPATIENT SERVICE COST CENTER 0.642592 0 0 1, 235 0 90. 01 04950 OTHER OUTPATIENT SERVICE COST CENTER 0.642592 0 0 1, 39, 642 0 90. 03 90. 01 04950 OTHER OUTPATIENT SERVICE COST CENTER 0.642592 0 0 139, 642 0 90. 03 90. 01 04950 DESERVATION BEDS (NON-DISTINCT PART) 1.434025 0 0 139, 642 0 90. 03 90. 01 09900 DESERVATION BEDS (NON-DISTINCT PART) 1.434025 0 0 139, 642 0 92. 00 00 09100 EMERGENCY 0.378692 0 0 139, 642 0 92. 00 00 09100 EMERGENCY 0.378692 0 0 0 3, 767, 920 0 00 09100 DESERVATION BEDS				0	0			•
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93. 00 04952 BEHAVI ORAL HEALTH 2. 367147 0 0 26, 675 0 93. 00 200. 00 201. 00 0 0 0 0 0 0 0 0 0				0	0	,	-	1
200.00 Subtotal (see instructions)				0	0			
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 0 0 201.00 Only Charges		l .	2. 367147	0	0			
Only Charges				0	0	3, 767, 920		
	201. 00				0	0		201. 00
202.00 Net Charges (line 200 +/- line 201) 0 0 3,767,920 0 202.00								
	202. 00	Net Charges (line 200 +/- line 201)		0	0	3, 767, 920	0	202. 00

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0065	Peri od: From 01/01/2016	Worksheet D Part V

12/31/2016 Date/Time Prepared: 5/23/2017 9:42 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 149, 692 50.00 05100 RECOVERY ROOM 0 21, 748 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 9, 006 52.00 53.00 05300 ANESTHESI OLOGY 00000000000000000 37, 288 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 84, 613 54.00 54.01 03630 ULTRA SOUND 10, 243 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 3, 196 54.02 57.00 05700 CT SCAN 5, 330 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 10,055 58.00 06000 LABORATORY 60.00 45, 464 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 2, 851 63.00 06400 INTRAVENOUS THERAPY 64.00 11, 322 64.00 06500 RESPIRATORY THERAPY 65 00 17 176 65 00 66.00 06600 PHYSI CAL THERAPY 32, 206 66.00 67.00 06700 OCCUPATI ONAL THERAPY 10, 403 67.00 06800 SPEECH PATHOLOGY 68.00 11,620 68.00 7, 686 06900 ELECTROCARDI OLOGY 69 00 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 267, 754 71.00 07200 IMPLANTABLE DEVICES CHARGED TO 72.00 72.00 PATI ENTS 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 0 0 138.390 03952 WOUND CARE (DIABETES CENTER) 76.00 9,882 76.00 76.02 03951 CASE MANAGEMENT 76.02 03950 PAIN MANAGEMENT 97, 950 76.03 76.03 0 3, 804 76. 97 07697 CARDIAC REHABILITATION 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 04950 OTHER OUTPATIENT SERVICE COST CENTER 0 706 90.00 90. 01 04951 PALLI ATI VE HEALTH 0000000 6, 341 90.01 90. 02 09000 VEIN CENTER 90.02 9,006 90.03 09001 OB GYN 90.03 09100 EMERGENCY 19, 440 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200, 250 92.00 92.00 93. 00 | 04952 | BEHAVI ORAL HEALTH 63, 144 93.00 200.00 Subtotal (see instructions) 1, 286, 566 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 202.00 1, 286, 566

Heal th	Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	552-10		
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0065	Peri od:	Worksheet D-1			
				From 01/01/2016 To 12/31/2016	Date/Time Prep 5/23/2017 9:42			
			Title XVIII	Hospi tal	PPS			
	Cost Center Description							
					1. 00			
	PART I - ALL PROVIDER COMPONENTS							
	I NPATI ENT DAYS							
1.00	.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 11,284							
2.00	2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 11,024							
3 00								

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11, 284	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11, 024	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	9, 113	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	39	5. 00
	reporting period	o	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	۷	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	221	7. 00
7.00	reporting period	22 '	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 665	9.00
40.00	newborn days)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	39	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	212. 56	17. 00
17.00	reporting period	212. 50	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	129. 14	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	13, 291, 668	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
22.00	5 x 1 ine 17)	0, 270	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 540	24.00
	7 x line 19)	_	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	36, 830	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13, 254, 838	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	13, 234, 030	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 + line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	13, 254, 838	37.00
37.00	27 minus line 36)	13, 234, 030	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 202. 36	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	4, 406, 649	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	4, 406, 649	41.00

Heal th	Financial Systems	SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		
			Title	XVIII	Hospi tal	5/23/2017 9: 4: PPS	2 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42. 00
43.00	INTENSIVE CARE UNIT	2, 375, 222	1, 157	2, 052. 9	1 522	1, 071, 619	43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					6, 228, 417	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ons)		11, 706, 685	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine s	services (from	m Wkst. D, su	m of Parts I and	693, 257	50.00
51. 00		ationt ancillary	, sarvicas (fi	rom Wkst D	cum of Darte II	354, 961	51. 00
51.00	and IV)	atrent ancirrary	services (ii	TOIII WKSt. D,	Sum Of Farts II	334, 701	31.00
52.00	Total Program excludable cost (sum of lines !		-4	:	h-4:-4	1, 048, 218	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		ated, non-pny	ysician anesti	netist, and	10, 658, 467	53.00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION	•					F4 00
54.00	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)				>	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (I	line 56 minus	line 53)	0	57. 00 58. 00
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, ເ	updated and c	ompounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	rost report und	lated by the r	markat haskat		0. 00	60. 00
61.00	If line 53/54 is less than the lower of lines					0.00	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i						
62.00	Relief payment (see instructions)	ristructions)				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	e cost report	ing period (See	8, 290	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	or 21 of the d	cost roportin	a ported (Soc	0	65. 00
65.00	instructions)(title XVIII only)	is after Decembe	er si or the t	cost reporting	g perrou (see	U	65.00
66.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	64 plus line 6	65)(title XVI	II only). For	8, 290	66.00
67. 00	1	e costs through	December 31 d	of the cost r	eporting period	0	67. 00
49.00	(line 12 x line 19)	o costs often Do	scombor 21 of	the cost ron	orting ported		68. 00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after be	ecember 31 01	the cost rep	orting period	U	68.00
69. 00	Total title V or XIX swing-bed NF inpatient i					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70. 00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)	,	(line 14 x li	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73))			74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from V	Worksheet B,	Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from pr					79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	n (line 78 mi	nus line 79)		80. 00 81. 00
82.00	Inpatient routine service cost per dreim frim						82.00
83.00	Reasonable inpatient routine service costs (5)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 911	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 202. 36	88. 00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				2, 297, 710	89.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 714, 152	13, 291, 668	0. 12896	4 2, 297, 710	296, 322	90.00
91.00 Nursing School cost	0	13, 291, 668	0.00000	0 2, 297, 710	0	91.00
92.00 Allied health cost	0	13, 291, 668	0.00000	0 2, 297, 710	0	92.00
93.00 All other Medical Education	0	13, 291, 668	0. 00000	0 2, 297, 710	0	93. 00

Heal th	Financial Systems SCHNECK MEDICAL	_ CENTER	In Lie	u of Form CMS-2	2552-10			
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0065	Peri od:	Worksheet D-1				
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared:			
			10 12/31/2010	5/23/2017 9: 4:				
		Title XIX	Hospi tal	Cost				
	Cost Center Description							
	DART I ALL DROWLDED COMPONENTS			1. 00				
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS							
1. 00	Inpatient days (including private room days and swing-bed day	e evaludina newborn)		11, 284	1. 00			
2. 00	Inpatient days (including private room days, excluding swing-			11, 024	2.00			
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days.	0	3.00			
	do not complete this line.							
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		9, 113	4.00			
5.00								
	reporting period							
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00			
7 00	reporting period (if calendar year, enter 0 on this line)		- 21 -6	221	7 00			
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through becembe	r 31 of the cost	221	7. 00			
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8. 00			
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember	or or the cost	Ü	0.00			
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	1, 025	9.00			
	newborn days)							
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00			
44.00	through December 31 of the cost reporting period (see instruc				44.00			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00			
12 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12. 00			
12.00	through December 31 of the cost reporting period	A only (Therauling priva	te room days)	U	12.00			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.00			
	after December 31 of the cost reporting period (if calendar y			_				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00			
15. 00	Total nursery days (title V or XIX only)							

	Cost Center Description		
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS	11 001	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11, 284	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	11, 024 0	2. 00 3. 00
3. 00	do not complete this line.	٠Į	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	9, 113	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	39	5.00
0.00	report in g peri od	٥,١	0.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	ol	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	221	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 025	9. 00
10 00	newborn days)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	٠Į	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	-	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1, 641	15.00
16. 00	Nursery days (title V or XIX only)	185	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	212. 56	17. 00
10.00	reporting period	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	129. 14	19. 00
19.00	reporting period	127. 14	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	report ing period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	13, 291, 668	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 290	
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 🛭	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 540	24. 00
	7 x line 19)	_	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
24 00	x line 20)	27, 020	27 00
26. 00 27. 00	Total swing-bed cost (see instructions)	36, 830	26. 00 27. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	13, 254, 838	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	ő	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	13, 254, 838	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 202. 36	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 232, 419	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 232, 419	41.00

Heal th	Financial Systems SCI	HNECK MEDIC	AL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2016	Worksheet D-1	
					Γο 12/31/2016		
			Ti tl	e XIX	Hospi tal	5/23/2017 9: 4 Cost	2 4111
		Total pati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 640, 287	2. 00 1, 641	3. 00 390. 18	4. 00 3 185	5. 00 72, 183	42.00
42.00	Intensive Care Type Inpatient Hospital Units	040, 207	1, 041	370. 10	103	72, 103	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	2, 375, 222	1, 157	2, 052. 9	130	266, 878	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wkst. [) 2 col 2	Line 200)			1. 00 515, 053	48. 00
	Total Program inpatient costs (sum of lines 41 th			ons)		2, 086, 533	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatier	t routino	convices (from	n Wkst D sum	of Dorts L and	0	50. 00
30.00		it routine s	services (IIO	ii wkst. D, Suii	i di Faits i allo		30.00
51. 00	Pass through costs applicable to Program inpatier and IV)	nt ancillary	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 50 ar					0	52.00
53.00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	capital rel	lated, non-phy	ysician anesth	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56. 00	Target amount (line 54 x line 55)					0.00	56.00
57. 00 58. 00	Difference between adjusted inpatient operating of Bonus payment (see instructions)	cost and tai	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59.00	Lesser of lines 53/54 or 55 from the cost reporti	ng period (endi ng 1996, ເ	updated and co	mpounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost	report un	dated by the m	markat haskat		0. 00	60. 00
61.00	1 3				the amount by	0.00	61.00
	which operating costs (line 53) are less than expanding amount (line 56), otherwise enter zero (see instr		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	•				0	62.00
63. 00	Allowable Inpatient cost plus incentive payment (PROGRAM INPATIENT ROUTINE SWING BED COST	see instru	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine costs th	rough Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs af</pre>	ter Decembe	er 31 of the d	cost reporting	period (See	0	65. 00
44.00	instructions)(title XVIII only)				•		44 00
66. 00	Total Medicare swing-bed SNF inpatient routine co CAH (see instructions)	ists (Title (54 prus rine d	os)(title XVII	i diliy). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine cos (line 12 x line 19)	sts through	December 31 d	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine cos	sts after De	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routi	ne costs (I	line 67 + line	- 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSIN	G FACILITY,	AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facility/I Adjusted general inpatient routine service cost p			,		-	70. 00 71. 00
72.00	Program routine service cost (line 9 x line 71)	•		ŕ			72.00
73. 00 74. 00	Medically necessary private room cost applicable Total Program general inpatient routine service of						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routi				art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)						76. 00
77. 00	Program capital-related costs (line 9 x line 76)						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line Aggregate charges to beneficiaries for excess costs)		rovi der record	ds)			78. 00 79. 00
80.00	Total Program routine service costs for compariso	on to the co			us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line service))				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see i	nstructi ons					83.00
84. 00 85. 00	Program inpatient ancillary services (see instructional littlization review - physician compensation (see		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of I	ines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THE Total observation bed days (see instructions)	OUGH COST				1, 911	87. 00
88.00	Adjusted general inpatient routine cost per diem	•	line 2)			1, 202. 36	88. 00
89. UU	Observation bed cost (line 87 x line 88) (see ins	structions)				2, 297, 710	89.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 714, 152	13, 291, 668	0. 12896	4 2, 297, 710	296, 322	90.00
91.00 Nursing School cost	0	13, 291, 668	0.00000	0 2, 297, 710	0	91.00
92.00 Allied health cost	0	13, 291, 668	0.00000	0 2, 297, 710	0	92.00
93.00 All other Medical Education	o	13, 291, 668	0.00000	0 2, 297, 710	0	93.00

	Financial Systems SCHNECK MEDICAL		ON 45 00/5		u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0065	Peri od: From 01/01/2016	Worksheet D-3	i
				To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared: 2 am
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDI ATRI CS			2, 537, 095		30.00
31.00	03100 INTENSIVE CARE UNIT			686, 710		31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 1263:	· · ·		
51. 00	05100 RECOVERY ROOM		0. 1554:	·	59, 842	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 3812	·	1, 601	1
53.00	05300 ANESTHESI OLOGY		0. 24394		93, 110	1
	05400 RADI OLOGY-DI AGNOSTI C		0. 3944	·	195, 630	
54. 01 54. 02	03630 ULTRA SOUND		0. 1334		14, 463	1
	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN		0. 13198 0. 02950	·	6, 751 48, 575	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0543		19, 061	1
	06000 LABORATORY		0. 1015		436, 688	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 51310		105, 764	
64. 00	06400 I NTRAVENOUS THERAPY		0. 5409	·	51, 091	1
65.00	06500 RESPI RATORY THERAPY		0. 3122	·	494, 630	
66.00	06600 PHYSI CAL THERAPY		0. 60062	26 307, 712	184, 820	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 2698	84 222, 179	59, 963	67.00
68.00	06800 SPEECH PATHOLOGY		0. 6580		24, 915	68.00
	06900 ELECTROCARDI OLOGY		0. 0744		37, 370	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3065		1, 453, 074	1
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 58068		526, 595	
	07300 DRUGS CHARGED TO PATIENTS		0. 70950		1, 387, 609	
	03952 WOUND CARE (DI ABETES CENTER)		0. 6364		9, 931	1
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT		1. 3870		0	
	03950 PATN MANAGEMENT 07697 CARDI AC REHABI LI TATI ON		0. 6563 3. 0804		758	
70. 97	OUTPATIENT SERVICE COST CENTERS		3. 00040	240	/30	70.97
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER		0. 64259	92 0	0	90.00
	04951 PALLI ATI VE HEALTH		1. 0961!		486	
90. 02	09000 VEIN CENTER		0. 2091	05	0	90.02
90.03	09001 OB GYN		1. 0758	39 0	0	90.03
	09100 EMERGENCY		0. 3786		248, 224	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 4340	·	63, 605	
	04952 BEHAVI ORAL HEALTH		2. 3671		0	
200.00	Total (sum of lines 50-94 and 96-98)			20, 941, 284	6, 228, 417	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1	20, 941, 284		202.00

Heal th	Financial Systems	SCHNECK MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT			CN: 15-0065	Peri od:	Worksheet D-3	
			Component	CCN: 15-U065	From 01/01/2016 To 12/31/2016		pared: 2 am
			Title	: XVIII	Swing Beds - SNI		
	Cost Center Description			Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
						col. 2)	
				1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1	ı	
	03000 ADULTS & PEDIATRICS				C		30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY				C		31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS						43.00
50.00	05000 OPERATING ROOM			0. 12633	36 0	0	50.00
	05100 RECOVERY ROOM			0. 15543		_	
	05200 DELIVERY ROOM & LABOR ROOM			0. 38126		_	52.00
	05300 ANESTHESI OLOGY			0. 24394		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 38673		0	54.00
54.01	03630 ULTRA SOUND			0. 13345		0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC			0. 13198	37 C	0	54.02
	05700 CT SCAN			0. 02950	9 4, 200	124	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 05436	56 C	0	58. 00
60.00	06000 LABORATORY			0. 10041		601	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.			0. 51310	03	0	63.00
64.00	06400 I NTRAVENOUS THERAPY			0. 54099		0	64.00
	06500 RESPI RATORY THERAPY			0. 31228	·	l .	1
	06600 PHYSI CAL THERAPY			0. 60062		5, 803	1
	06700 OCCUPATI ONAL THERAPY			0. 26988		_	
	06800 SPEECH PATHOLOGY			0. 65807		ı .	
	06900 ELECTROCARDI OLOGY			0. 07415		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1. 30659			1
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0. 58068		0 224	72.00
	03952 WOUND CARE (DIABETES CENTER)			0. 70950	·	9, 224	1
				0. 63645			1
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT			1. 38701		_	76. 02 76. 03
	07697 CARDI AC REHABI LI TATI ON			0. 65633 3. 0804 <i>6</i>		_	
70. 77	OUTPATIENT SERVICE COST CENTERS			3.00040	00	0	70. 77
90 00	04950 OTHER OUTPATIENT SERVICE COST CENTER			0. 64259	92 0	0	90.00
	04951 PALLI ATI VE HEALTH			1. 09615		_	
	09000 VEIN CENTER			0. 20910		0	
	09001 OB GYN			1. 07588		_	
	00100 EMERCENCY			0 27060		_	1

0. 378692

1. 434025 2. 367147

35, 597

35, 597

91.00 0

0 92.00

0 93.00

17, 539 200. 00 201. 00 202. 00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

93. 00 04952 BEHAVI ORAL HEALTH

200. 00 201. 00

202.00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	ARY SERVICE COST APPORTIONMENT Provider CCN:		Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 5/23/2017 9:4	pared:
		Ti ti	e 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 . 2)	
	INDATIENT POUTINE CERVICE COCT CENTERS		1.00	2. 00	3. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1	171 151		1
30.00	03000 ADULTS & PEDIATRICS			171, 151		30.00
	03100 I NTENSI VE CARE UNI T			52, 010 0		31. 0 43. 0
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS					43.0
50. 00	05000 OPERATING ROOM		0. 12633	36 277, 977	35, 119	50.0
	05100 RECOVERY ROOM		0. 12033		3, 488	1
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 38126	· ·	167, 270	1
	05300 ANESTHESI OLOGY		0. 24394		20, 309	1
	05400 RADI OLOGY-DI AGNOSTI C		0. 38673		8, 137	
	03630 ULTRA SOUND		0. 13345		965	1
	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 13198		43	
	05700 CT SCAN		0. 02950		1, 987	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 05436		905	
60.00	06000 LABORATORY		0. 10041		24, 922	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 51310		5, 116	1
64. 00	06400 I NTRAVENOUS THERAPY		0. 54099		3, 069	
65. 00	06500 RESPI RATORY THERAPY		0. 31228		33, 562	65.0
66. 00	06600 PHYSI CAL THERAPY		0. 60062	26 5, 902	3, 545	66.0
67. 00	06700 OCCUPATI ONAL THERAPY		0. 26988	4, 332	1, 169	67.0
68. 00	06800 SPEECH PATHOLOGY		0. 65807	73 601	396	68.0
69. 00	06900 ELECTROCARDI OLOGY		0. 07415	54 24, 312	1, 803	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 30659	72, 408	94, 608	71.0
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 58068		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 70950		80, 639	
	03952 WOUND CARE (DIABETES CENTER)		0. 63645		579	1
	03951 CASE MANAGEMENT		1. 38701		0	1
	03950 PAIN MANAGEMENT		0. 65633		122	
76. 97	07697 CARDI AC REHABI LI TATI ON		3. 08046	55 0	0	76. 9
	OUTPATIENT SERVICE COST CENTERS		1 0 / 405			4
	04950 OTHER OUTPATIENT SERVICE COST CENTER		0.64259		0	1
	04951 PALLI ATI VE HEALTH		1. 09615		2, 193	
	09000 VEIN CENTER		0. 20910		0	
	09001 OB GYN		1. 07588		0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 37869 1. 43402		24, 341 766	
	04952 BEHAVI ORAL HEALTH		2. 36714		766	1
93.00 200 00	•		2. 30/14	1 505 407	515 053	

515, 053 200. 00 201. 00 202. 00

1, 595, 407 0 1, 595, 407

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

200. 00 201. 00 202. 00

Health Financial Systems SCHNECK MEDICAL CE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pro		CN: 15-0065	Period:	u of Form CMS-2 Worksheet D-3	
TIMPATTENT ANCILLARY SERVICE COST APPORTIONMENT	ovider C	CN: 15-0065	From 01/01/2016	worksneet D-3	
Con	mponent	CCN: 15-U065	To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared:
	Ti tl	e XIX	Swing Beds - NF	Cost	2 (111
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2. 00	col. 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS			اها		
50. 00 05000 0PERATING ROOM		0. 12633		0	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 15543 0. 3812 <i>6</i>		0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY		0. 36126	1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 38673		0	54.00
54. 01 03630 ULTRA SOUND		0. 13345		0	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 13198	1	0	54. 02
57. 00 05700 CT SCAN		0. 02950		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.05436	0	0	58.00
60. 00 06000 LABORATORY		0. 10041		0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 51310		0	63.00
64. 00 06400 NTRAVENOUS THERAPY		0. 54099		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 31228		0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 60062 0. 26988		0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 26988		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 07415		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 30659		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 58068		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 70950	0	0	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)		0. 63645	55 0	0	76. 00
76. 02 03951 CASE MANAGEMENT		1. 38701		0	76. 02
76. 03 03950 PAI N MANAGEMENT		0. 65633		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		3. 08046	5 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 04950 OTHER OUTPATIENT SERVICE COST CENTER		0. 64259	0	0	90.00
90. 01 04951 PALLIATIVE HEALTH		1. 09615	1	0	90.00
90. 02 09000 VEI N CENTER		0. 20910	-	0	90.02
90. 03 09001 0B GYN		1. 07588		0	1
91. 00 09100 EMERGENCY		0. 37869		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 43402	25 0	0	92.00
93. 00 04952 BEHAVI ORAL HEALTH		2. 36714		0	
200.00 Total (sum of lines 50-94 and 96-98)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	0		202. 00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0065	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 9:42 am

				5/23/2017 9: 4	2 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurriinstructions)	ng prior to October 1 (see	0 5, 117, 242	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	ng on or after October	1 (see	1, 980, 203	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)	r di scharges occurri ng	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo October 1 (see instructions)	r di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			326, 560 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	0 87. 07	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet t			0. 00	6. 00
7. 00	for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u			0. 00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instruction	under 42 CFR §412.105(f		0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).	0. 00	8. 00		
8. 01	The amount of increase if the hospital was awarded FTE cap slo the cost report straddles July 1, 2011, see instructions.	0. 00	8. 01		
8. 02	The amount of increase if the hospital was awarded FTE cap slounder section 5506 of ACA. (see instructions)	0. 00	8. 02		
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	0. 00	9. 00		
	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.		10.00 11.00		
12.00	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	tember 30, 1997,	0. 00 0. 00	1	
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
	Adjustment for residents in initial years of the program			0.00	16. 00
	Adjustment for residents displaced by program or hospital clos	ure			17.00
	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4) Prior year resident to bed ratio (see instructions)	•		0. 000000 0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0.000000	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section	on 122 of the MMA		0	•
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.		ec. 412.105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	0. 00	25. 00
	Resident to bed ratio (divide line 25 by line 4)			0. 000000	1
	IME payments adjustment factor. (see instructions)			0. 000000	1
	IME add-on adjustment amount (see instructions)	0	ł		
	IME add-on adjustment amount - Managed Care (see instructions)	0	1		
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01	0	29. 00 29. 01		
20.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pa	3. 89	20.00		
	Percentage of SSI recipient patient days to medicare Part A part Percentage of Medicaid patient days (see instructions)	trent days (See Firstruc	LI UIIS)	3. 89 25. 90	•
	Sum of lines 30 and 31			25. 90 29. 79	1
	Allowable disproportionate share percentage (see instructions)			13. 79	
	Disproportionate share adjustment (see instructions)			244, 685	1
2 00	i in the second			, 500	,

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0065	Peri od: From 01/01/2016 To 12/31/2016				
		Title XVIII	Hospi tal	PPS			
			Prior to 10/1				
	Uncompensated Care Adjustment		1. 00	2. 00			
35. 00	Total uncompensated care amount (see instructions)		0	0	35.00		
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	35. 01		
35. 02	Hospital uncompensated care payment (If line 34 is zero, e (see instructions)	enter zero on this line)	625, 002	557, 424	35. 02		
35. 03	5.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 467,898 5.00 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 608,400						
30.00	Additional payment for high percentage of ESRD beneficiary				36.00		
40.00	Total Medicare discharges on Worksheet S-3, Part I excludin	ng discharges for MS-DRGs	0		40. 00		
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00		
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	IS-DRGs 652, 682, 683, 684	1 0		41.01		
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0. 00		42.00		
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	682, 683, 684 an 685. (see	0		43.00		
44. 00							
45.00	Average weekly cost for dialysis treatments (see instruction		0. 00		45.00		
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41. 01)	8, 277, 090		46. 00 47. 00		
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0, 277, 090		48.00		
	only. (see instructions)		Ĭ				
				Amount			
49. 00	Total payment for inpatient operating costs (see instruction	une)		1. 00 8, 277, 090	49. 00		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I)	621, 807	1		
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00		
52.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0			
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0			
54. 00	Islet isolation add-on payment			0			
55. 00	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 in	itructions)		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			
59. 00 60. 00	Total (sum of amounts on lines 49 through 58)			8, 898, 897 0	1		
61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 min	us line 60)		8, 898, 897	1		
62. 00	Deductibles billed to program beneficiaries	ids Title 60)		980, 000			
63.00	. •			11, 592	1		
64.00	Allowable bad debts (see instructions)			77, 290	64.00		
65.00	Adjusted reimbursable bad debts (see instructions)			50, 239			
66.00	Allowable bad debts for dual eligible beneficiaries (see in	istructi ons)		39, 412	•		
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		!	7, 957, 544	1		
68. 00 69. 00	Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96			0	1		
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)). (FOI 3CH SEE THSTI UCTIO	15)	0	1		
70. 50	RURAL DEMONSTRATION PROJECT			0	70.50		
70. 88	SCH or MDH volume decrease adjustment	0	1				
70. 89	Pioneer ACO demonstration payment adjustment amount (see in		0	1			
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90		
	HSP bonus payment HRR adjustment amount (see instructions)			0			
70. 91							
70. 91 70. 92	2 Bundled Model 1 discount amount (see instructions)						
70. 91 70. 92 70. 93	· · · · · · · · · · · · · · · · · · ·			53, 836 1 792	1		

Health Financial Systems SCHNECK MEDICA	I CENTER		In lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/23/2017 9:4	pared:
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1)			2016	316, 768	
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a			2017	,	70. 97
70.98 Low Volume Payment-3				0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			8, 329, 865	
71.01 Sequestration adjustment (see instructions)				166, 597	71. 01
72.00 Interim payments				7, 934, 318	
73.00 Tentative settlement (for contractor use only)				0	73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72				228, 950	
75.00 Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2	ance with			491, 405	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see in:	structions)			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 inst				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instru				0	93.00
94.00 The rate used to calculate the time value of money (see insti				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 instru	ctions)		1	0	96.00
			Prior to 10/1		
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0. 0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructions	s)		0	0	104. 00

Health Financial Systems	SCHNECK MEDICAL	CENTER		In Lieu	of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN:		From 01/01/2016	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/23/2017 9:42 am
		Title XV	/111	Hospi tal	PPS

							5/23/2017 9: 4	2 am
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Hospi tal Peri od On/After	PPS Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	10/01 4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	2.00	0	4.00	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	5, 117, 242	0	5, 117, 242		5, 117, 242	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 980, 203	0		1, 980, 203	1, 980, 203	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	326, 560	0	239, 776	86, 784	326, 560	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3.00	0	0	0	0	0	4. 00
5. 00	Indirect Medical Education Adj Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0. 000000	0. 000000	0. 000000	0. 000000	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)				LL - AAAAA			
7. 00	Indirect Medical Education Adjustment factor	27.00	0. 000000	0.000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0. 000000	0.000000	0.000000	0. 000000	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.00	for managed care (see instructions)	20.00	0	0	0	0	0	0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0	0	0	0	9. 00 9. 01
9. 01	care (sum of lines 6.01 and 8.01)	27.01	J	0	Ü	0	0	7.01
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1379	0. 1379	0. 1379	0. 1379		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	244, 685	0	176, 417	68, 268	244, 685	11. 00
11. 01	Uncompensated care payments	36. 00	608, 400	0	467, 898	140, 502	608, 400	11. 01
12. 00	Additional payment for high per Total ESRD additional payment (see instructions)	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	8, 277, 090 0	0	6, 001, 333 0	2, 275, 757 0	8, 277, 090 0	13. 00 14. 00
11.00	(completed by SCH and MDH, small rural hospitals only.) (see instructions)	10. 00	3	S	J	0	G	11.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	8, 277, 090	0	6, 001, 333	2, 275, 757	8, 277, 090	15. 00
16. 00	Payment for inpatient program capital	50. 00	621, 807	0	449, 227	172, 580	621, 807	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

LOW VO	Financial Systems LUME CALCULATION EXHIBIT 4			CAL CENTER Provider CO	N: 15-0065	Peri od:	u of Form CMS-2 Worksheet F	
LOW VO	LOWIE GALGULATION EATIBIT 4			FIOVIDEI C	ы. 19-0003	From 01/01/2016 To 12/31/2016	Part A Exhibi	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18.00
19 00	SUBTOTAL			0	6, 450, 56	2, 448, 337	8, 898, 897	19 00
171.00	000101712	W/S L, line	(Amounts from L)	0	0, 100, 00	27 1107 007	0,0,0,0,7	171.00
		0	1. 00	2. 00	3. 00	4.00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	563, 196	0	405, 15	7 158, 039	563, 196	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
	Capital DRG outlier payments	2.00	58, 611	0	44, 07	70 14, 541	58, 611	
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0. 000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	621, 807	0	449, 22	172, 580	621, 807	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)	0.00	0.00	1.00		
27.00		0	1. 00	2. 00	3. 00	4.00	5. 00	27.00
	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 04910 316, 76		316, 768	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				3, 499	3, 499	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

| Peri od: | Worksheet E | From 01/01/2016 | Part A Exhibit 5 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | Pr
 Heal th Financial Systems
 SCHNECK MEDICAL

 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5
 Provi der CCN: 15-0065

				11	0 12/31/2016	Date/lime Pre 5/23/2017 9:4	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
		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	1. 01	5, 117, 242	5, 117, 242		5, 117, 242	1. 01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for	1. 02	1, 980, 203		1, 980, 203	1, 980, 203	1. 02
	discharges occurring on or after October 1			_		_	
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
1 04	DDC for Fodoral anglific appreting normant	1. 04			0	0	1 04
1. 04	DRG for Federal specific operating payment	1. 04	0		U	U	1. 04
	for Model 4 BPCI occurring on or after October 1						
2. 00	Outlier payments for discharges (see	2. 00	326, 560	239, 776	86, 784	326, 560	2. 00
2.00	instructions)	2.00	320, 300	237, 110	00, 704	320, 300	2.00
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2.0.	BPCI	2.02		ŭ	Ü	· ·	2.0.
3.00	Operating outlier reconciliation	2. 01	o	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0.000000	0.000000	0.000000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)		_	_		_	
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	8.00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
0.00	care (see instructions)	20.00		0	0	0	0 00
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00 29. 01	0	0	0	0	9. 00 9. 01
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	U	U	U	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 1379	0. 1379	0. 1379		10. 00
10.00	(see instructions)	00.00	0.1077	0. 1077	0. 1077		10.00
11. 00	Di sproporti onate share adjustment (see	34. 00	244, 685	176, 417	68, 268	244, 685	11.00
	instructions)		·	•			
11. 01	Uncompensated care payments	36. 00	608, 400	467, 898	140, 502	608, 400	11.01
	Additional payment for high percentage of ES	RD beneficiary	di scharges				
12.00	Total ESRD additional payment (see	46. 00	0	0	0	0	12.00
	instructions)						
13. 00	Subtotal (see instructions)	47. 00	8, 277, 090	6, 001, 333	2, 275, 757	8, 277, 090	13.00
14. 00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14. 00
	and MDH, small rural hospitals only.) (see						
45.00	instructions)	40.00	0 077 000		0 075 757	0 077 000	45 00
15. 00	Total payment for inpatient operating costs	49. 00	8, 277, 090	6, 001, 333	2, 275, 757	8, 277, 090	15. 00
1/ 00	(see instructions)	F0.00	/04 007	440.007	470 500	(04 007	47.00
16.00	Payment for inpatient program capital	50. 00	621, 807	449, 227	172, 580	621, 807	16.00
17.00	Special add-on payments for new technologies	54. 00	U	U	U	0	17.00
17. 01	Net organ acquisition cost	40.00		0		_	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	ا	0	U	0	17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
10.00	amount (see instructions)	73.00	١	U	U		10.00
19. 00	,			6, 450, 560	2, 448, 337	8, 898, 897	19, 00
	·-···	I	1	5, 100, 000	_, 110, 007	5, 5, 5, 5, 7	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		Inlie	u of Form CMS-2	2552_10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider CO	<u> </u>	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi Date/Time Pre 5/23/2017 9:4	t 5 pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1, 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1, 00	563, 196	405, 15			20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	303, 170	403, 13	130,037	0	20.00
21.00 Capital DRG outlier payments	2.00	58, 611	44, 070	14, 541	58, 611	
21.01 Model 4 BPCI Capital DRG outlier payments	2.00	30,011	44,070	14, 541	0 30,011	1
22.00 Indirect medical education percentage (see	5. 00	0.0000	0. 0000	0.0000	_	22.00
instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	621, 807	449, 22	172, 580	621, 807	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1. 00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70, 96	316, 768	316, 768	3	316, 768	28.00
29.00 Low volume adjustment on or after October 1	70. 97	3, 499		3, 499	3, 499	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	53, 836	38, 396	15, 440		
30.01 HVBP payment adjustment for HSP bonus	70. 90	0	(0	30. 01
payment (see instructions)	70.04					
31.00 HRR adjustment (see instructions)	70. 94	-1, 782	(-1, 782		
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31.01
					(Amt. to	
					Wkst. E, Pt.	
	0	1.00	2. 00	3. 00	4.00	
32.00 HAC Reduction Program adjustment (see	70. 99		(32.00
100.00 Transfer HAC Reduction Program adjustment to		N				100.00

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLE	ENT Provi der CCN: 15-0065	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 9:42 am
	Title XVIII	Hospi tal	PPS

		10 12/31/2010	5/23/2017 9:4	
		Title XVIII Hospital	PPS	2 alli
		The Arrival Hoopital		
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1. 00	Medical and other services (see instructions)		10, 666	1
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)	12, 115, 735	1
3. 00	PPS payments		8, 866, 911	3. 00
4.00	Outlier payment (see instructions)		211, 266	1
5.00	Enter the hospital specific payment to cost ratio (see instru	icti ons)	0.000	•
6.00	Line 2 times line 5		0	
7. 00	Sum of line 3 plus line 4 divided by line 6		0.00	1
8.00	Transitional corridor payment (see instructions)	IV col 12 line 200	0 0	8. 00 9. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	1 V, COI. 13, 11 He 200	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		10, 666	•
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		10,000	11.00
	Reasonable charges			
12. 00	Ancillary service charges		16, 985	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	,	16, 985	14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for	payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	or payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13((e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	
18.00	Total customary charges (see instructions)		16, 985	1
19. 00	Excess of customary charges over reasonable cost (complete on	ily if line 18 exceeds line 11) (see	6, 319	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	Jy if line 11 eyecode line 10) (coe	0	20.00
20.00	instructions)	if y if fille if exceeds fille 16) (see		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH se	e instructions)	10 666	21.00
22. 00	Interns and residents (see instructions)	or matractions,	0	1
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,	9, 078, 177	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		•	
25. 00	Deductibles and coinsurance (for CAH, see instructions)		0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (fo	or CAH, see instructions)	1, 888, 021	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 and 23] (see	7, 200, 822	27. 00
00.00	instructions)	1 50)		00.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I		0	•
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		7 200 022	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments		7, 200, 822 15, 801	1
32.00	Subtotal (line 30 minus line 31)		7, 185, 021	•
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CFS)	7, 103, 021	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0207	0	33.00
	Allowable bad debts (see instructions)		304, 045	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		197, 629	1
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	238, 931	36.00
37.00	Subtotal (see instructions)		7, 382, 650	37.00
	MSP-LCC reconciliation amount from PS&R		-586	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instruction		0	
39. 98	Partial or full credits received from manufacturers for repla	iced devices (see instructions)	895	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
40.00	Subtotal (see instructions)		7, 383, 236	1
40. 01	Sequestration adjustment (see instructions)		147, 665	1
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)		7, 038, 806	1
43.00	Balance due provider/program (see instructions)		196, 765	1
44. 00	Protested amounts (nonallowable cost report items) in accorda	unce with CMS Pub 15-2 chapter 1	170, 703	1
44.00	§115. 2	ince with one rub. 15 2, chapter 1,		14.00
	TO BE COMPLETED BY CONTRACTOR			1
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
	The rate used to calculate the Time Value of Money		0.00	92.00
93. 00	Time Value of Money (see instructions)		0	1
94.00	Total (sum of lines 91 and 93)		0	94.00

Peri od: Worksheet E-1 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/23/2017 9:42 am Provi der CCN: 15-0065

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 "MONE" or enter a zero.						5/23/2017 9: 42	2 am
1.00							
1.00 1.00 1.00 1.00 3.00 4.00 1.00			Inpatien	t Part A	Par	rt B	
Total Interlin payments paid to provider 7,934,318 7,038,806 1.00 2.0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 1.00			1. 00	2.00	3. 00	4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 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 0	1.00	Total interim payments paid to provider		7, 934, 31	8	7, 038, 806	1.00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)	2.00				0	0	2.00
write "NONE" or enter a zero .0 Usit separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider .0 0 0 0 3.02 .3.03 .3.04 .3.05 .5.01 .5.02 .5.03 .5.03 .5.04 .5.04 .5.04 .5.05		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 3.06 Provider to Program 3.50 3.51 3.51 3.51 3.52 3.53 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program TENTATI VE TO PROGRAM D							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3. 00						3. 00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02 0 0 3.02 3.03 3.04 3.05 3.05 3.05 3.06 3.07 3					ما		
3. 03 3. 04 3. 05 3. 06 3. 07 3. 08 3. 09		ADJUSTMENTS TO PROVIDER					
3.04 0 0 0 3.04 3.05 3.05 3.06 0 0 0 3.06					~		
3. 05 Provider to Program						1	
Provider to Program ADJUSTMENTS TO PROGRAM 0							
3.50 3.50	3.05	Described to Bossess			0	0	3.05
3.51 0 0 3.51 3.52 3.53 0 0 0 0 3.53 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.54 3.59 3.50-3.98 0 0 0 3.54 3.50 3.59 3.50-3.98 0 0 0 3.54 3.50	2 50						2 50
3.52 3.53 3.54 3.99 3.50 3.53 3.50 3.50 3.53 3.50		ADJUSTNIENTS TO PROGRAM					
3.53 3.54 3.54 3.54 0 0 0 0 3.53 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 7,934,318 7,038,806 4.00 Total interim payments (sum of lines 1, 2, and 3.99)					~	- 1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 7,934,318 7,038,806 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor Number							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 01_3 49 minus sum of lines					
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3. 77						3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			7 934 31	8	7 038 806	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	00			,,,,,,,,,		,, 555, 555	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) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider							
TENTATI VE TO PROVIDER							
5. 02							
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM 0 0 5.50	5. 03	Decided to December 1			0	0	5.03
5.51 0	F F0						F F0
5. 52 0 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 228, 950 196, 765 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 6. 02 7, 235, 571 7, 00 Total Medicare program liability (see instructions) 8, 163, 268 7, 235, 571 7, 00 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00 1. 00 2. 00 1.		TENTATIVE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.40 minus sum of lines			~		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 228,950 196,765 0 196,765 0 0 6.02 7,235,571 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	J. 77					١	5. 79
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 228, 950 0 196, 765 6. 01 0 6. 02 7, 235, 571 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	6 00						6 00
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 228, 950	5. 00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 6.02 7, 235, 571 7, 00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01			228 95	o	196, 765	6. 01
7.00 Total Medicare program liability (see instructions) 8,163,268 7,235,571 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00					-		7. 00
Number (Mo/Day/Yr) 0 1.00 2.00							
0 1.00 2.00							
8.00 Name of Contractor 8.00)			
	8. 00	Name of Contractor					8. 00

Health Financial Systems SCHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 SCHNECK MEDICAL CENTER

Provider CCN: 15-0065 | Period: | Worksheet E-1 | From 01/01/2016 | Part | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0065

		Component	CCN. 15-0005	0 12/31/2010	5/23/2017 9: 42	
		Title	XVIII Sv	ving Beds - SNF		
		Inpatier	t Part A	Par	t B	
		(11)		,,,,		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interim payments poid to provider	1.00	2. 00 5, 328	3. 00	4. 00	1. 00
2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		5, 328 0		0	2.00
2.00	submitted or to be submitted to the contractor for		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	I	0		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		0		0	3. 01
3. 03			0		l ő	3. 03
3. 04			0		l ol	3. 04
3. 05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0 0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 99
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 328		o	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	Г		I	
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		0		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		5, 120		4, 978	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 448		4, 978	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
5. 50	Inamo of Sofitiactor	I		ļ	ı	0.00

Heal th	Financial Systems	SCHNECK MEDICAL	_ CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-0065	Peri od: From 01/01/2016	Worksheet E-1 Part II	
				To 12/31/2016		
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD	COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					1.00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 4,187					2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 69					3.00
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 10,27					4.00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200			296, 642, 858	5.00
6.00	Total hospital charity care charges from Wkst	. S-10, col. 3 l	ine 20		2, 494, 748	6.00
7. 00	CAH only - The reasonable cost incurred for t line 168	he purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see	instructions)			o	8.00
9.00	Sequestration adjustment amount (see instruct	i ons)			0	9.00
10.00	Calculation of the HIT incentive payment after	er sequestration	(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &	CAH				
30.00	Initial/interim HIT payment adjustment (see i	nstructions)			0	30.00
31.00	Other Adjustment (specify)				0	31.00
32.00	Balance due provider (line 8 (or line 10) min	nus line 30 and l	ine 31) (see instructio	ns)	0	32.00

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-0065	Peri od: From 01/01/2016	Worksheet E-2	
		Component CCN: 15-U065			
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	

		•		5/23/2017 9:4	2 am
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		6, 724	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		,		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.00
	instructions)				
5.00	Program days		39	0	5.00
6.00	Interns and residents not in approved teaching program (see in			0	0.00
7.00	Utilization review - physician compensation - SNF optional met	hod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		6, 724	0	
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		6, 724	0	
11.00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11.00
	professional services)				
	Subtotal (line 10 minus line 11)		6, 724	0	
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	1, 288	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	5, 436	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		8, 038		17.00
	Adjusted reimbursable bad debts (see instructions)		5, 225	5, 080	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	18.00
19.00	Total (see instructions)		10, 661	5, 080	19.00
	Sequestration adjustment (see instructions)		213	102	19. 01
20.00	Interim payments		5, 328	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, a		5, 120	4, 978	22.00
23.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-0065	Peri od: From 01/01/2016	Worksheet E-2	
		Component CCN: 15-U065			
		Title XIX	Swing Beds - NF	Cost	
			Part A	Part B	
			1. 00	2. 00	

				3/23/2017 9.42	2 0111
		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 instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		0		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in				
4.00	Per diem cost for interns and residents not in approved teach	ing program (see	0.00		4.00
	instructions)				
5. 00	Program days		0		5.00
6.00	Interns and residents not in approved teaching program (see i		0		6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0		11.00
	professional services)				
	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records) (excl ude coi nsurance	0		13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14.00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	0		15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)	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 (see inst	ructions)	0		18.00
19. 00	Total (see instructions)		0		19.00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
20.00			0		20.00
	Tentative settlement (for contractor use only)		0		21.00
	Balance due provider/program (line 19 minus lines 19.01, 20,		0		22.00
23.00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2				

Health Financial Systems SCHNECK ME BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0065 Period: From 01/

Peri od: Worksheet G From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 9:42 am

Cemeral Fault	onl y)				12/31/2010	5/23/2017 9: 4	
DEBENT ASSETS 1.00			General Fund				
CURRENT ASSETS			1 00			4 00	
Cash on hand in banks		CURRENT ASSETS	1.00	2.00	3.00	4.00	
Notes receivable							
Accounts receivable					-		
1,000 Common 1,00			٧		0		1
All owences for uncell ecit ble notes and accounts receivable -48, 650,224 0 0 0 0 0 0 0 0 0					0		
1.00 Inventory				1	Ö		1
9.00 Other current asserts 13,508,890 O O O O 0 0,00 11.00 Discreption of the Flunds 10.00 Dis	7.00			1	0	0	7.00
10.00 Due from other Tunds				1	0	_	
11.00 Total current assets (sum of lines 1-10) 101, 373, 197 0 0 0 11.00			13, 508, 890	1	0	_	
FIXED_ASSETS			U 101 272 107	1	- 1	_	
12.00 Land	11.00	,	101, 373, 177]	<u> </u>	0	11.00
14.00 Accumulated depreciation -2,339,966 0 0 14.00	12.00		8, 026, 498	0	0	0	12.00
15.00 Buildings		•	1	1	0	_	1
16.00 Accumul ated depreciation -38, 461, 429 0 0 0 16.00 17.00 Leasehold improvements 0 0 0 0 17.00 17.		•			0	_	
17.00 Leasehold Improvements			1		0	_	1
18.00 Accumul ated depreciation 0 0 0 18.00 19.00 19.00 61.00 19.00 61.0			-30, 401, 427		0		1
20.00 Accumulated depreciation -4,120,671 0 0 0 20.00		•	Ö	Ö	Ö		
21.00 Automobiles and trucks	19. 00	Fi xed equi pment	5, 325, 703	0	0	0	19. 00
22.00 Accumulated depreciation 0 0 0 22.00			-4, 120, 671		0		1
23.00 Maj or movable equipment 46.411.273 0 0 0 23.00			0	1	0		
24. 00 Accumulated depreciation -35, 729, 632 0 0 0 24. 00			0 46 411 273		0		1
25.00 Minor equipment depreciable 3,775, 424 0 0 0 25.00 26.00 Accumulated depreciation -3,334,438 0 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 0 0 28.00 28.00 28.00 28.00 0 0 0 0 0 0 0 28.00 28.00 29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 29.0					0		
27.00 HIT designated Assets 0 0 0 0 27.00		,	1		0		1
28. 00 Accumulated depreciation 0 0 0 0 0 0 28. 00		Accumulated depreciation	-3, 334, 438	0	0	0	
29.00 Minor equipment-nondepreciable 0 0 0 0 29.00			0		0		1
30.00 Total fixed assets (sum of lines 12-29) 66,937,411 0 0 0 30.00			0		0		
OTHER ASSETS 9,303,804 0 0 0 31.00 32.00 32.00 Deposits on leases 9,303,804 0 0 0 0 32.00 32.00 Deposits on leases 0 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 33.00 35.00 Total other assets (sum of lines 31-34) 158, 449, 721 0 0 0 35.00 0 0 35.00 0 0 0 35.00 0 0 0 0 35.00 0 0 0 0 0 35.00 0 0 0 0 0 0 0 0 0			66 937 411		- 1		
22.00 Deposits on leases 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets 149,145,917 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 158,449,721 0 0 0 35.00 50.00 Total other assets (sum of lines 11, 30, and 35) 326,760,329 0 0 0 36.00 50.00 CURRENT LIABILITIES	30.00		00, 737, 411		<u> </u>		30.00
33.00 Due from owners/officers 0 0 0 0 0 33.00	31.00	Investments	9, 303, 804	. 0	0	0	31.00
34.00 Other assets 149,145,917 O O O 34.00		į ·	0	1	0	_	
35.00 Total other assets (sum of lines 31-34) 158, 449, 721 0 0 0 35.00			140 145 017		0	_	1
36.00 Total assets (sum of lines 11, 30, and 35) 326, 760, 329 0 0 0 36.00				1	0	_	
CURRENT LIABILITIES		1		1	- 1		
38.00 Salaries, wages, and fees payable 9, 961, 117 0 0 0 38.00 39.00 Payroll taxes payable 24, 264 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
39.00 Payrol taxes payable			1		0		1
A0.			1		0		1
41.00 Deferred income 42.00 Accelerated payments 0 0 0 0 0 42.00 42.00 Accelerated payments 0 0 0 0 0 0 42.00 42.00 43.00 Due to other funds 0 0 0 0 0 0 0 43.00 44.00 Other current liabilities 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		0		
42.00 Accelerated payments 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 0 43.00 Other current liabilities 0 0 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 13,066,918 0 0 0 0 LONG TERM LIABILITIES 0 0 0 0 0 46.00 Mortgage payable 28,353,826 0 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 49.00 Other long term liabilities (sum of lines 46 thru 49) 36,926,610 0 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,926,610 0 0 0 10 Total liabilities (sum of lines 45 and 50) 49,993,528 0 0 0 51.00 CAPITAL ACCOUNTS 276,766,801 52.00 52.00 General fund balance 276,766,801 0 55.00 55.00 Donor created - endowment fund balance 0 55.00 55.00 Plant fund balance - invested in plant 0 55.00 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 0 0 0 59.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 0 42.00 0 0 0 0 0 44.00 0 0 0 0 0 45.00 0 0 0 0 46.00 0 0 0 0 47.00 0 0 0 48.00 0 0 0 0 48.00 0 0 0 49.00 0 0 0 49.00 0 0 0 49.00 0 49.00 0 0 49.00 0 49.		, , , , , , , , , , , , , , , , , , , ,	ĺ	Ö	Ö		
44.00 Other current liabilities	42.00		0			I	42.00
45. 00 Total current liabilities (sum of lines 37 thru 44)			0		0		
LONG TERM LIABILITIES			1	-	- 1		
46.00 Mortgage payable 0 0 0 46.00 47.00 Notes payable 28,353,826 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 48.00 49.00 Other long term liabilities 8,572,784 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,926,610 0 0 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 49,993,528 0 0 0 51.00 52.00 General fund bal ance 276,766,801 0 52.00 53.00 52.00 53.00 52.00 53.00 50.00 53.00 50.00 54.00 55.00 55.00 55.00 60	45.00		13,066,918	<u> </u>	U	0	45.00
47. 00 Notes payable 28, 353, 826 0 0 0 47. 00 48. 00 Unsecured Loans 0 0 0 0 0 0 48. 00 49. 00 Other Long term Liabilities (sum of Lines 46 thru 49) 36, 926, 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46. 00		О	0	O	0	46. 00
49.00 Other long term liabilities 50.00 Total long term liabilities (sum of lines 46 thru 49) 50.00 Total liabilities (sum of lines 46 thru 49) 50.00 Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund bal ance 52.00 Specific purpose fund 53.00 Donor created - endowment fund bal ance - restricted 55.00 Donor created - endowment fund bal ance - unrestricted 56.00 Governing body created - endowment fund bal ance 57.00 Plant fund bal ance - invested in plant 58.00 Plant fund bal ance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund bal ances (sum of lines 51 and 326, 760, 329) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			28, 353, 826	0	0	0	47.00
Total long term liabilities (sum of lines 46 thru 49) 36, 926, 610 0 0 0 0 50.00			0		ĭ		
Total liabilities (sum of lines 45 and 50) 49,993,528 0 0 0 0 51.00					-		1
CAPITAL ACCOUNTS 52.00 General fund balance 276,766,801 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 276,766,801 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 60.00					- 1		
52.00 General fund balance 52.00 Specific purpose fund 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 276,766,801 0 0 52.00 53.00 0 53.00 0 55.00 0 55.00 0 55.00 0 56.00 0 57.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		47, 773, 320	<u> </u>	<u> </u>		31.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 54.00 55.00 56.00 57.00 58.00 59.00 60.00	52.00		276, 766, 801				52.00
55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 60.00		, , , , , , , , , , , , , , , , , , , ,		0		I	
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329) 56.00 57.00 58.00 0 0 0 0 59.00 0 0 60.00					- 1	1	
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 60.00					- 1	1	
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 60.00						0	
59.00 Total fund balances (sum of lines 52 thru 58) 276,766,801 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 0.00 326,760,329 0 0 0 60.00		· '					
60.00 Total liabilities and fund balances (sum of lines 51 and 326,760,329 0 0 0 0 60.00						1	
				1	-		1
	60.00		326, 760, 329		o	0	60.00
		11	ı	ı	'		1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES SCHNECK MEDICAL CENTER

Provi der CCN: 15-0065

					rom 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
		Genera	I Fund	Special Pu	urpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILE TO CONSOLIDATED B.S.	14, 227, 503 0 0 0	249, 140, 045 13, 399, 258 262, 539, 303	(0	0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	5 0 0 0 0	14, 227, 503 276, 766, 806 5 276, 766, 801			0 0 0 0 0	10.00 11.00 12.00 13.00 14.00
	Sheet (Title II IIII hus Title 18)	Endowment Fund	PI ant	Fund			
		6. 00	7.00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILE TO CONSOLIDATED B.S.	0		(1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING	0	000000000000000000000000000000000000000	(9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0		(18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2016 | Parts | & II | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0065

Cost Center Description Inpatient Outpatient Total				0 12/31/2016	Date/lime Pre 5/23/2017 9:4	
PART I - PATIENT REVENUES		Cost Center Description	Inpati ent	Outpati ent		Z GIII
Comparison Com		'	1.00	2. 00	3. 00	
1.00		PART I - PATIENT REVENUES				
2.00 SUBPROVIDER - I PF		General Inpatient Routine Services				
3.00 SUBPROVIDER - IRF	1.00		11, 572, 372	2	11, 572, 372	1
4. 00 SUBPROVIDER	2.00					2.00
S. 00						1
Swing bed - NF Company						1
7. 00 SKILLED NURSING FACILITY			1		-	1
8. 00 NURSING FACILITY					0	
9,00 THER LONG TERM CARE Total general inpatient care services (sum of lines 1-9) 11,572,372 11,572,372 10,00 11 11,572,372 11,572,372 10,00 11 11,572,372 11,572,372 10,00 11 11,572,372 11,572,372 10,00 11 11,572,372 11,572,372 10,00 11,572,372 11,572,372 10,00 11,572,372 11,572,372 10,00 11,572,372 12,572,572 12,572,572 12,572,572 12,572,572 12,572,572 12,572,572 12,572,572 12,572,572 12,572,572 12,572,5						1
10.00 Total general inpatient care services (sum of lines 1-9) 11,572,372 11,572,372 11,572,372 11,00						
Intensive Care Type Inpatient Hospital Services						1
11.00 INTENSIVE CARE UNIT 1,636,313 1,636,313 1,00 12.00 13.00 14.00 SURN INTENSIVE CARE UNIT 13.00 SURN INTENSIVE CARE UNIT 13.00 SURN INTENSIVE CARE UNIT 14.00 15.00	10. 00		11, 572, 372	2	11, 572, 372	10.00
12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 13.00 1			1			
13. 00 BURN INTENSIVE CARE UNIT			1, 636, 313	5	1, 636, 313	
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 00 15. 00 1						
15. 00 OTHER SPECIAL CARE (SPECIFY) 15. 00 Total intensive care type inpatient hospital services (sum of lines 1,636,313 1,636						1
16. 00 Total intensive care type inpatient hospital services (sum of lines 1, 636, 313 1, 636, 313 11, 11, 11, 11, 11, 11, 11, 11, 11, 1						
11-15			4 (0) 01		4 (0) 010	
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 13, 208, 685 13, 208, 685 17. 00 18. 00 Ancillary services 51, 088, 217 214, 513, 457 265, 601, 674 18. 00 20	16.00	1	1, 636, 313		1, 636, 313	16.00
18.00 Ancillary services 51,088,217 214,513,457 265,601,674 18.00 19.00 0 0 0 0 0 0 0 0 0	17 00		12 200 (05		12 200 /05	17.00
19.00 Outpatient services						
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22. 00 HOME HEALTH AGENCY 2, 524, 018 2, 524, 018 23. 00 AMBULANCE SERVICES 23. 00 24. 00 CMHC 24. 00 25. 00 HOSPICE 0 2, 229, 671 2, 229, 671 27. 00 NONREIMBURSABLE COST CENTERS 2, 675, 774 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 71, 824, 587 255, 307, 822 327, 132, 409 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) 0 37. 00 SECURE (SECURE) 0 0 38. 00 39. 00 0 39. 00 39. 00 39. 00 39. 00 39. 00 0 0 39. 00						
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 2, 524, 018 2, 524, 018 2, 524, 018 22. 00 23. 00 24. 00 2, 524, 018 2, 524, 018 2, 524, 018 22. 00 24. 00 CMHC 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 HOSPICE 0 0 2, 229, 671 2, 229, 671 26. 00 27. 00 NONREI MBURSABLE COST CENTERS 2, 675, 774 11, 020, 981 13, 696, 755 70. 00 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 71, 824, 587 255, 307, 822 327, 132, 409 29. 00 30. 00 0 31. 00 31. 00 32. 00 0 31. 00 32. 00 33. 00 0 0 32. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) 0 36. 00 37. 00 38. 00 39. 00 38. 00 39. 00 0 39. 00 39. 00 0 0 39. 00 30. 00 0 39. 00 30. 00 0 39. 00 30. 00 0 39. 00 30. 00 0 39. 00 30. 00 0 39. 00 30. 00		· •	l l			•
22. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPICE 27. 00 NONREI MBURSABLE COST CENTERS 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 71, 824, 587 255, 307, 822 327, 132, 409 28. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 37. 00 39. 0					-	1
23.00 AMBULANCE SERVICES (CMHC 25.00 AMBULATORY SURGICAL CENTER (D. P.) HOSPICE NONREI MBURSABLE COST CENTERS Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 71, 824, 587 255, 307, 822 327, 132, 409 28.00 29.00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) ADD (SPECIFY) Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 23.00 24.00 24.00 25.00 26.00 2, 229, 671 2, 229, 671 26.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 27.00 27.00 28.00 29.00 29.00 30.00 31.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00					-	1
24. 00 25. 00 26. 00 26. 00 27. 00 NONREIMBURSABLE COST CENTERS 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00 2				2, 324, 010	2, 324, 010	1
25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPICE						1
26. 00 HOSPICE						
27. 00 NONREIMBURSABLE COST CENTERS 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. Total patient revenues (sum of lines 17-27) (transfer colum				2 220 671	2 220 671	1
28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.			1			
G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 38.00 39.00 0 0 37.00 38.00 39.00						1
PART II - OPERATING EXPENSES 29.00	20.00		71,021,007	200,007,022	027, 102, 107	20.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 123, 376, 482 29. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30.						
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33	29.00			123, 376, 482		29.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00						1
33.00 34.00 35.00 36.00 37.00 38.00 38.00 39.00 30.00	31.00					1
34.00 35.00 36.00 37.00 38.00 39.00 34.00 0 35.00 36.00 37.00 0 38.00 39.00						•
35.00 36.00 37.00 38.00 39.00 35.00 0 36.00 37.00 38.00 39.00	33.00)		33.00
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 0 38.00 39.00	34.00					34.00
37. 00 DEDUCT (SPECIFY)	35.00					35.00
38. 00 39. 00 0 39. 00	36.00	Total additions (sum of lines 30-35)		0		36.00
39.00	37.00	DEDUCT (SPECIFY))		37.00
	38.00)		38.00
	39.00					39.00
40.00	40.00		(40.00
41.00	41.00					41.00
42.00 Total deductions (sum of lines 37-41) 0 42.00	42.00			0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 123, 376, 482 43.00	43.00		er	123, 376, 482		43.00
to Wkst. G-3, line 4)		to Wkst. G-3, line 4)	1	1		l

	Financial Systems SCHNECK MEDICAL MENT OF REVENUES AND EXPENSES	L CENTER Provider CCN: 15-0065	Period:	u of Form CMS-2 Worksheet G-3	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0065	From 01/01/2016	worksneet G-3	
			To 12/31/2016	Date/Time Pre	
				5/23/2017 9: 4	2 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		327, 132, 409	1.00
2.00	Less contractual allowances and discounts on patients' accour			198, 468, 041	2.00
3.00	Net patient revenues (line 1 minus line 2)			128, 664, 368	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		123, 376, 482	4.00
5.00	Net income from service to patients (line 3 minus line 4)			5, 287, 886	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			931, 725	6.00
7.00	Income from investments			3, 674, 206	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		6, 840	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			89, 390	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13. 00				0	13.00
14. 00				378, 721	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17. 00				164, 938	
18. 00				36, 944	
19. 00				9, 550	
20. 00	1			7, 007	20.00
21. 00	9			0	21.00
22. 00	Rental of hospital space			54, 718	
23. 00	Governmental appropriations			0	23.00
24. 00	CONTRACT REVENUE			1, 562, 567	24.00
24. 01				160, 697	
24. 02				428, 557	
24. 03	I NREALI ZED GAI N/LOSS			-5, 222	
24. 04				610, 734	24. 04
	Total other income (sum of lines 6-24)			8, 111, 372	
26. 00				13, 399, 258	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			12 200 250	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		ļ	13, 399, 258	∠9.00

	Financial Systems LLOCATION - HHA GENERAL SERVICE	T202	SCHNECK MEDIC	CAL CENTER Provider C	CN: 15 0045	Peri od:	w of Form CMS-2 Worksheet H-1	
CUST A	LLUCATION - HHA GENERAL SERVICE	<u> </u>				From 01/01/2016	Part I	
				HHA CCN:	15-7155	To 12/31/2016	5/23/2017 9: 4	epared: 12 am
						Home Health Agency I	PPS	
			Capital Rela	ated Costs		, Agency :		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bl dgs & Fi xtures	Movable Equipment	PI ant Operati on Mai ntenanc		Subtotal (col s. 0-4)	
	OFNEDAL CEDIU OF COCT OFNEDO	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment	O		0			0	2.00
3.00	Plant Operation & Maintenance	3, 452	0	0	3, 4		0	
4. 00 5. 00	Transportation Administrative and General	0 512, 797	0	0	•	0 0 152 0		4.00
	HHA REIMBURSABLE SERVICES						·	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	424, 070 237, 177	0	0	•	0 0		1
8.00	Occupational Therapy	179, 737	Ö	0		0 0	179, 737	8.00
9. 00 10. 00	Speech Pathology Medical Social Services	19, 704 1, 038	0	0		0 0	,	
11. 00	Home Heal th Ai de	52, 478	0	0	i .	0 0	52, 478	
12. 00 13. 00	Supplies (see instructions) Drugs	2, 133 0	0	0		0 0	2, 133 0	1
14. 00	DME	0	0	0		0 0		1
15 00	HHA NONREI MBURSABLE SERVI CES				I			15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	•	0 0		
17.00	Private Duty Nursing	0	0	0		0 0	1	
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		0 0	0	1
20.00	Day Care Program	o o	o	0		0 0	Ö	20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23. 00	All Others (specify)	0	0	0		0 0	0	1
23. 50	Tel emedi ci ne	0	0	0		0 0	1	
24.00	Total (sum of lines 1-23)	1, 432, 586 Admi ni strati v		0	3, 4	152 0	1, 432, 586	24.00
		e & General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	3.00	0.00					
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable							2.00
3. 00	Equipment Plant Operation & Maintenance							3.00
4. 00	Transportation							4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	516, 249						5.00
6. 00	Skilled Nursing Care	238, 914	662, 984					6.00
7.00	Physical Therapy	133, 621	370, 798					7.00
8. 00 9. 00	Occupational Therapy Speech Pathology	101, 261 11, 101	280, 998 30, 805					8. 00 9. 00
10.00	Medical Social Services	585	1, 623					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	29, 565 1, 202						11. 00 12. 00
13. 00	Drugs	0	0					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15. 00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16. 00 17. 00
17. 00 18. 00	Private Duty Nursing Clinic	0						17.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program Home Delivered Meals Program	0	0					20.00
			١					
21. 00 22. 00	Homemaker Service	0	0					22. 00
21. 00 22. 00 23. 00	Homemaker Service All Others (specify) Telemedicine	0	0 0 0					22. 00 23. 00 23. 50

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SIS		Provider CO	CN: 15-0065 15-7155	Period: From 01/01/2016 To 12/31/2016		pared:
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	Plant	Transnortati	o Reconciliatio	Administrativ	+
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance	11 (MI LE/10E)	"	(ACCUM. COST)	
		,	VALUE)	(SQUARE FEET)			,	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	4, 000				0		1.00
	Fixtures					_		
2. 00	Capital Related - Movable		1, 840			0		2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	4, 000		0		3.00
4. 00	Transportation (see		0	4,000		0		4.00
4.00	instructions)	٥	O	0				4.00
5.00	Administrative and General	4,000	1, 840	4, 000		0 -516, 249	916, 337	5.00
	HHA REIMBURSABLE SERVICES	· · · · · ·	·		•		·	1
6.00	Skilled Nursing Care	0	0	0		0 0	424, 070	6.00
7.00	Physi cal Therapy	0	0	0		0	237, 177	
8.00	Occupational Therapy	0	0	0		0	179, 737	
9. 00	Speech Pathology	0	0	0		0	19, 704	1
	Medical Social Services	0	0	0		0	1, 038	1
11.00	Home Health Aide	0	0	0		0	52, 478	
12.00	Supplies (see instructions)	0	0	0		0	2, 133	
13. 00 14. 00	Drugs DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES	l O	0	0		0 0		14.00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
	Respiratory Therapy	l o	0	Ö		0 0	Ö	
17.00	Private Duty Nursing	o	0	0		0 0	0	17.00
18.00	Clinic	О	0	0		0 0	0	18.00
19.00	Health Promotion Activities	O	0	0		0 0	0	19.00
	Day Care Program	0	0	0		0	0	20.00
	Home Delivered Meals Program	0	0	0		0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
	All Others (specify)	0	0	0		0	0	23. 00
	Telemedicine	1 000	1 040	0		0 514 340	014 227	
24. 00 25. 00	Total (sum of lines 1-23) Cost To Be Allocated (per	4,000	1, 840 0	4, 000 3, 452		0 -516, 249	916, 337 516, 249	
∠5.00	Worksheet H-1, Part I)	١	U	3, 452			310, 249	25.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 863000	0. 00000	00	0. 563383	26. 00

						Home Health Agency I	PPS	
			CAPI TAL REI	ATED COSTS		Agency i		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2.00	4. 00	4A	5. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	0 662, 984 370, 798 280, 998 30, 805 1, 623 82, 043 3, 335 0	21, 604 0 0 0 0 0 0 0 0 0	918 0 0 0 0 0 0 0	102, 406 117, 048 65, 463 49, 609 5, 439 286 14, 484 0 0	124, 928 780, 032 436, 261 330, 607 36, 244 1, 909 96, 527 3, 335 0	81, 684 61, 902 6, 786 357 18, 073	5. 00 6. 00 7. 00 8. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 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	0 0 0 0 0 0 0 0 0 1, 432, 586	0 0 0 0 0 0 0 0 21, 604	0 0 0 0 0 0 0 918	0 0 0 0 0 0 0 0 0 354, 735	0 0 0 0 0 0 0 0 1, 809, 843 0. 000000		13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
	cost center bescription	PLANT	LINEN SERVICE				ADMINISTRATIO N	
1 00		7. 00	8. 00	9. 00	10.00	11.00	13.00	4 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 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 Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	34, 254 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 00 00 00 00 00 00 00 00 00 00 00 00	10, 746 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 756 7, 102 2, 961 2, 033 181 15 1, 286 0 0 0 0 0 0 0 0 0 17, 334	55, 812 105, 542 43, 991 30, 201 2, 684 220	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 19. 00 19. 50

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

Peri od: Worksheet H-2
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 9: 42 am Provi der CCN: 15-0065 HHA CCN: 15-7155 Home Health PPS

						Home Health	PPS	
					OTHER GENERAL	Agency I		
					SERVI CE			
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSI CI AN	Subtotal	
		SERVICES &		RECORDS &	PRI VATE	ANESTHETI STS		
		SUPPLY	45.00	LI BRARY	PRACTI CE	10.00	04.00	
1 00	Administrative and General	14. 00	15. 00 0	16.00	18. 00	19. 00	24. 00	1.00
1. 00 2. 00	Skilled Nursing Care	0	0		_	0	268, 718 1, 038, 727	2. 00
3. 00	Physical Therapy	0	0		_	0	564, 897	3.00
4. 00	Occupational Therapy	0	0		0	0	424, 743	4. 00
5. 00	Speech Pathology	Ö	0	1	Ö	_	45, 895	5. 00
6. 00	Medical Social Services	0	0	Ö	ō	0	2, 501	6.00
7.00	Home Health Aide	0	0	0	0	0	134, 988	7.00
8.00	Supplies (see instructions)	544	0		0	0	4, 503	8.00
9. 00	Drugs	0	0		_	0	0	9. 00
10.00		0	0		0	0	0	10.00
11.00	1	0	0			_	0	11.00
12. 00 13. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	0		_	_	0	12. 00 13. 00
14. 00		0	0				0	14. 00
15. 00	1	0	0		_	_	0	15. 00
16. 00	1	o o	0	1		-	Ö	16.00
17. 00		0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50		0	0		0	0	0	19. 50
20.00	, , , ,	544	0	15, 831	0	0	2, 484, 972	20.00
21. 00	•							21.00
	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	Intern &	Subtotal	Allocated HHA	Total HHA			
		Resi dents		A&G (see Part	Costs			
		Cost & Post		11)				
		Stepdown Adjustments						
		25. 00	26. 00	27. 00	28.00			
1. 00	Administrative and General							
2 00	Admirti Strati ve and deneral	0	268, 718		20.00			1.00
2. 00	Skilled Nursing Care	0	268, 718 1, 038, 727					1. 00 2. 00
3.00				125, 944	1, 164, 671			2. 00 3. 00
3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	0	1, 038, 727 564, 897 424, 743	125, 944 68, 493 51, 500	1, 164, 671 633, 390 476, 243			2. 00 3. 00 4. 00
3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0	1, 038, 727 564, 897 424, 743 45, 895	125, 944 68, 493 51, 500 5, 565	1, 164, 671 633, 390 476, 243 51, 460			2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501	125, 944 68, 493 51, 500 5, 565 303	1, 164, 671 633, 390 476, 243 51, 460 2, 804			2. 00 3. 00 4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988	125, 944 68, 493 51, 500 5, 565 303 16, 367	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503	125, 944 68, 493 51, 500 5, 565 303 16, 367 546	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503	125, 944 68, 493 51, 500 5, 565 303 16, 367 546	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	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	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	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	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0			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
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	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	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0			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
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	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	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00	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	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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 Homemaker Service	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	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 Homemaker Service All Others (specify)	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	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 Homemaker Service All Others (specify) Telemedicine	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	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 Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 50 20. 00	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 Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 50 20. 00	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 Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 50 20. 00	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 Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 50 20. 00	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 Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 0 0 0	1, 038, 727 564, 897 424, 743 45, 895 2, 501 134, 988 4, 503 0 0 0 0 0 0	125, 944 68, 493 51, 500 5, 565 303 16, 367 546 0 0 0 0 0 0 0 0 0	1, 164, 671 633, 390 476, 243 51, 460 2, 804 151, 355 5, 049 0 0 0 0 0 0 0 0 0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00

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

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	HHA COST CENTERS STATISTICAL Provider CCN: 15-0065	Period: Worksheet H-2 From 01/01/2016 Part II
5.10.10	HHA CCN: 15-7155	To 12/31/2016 Date/Time Prepared:

						Home Health	PPS	
						Agency I		
		CAPITAL REL	ATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE		ADMI NI STRATI V	OPERATION OF	
		(SQUARE	(DOLLAR	BENEFITS	n	E & GENERAL	PLANT	
		FEET)	VALUE)	DEPARTMENT		(ACCUM.	(SQUARE	
				(GROSS		COST)	FEET)	
		1.00	2.00	SALARI ES)	ГА	F 00	7.00	
1 00	Administrative and General	1. 00 1, 690	2. 00 1, 840	4.00	5A	5. 00 124, 928	7. 00 1, 690	1. 00
1. 00 2. 00	•	1, 690	1, 840		1		1, 690	2. 00
3. 00	Skilled Nursing Care Physical Therapy		0	424, 070	1		0	3. 00
4. 00	, ,		0	237, 177 179, 737	1		0	4. 00
5. 00	Occupational Therapy Speech Pathology		0	19, 704			0	5. 00
6. 00	Medical Social Services		0	1, 038			0	6. 00
7. 00	Home Health Aide		0	52, 478	1		0	7. 00
8. 00	Supplies (see instructions)		0	52,470			0	8. 00
9. 00	Drugs		0			-,	0	9. 00
10.00	DME		0			1	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0		_	Ö	11. 00
12. 00	Respiratory Therapy		0				o o	12. 00
13. 00	Pri vate Duty Nursing	0	0	٥	1	1	o o	13. 00
14. 00	Clinic	0	0	0			Ö	14. 00
15. 00	Health Promotion Activities	0	0	0			Ö	15. 00
16. 00	Day Care Program	0	0	0	l č	0	o o	16. 00
17. 00	Home Delivered Meals Program	0	0	0	d	0	0	17. 00
18. 00	Homemaker Service	0	0	l o	d	0	o	18. 00
19. 00	1	0	0	l o	ď	0	o	19. 00
19. 50	Tel emedi ci ne	0	0	0		0	0	19. 50
20.00	Total (sum of lines 1-19)	1, 690	1, 840	1, 285, 226		1, 809, 843	1, 690	
21.00	Total cost to be allocated	21, 604	918		1	338, 868		
22.00		12. 783432	0. 498913			0. 187236		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	·	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	ADMI NI STRATI O	SERVICES &	
		(POUNDS OF	FEET)	SERVED)	SERVI CE)	N	SUPPLY	
		LAUNDRY)				(DI RECT	(COSTED	
						NRSI NG HRS)	REQUIS.)	
		8. 00	9. 00	10. 00	11. 00	13. 00	14. 00	
1. 00	Administrative and General	0	1, 690	0	8, 111	· ·	0	1.00
2.00	Skilled Nursing Care	0	0	0	15, 338		0	2.00
3. 00	Physical Therapy	0	0	0	6, 393		0	3.00
4. 00	Occupational Therapy	0	0	0	4, 389		0	4.00
5. 00	Speech Pathology	0	0	0	390		0	5.00
6. 00	Medical Social Services	0	0	0	32		0	6.00
7.00	Home Heal th Ai de	0	0	0	2, 776	2, 776	0	7.00
8. 00	Supplies (see instructions)	0	0	0		0	5, 994	
9.00	Drugs	0	0	0		0	0	9.00
10.00	DME	0	0	0			0	10.00
11.00	Home Dialysis Aide Services		0	0			0	11.00
12.00	Respiratory Therapy		0	0	1	1	0	12.00
13.00	Private Duty Nursing	0	0	0	C		0	13.00
	Clinic	0	0	0			0	
16. 00	Health Promotion Activities Day Care Program	0	0	0	C	-	0	
17. 00	9		0				0	
18. 00	Homemaker Service		0				0	
19. 00	All Others (specify)		0				0	
	Tel emedi ci ne		0				0	19.50
20.00			1, 690	0	37, 429	37, 429	· -	20.00
21. 00			10, 746		17, 334	· ·		21.00
22. 00	1	0. 000000	6. 358580					
00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		2. 000000		300117	5.00.002		

	Financial Systems		SCHNECK MEDI			In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATISTIC	AL Provider C	CN: 15-0065	Peri od:	Worksheet H-2	2
BASIS				HHA CCN:	15-7155	From 01/01/2016 To 12/31/2016		
						Home Health	PPS	
						Agency I		
				OTHER GENERAL				
				SERVI CE				4
	Cost Center Description	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSI CI A			
		(COSTED	RECORDS &	PRI VATE	ANESTHETI ST	S		
		REQUIS.)	LI BRARY	PRACTI CE	(ASSI GNED			
			(GROSS	(TIME	TIME)			
			CHARGES)	SPENT)				4
		15. 00	16. 00	18. 00	19. 00	_		
1. 00	Administrative and General	0	2, 524, 018	0		0		1.00
2.00	Skilled Nursing Care	0	0	0		0		2.00
3. 00	Physi cal Therapy	0	0	0		0		3. 00
4.00	Occupational Therapy	0	0	0		0		4.00
5.00	Speech Pathology	0	0	0		0		5.00
6. 00	Medical Social Services	0	0	0		0		6.00
7.00	Home 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		0		10.00
11. 00	Home Dialysis Aide Services	0	0	0		0		11.00
12.00	Respiratory Therapy	0	0	0		0		12.00
13. 00 14. 00	Private Duty Nursing	0	0	0		0		13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0		0		15.00
16. 00	Day Care Program	0	0	0		0		16.00
17. 00	Home Delivered Meals Program	0	0			0		17. 00
18. 00	Homemaker Service	0	0			0		18.00
19. 00	All Others (specify)	0	0			0		19.00
19. 50	Tel emedi ci ne	0	0	0		0		19.50
20. 00	Total (sum of lines 1-19)	0	2, 524, 018			0		20.00
21. 00	Total cost to be allocated		15, 831			0		21.00
	Unit cost multiplier	0. 000000	0. 006272	0. 000000	0. 0000	00		22. 00
00	10 t 000ta. t. pi i oi	3. 000000	J. 000272	1 2.000000	0.0000	001		1 22.00

	Financial Systems		SCHNECK MEDI			In Lie	u of Form CMS-2	
APP0R1	FIONMENT OF PATIENT SERVICE COST	ΓS		Provider C	CN: 15-0065 15-7155	Peri od: From 01/01/2016 To 12/31/2016		pared:
				Title	e XVIII	Home Health Agency I	PPS	2 4111
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
			Part I)	Part II)	2.00	4.00	col . 4)	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	1.00 PROGRAM COST, A	2.00 AGGREGATE OF T	3.00 HE PROGRAM LI	4.00 MITATION COST, C	5.00 OR BENEFICIARY	
	COST LIMITATION							
1. 00	Cost Per Visit Computation Skilled Nursing Care	2.00	1, 164, 671		1, 164, 67	3, 977	292. 85	1.00
2.00	Physi cal Therapy	3.00	633, 390		633, 39	2, 716	233. 21	2.00
3.00	Occupational Therapy	4.00		C	1, =			3.00
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00			51, 4 <i>6</i> 2, 80			
6. 00	Home Health Aide	7. 00			151, 35			1
7. 00	Total (sum of lines 1-6)		2, 479, 923	C				7.00
					Program Visit	:S		
	0		ODCA N. (4)	B		nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to	Subject to Deductibles		
					Deducti bl es	&		
		0	1. 00	2. 00	Coi nsurance 3. 00	4. 00	5. 00	
	Limitation Cost Computation		1.00	2.00	3.00	4.00	3.00	
8.00	Skilled Nursing Care		18020	C		24		8.00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care		31140 99915		2, 17	59 75		8. 01 8. 02
9. 00	Physical Therapy		18020	C		3 5		9.00
9. 01	Physi cal Therapy		31140	C		31		9. 01
9. 02	Physi cal Therapy		99915	C	1 ., .			9.02
10. 00 10. 01	Occupational Therapy Occupational Therapy		18020 31140		1	33 4		10.00
10. 01	Occupational Therapy		99915	Ċ	1, 09			10.01
11.00	Speech Pathology		18020	C)	0		11.00
11. 01	Speech Pathology		31140	C)	0		11.01
11. 02 12. 00	Speech Pathology Medical Social Services		99915 18020		10	01 2		11. 02 12. 00
12. 00	Medical Social Services		31140		Ó	0		12.00
12.02	Medical Social Services		99915	C) 1	6		12.02
13.00	Home Health Aide		18020	C	•	4		13.00
13. 01 13. 02	Home Heal th Ai de Home Heal th Ai de		31140 99915	[C	1	6		13. 01 13. 02
	Total (sum of lines 8-13)		77713	C	5, 91			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges		
		H-2 Part I, col. 28, line		Ancillary Costs (from	Costs (cols. 1 + 2)	(from HHA Records)	÷ col. 4)	
		20, 11116	Part I)	Part II)	1 + 2)	Records)		
	Supplies and Drugs Cost Comput	0	1. 00	2.00	3. 00	4. 00	5. 00	
15. 00	Cost of Medical Supplies	8.00	5, 049	C	5, 04	.9 0	0. 000000	15.00
16. 00	Cost of Drugs	9. 00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par			Part B		
	Cost Center Description	Part A	Not Subject	Subject to Deductibles &	Part A	Not Subject	Subject to Deductibles &	
			to Deductibles &	Coi nsurance		to Deductibles &	Coinsurance	
			Coi nsurance			Coi nsurance		
	PART I - COMPUTATION OF LESSER	0F AGGREGATE	7.00 PROGRAM COST. A	8.00 AGGREGATE OF T	9.00 HE PROGRAM LI	10.00 MITATION COST. (11.00 OR BENEFICIARY	
	COST LIMITATION	1. ACCINEDATE					522. 1 5171(1	
1 00	Cost Per Visit Computation Skilled Nursing Care	Ιο	2, 328		I	0 681, 755		1.00
1. 00 2. 00	Physical Therapy					0 352, 147		2.00
3. 00	Occupati onal Therapy	Ö	1		1	0 298, 728		3.00
4.00	Speech Pathology	0	101		1	0 29, 700		4.00
5.00	Medical Social Services	0	18			0 1, 577		5.00
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)		815 5, 918		1	0 85, 363 0 1, 449, 270		6. 00 7. 00
		'	, 5, , 10	•	1	1 ., , 270	'	

INSTITUTE 18 18 18 18 18 18 18 1		Financial Systems IONMENT OF PATIENT SERVICE COST	ΓS	SCHNECK MEDI	CAL CENTER Provider Co	CN: 15-0065	In Lie Period: From 01/01/2016	worksheet H-3	
Cost Center Description 6.00 7.00 8.00 9.00 10.00 11.00					HHA CCN:	15-7155	To 12/31/2016	Date/Time Pre	pared: 2 am
Cost Center Description 6.00 7.00 8.00 9.00 10.00 11.00					Title	e XVIII		PPS	
Limitation Cost Computation		Cost Center Description							
Skilled Bursing Care		limitation Cost Computation	6. 00	7. 00	8. 00	9.00	10. 00	11.00	
Cost Center Description Part A Part B Not Subject to Deductibles & Col nsurance Co	8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
Cost Center Description Part A Description Part B Not Subject to Deductibles & Col nsurance Colnsurance			Progi	ram Covered Cha	arges				
Cost Center Description Part A Deductibles & Coinsurance Coinsuran						Services			
Supplies and Drugs Cost Computations		Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Deductibles &	
15.00 Cost of Medical Supplies 0 0 0 0 0 0 0 0 0			6. 00		8. 00	9.00		11.00	
16.00 Cost of Drugs Cost Center Description Total Program Cost (sum of cols. 9-10) Cost Center Description Total Program Cost (sum of cols. 9-10) Cost Center Description Total Program Cost (sum of cols. 9-10) Cost Center Description Total Program Cost (sum of cols. 9-10) Cost Per Visit Computation Cost Coupational Therapy 298, 728 Cost Center Description	15 00			0	1 0	1		1 0	15.00
Cost (sum of cols. 9-10) PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation				_		1			
COST LIMITATION Cost Per Visit Computation		Cost Center Description	Cost (sum of cols. 9-10)						
Cost Per Visit Computation			OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, (OR BENEFICIARY	
1. 00									-
3.00 Occupational Therapy		Skilled Nursing Care							1.00
4.00		3							2. 00 3. 00
5.00 Medi cal Social Services 1,577 6.00 Home Heal th Ai de 85,363 7.00 Total (sum of lines 1-6) 1,449,270 Cost Center Description 12.00 Limitation Cost Computation 8.00 Skilled Nursing Care 8.01 Skilled Nursing Care 8.02 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 9.02 Physical Therapy 10.00 Occupational Therapy 10.00 Occupational Therapy 10.00 Occupational Therapy 11.00 Speech Pathology 11.01 Speech Pathology 11.02 Speech Pathology 11.02 Speech Pathology 12.00 Medical Social Services 12.01 Medical Social Services									4.00
7. 00 Total (sum of lines 1-6) 1, 449, 270 Cost Center Description 12. 00 Limitation Cost Computation 8. 00 Skilled Nursing Care 8. 01 Skilled Nursing Care 9. 00 Physical Therapy 9. 01 Physical Therapy 9. 02 Physical Therapy 10. 00 Occupational Therapy 10. 00 Occupational Therapy 10. 01 Occupational Therapy 11. 00 Speech Pathology 11. 01 Speech Pathology 11. 02 Speech Pathology 12. 00 Medical Social Services 12. 01 Medical Social Services									5.00
Limitation Cost Computation 8.00 Skilled Nursing Care 8.01 Skilled Nursing Care 8.02 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy 10.02 Speech Pathology 11.02 Speech Pathology 11.02 Speech Pathology 12.00 Medical Social Services									6. 00
Limitation Cost Computation 8. 00 Skilled Nursing Care 8. 01 Skilled Nursing Care 8. 02 Skilled Nursing Care 9. 00 Physical Therapy 9. 01 Physical Therapy 9. 02 Physical Therapy 10. 00 Occupational Therapy 10. 01 Occupational Therapy 10. 02 Occupational Therapy 11. 00 Speech Pathology 11. 01 Speech Pathology 11. 02 Speech Pathology 12. 00 Medical Social Services 12. 01 Medical Social Services	7.00		1, 449, 270						7.00
Limitation Cost Computation 8.00			12. 00						
8.01 Skilled Nursing Care 8.02 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 9.02 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy 10.02 Occupational Therapy 11.00 Speech Pathology 11.01 Speech Pathology 11.02 Speech Pathology 12.00 Medical Social Services 12.01 Medical Social Services									
12.02 Medical Social Services	8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide 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 14.00

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0065	Peri od:	Worksheet H-3	
			HHA CCN:	15-7155	From 01/01/2016 To 12/31/2016			
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	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 COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSPI	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 600626	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 269884	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 658073	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	1. 306593	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 709503	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems SCHNECK MEDIC. ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO	CN: 15-0065	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7155	From 01/01/2016 To 12/31/2016	Part I-II	
			XVIII	Home Health	5/23/2017 9: 4 PPS	
	<u> </u>	11110	XVIII	Agency I		
			Part A	Not Subject	t B Subject to	
			rai t A	to	Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
			1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS Reasonable Cost of Part A & Part B Services	STOMARY CHARGE	ES			1
0	Reasonable cost of services (see instructions)			0 0	0	1
0	Total charges			0 0	0	2
0	Customary Charges Amount actually collected from patients liable for payment 1	for services		0 0	0	3
O	on a charge basis (from your records)	TOT SET VICES			Ĭ	ľ
0	Amount that would have been realized from patients liable for			0 0	0	4
	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)	1 accordance				
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000		l .	
0	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	t (complete		0 0	0	
J	only if line 6 exceeds line 1)	t (comprete				'
C	Excess of reasonable cost over customary charges (complete (1 exceeds line 6)	only if line		0 0	0	8
)	Primary payer amounts			0 0		9
				Part A Services	Part B Services	
				1. 00	2. 00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10
00	Total PPS Reimbursement - Full Episodes without Outliers			0	1	
00	Total PPS Reimbursement - Full Episodes with Outliers			0	37, 017	
00	Total PPS Reimbursement - LUPA Episodes			0	11, 076	
00	Total PPS Reimbursement - PEP Episodes			0	4, 922	
00	Total PPS Outlier Reimbursement - Full Episodes with Outlier	^S		0	4, 241	
00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			0	0	1
00	DME Payments			0	Ö	1
00	Oxygen Payments			0	Ö	
	Prosthetic and Orthotic Payments			0	0	20
	Part B deductibles billed to Medicare patients (exclude coir	nsurance)			0	21
00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	968, 978	22
00 00	Evenes responsible seet (from line 0)			0	0	
00 00 00 00	Excess reasonable cost (from line 8)			0	968, 978	
00 00 00 00	Subtotal (line 22 minus line 23)					25
00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)			_	0	
00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0		26
00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	i netrusti ar-\		0		26 27
00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see)		968, 978	26 27 28
00 00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li)	0	968, 978 968, 978	26 27 28 29
00 00 00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ne 27))	0	968, 978 968, 978 0	26 27 28 29 30
00 00 00 00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	ne 27))	0 0 0	968, 978 968, 978 0 0	26 27 28 29 30 30
00 00 00 00 00 00 00 00 00 00 50	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	ne 27))	0 0 0 0	968, 978 968, 978 0 0 968, 978	26 27 28 29 30 30 31
00 00 00 00 00 00 00 00 00 00 50 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	ne 27))	0 0 0	968, 978 968, 978 0 0 968, 978 19, 380	26 27 28 29 30 30 31
00 00 00 00 00 00 00 00 00 00 50 00 01	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	ne 27))	0 0 0 0 0 0	968, 978 968, 978 0 968, 978 19, 380 949, 599	26 27 28 29 30 30 31 31
00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	ne 27))	0 0 0 0 0	968, 978 968, 978 0 968, 978 19, 380 949, 599	26 27 28 29 30 31 31 32 33

Health Financial Systems SCHNECK MEDICAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 SCHNECK MEDICAL CENTER Provi der CCN: 15-0065 15-0065 Peri od: From 01/01/2016 15-7155 To 12/31/2016 Date/Time Prepared: 5/23/2017 9: 42 am TO PROGRAM BENEFICIARIES

HHA CCN:

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.						5/23/2017 9: 42	2 am_
Inpatient Part A						PPS	
Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00						<u> </u>	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 949,599 1.			Inpatien	t Part A	Pai	rt B	
1.00 Total interim payments paid to provider 0 949,599 1.			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 neter a zero.			1. 00	2. 00			
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero						949, 599	1. 00
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2.00
3.01	3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
3. 03 3. 03 3. 04 3. 05 3. 05 3. 06 3. 00	2 01	Program to Provider		I			2 01
3.03							3. 01
3.05							3. 02
3.05 Provider to Program							3. 04
Provider to Program					-	1	3. 05
3.51		Provider to Program					
3.52	3.50				0	0	3.50
3.53 3.54 3.54 3.59 3.59 3.50-3.98 3.50-							3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.3.50-3.98) 0 0 0 0 3.3.50-3.98) 0 0 0 0 0 0 0 0 0					-	1	3. 52
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					-		3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR					-	1	3. 54
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR	3. 99				0	0	3. 99
To BE COMPLETED BY CONTRACTOR	4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	949, 599	4. 00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NDNE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0				Т			
Program to Provider S	5. 00	desk review. Also show date of each payment. If none,					5. 00
5.02		Program to Provider					
5.03 Provider to Program O					~		5. 01
Provider to Program							5. 02
0	5. 03	Described to Describe			0	0	5. 03
5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 6.60 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 0 0 0 0 0 0 0 0 0	E E0	Provider to Program					5. 50
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 6. 6. 6. 6. 02 SETTLEMENT TO PROGRAM 0 1 6. 7.00 Total Medicare program liability (see instructions) O Mumber O Mumber O Mumber O Mumber O Mumber O Mo/Day/Yr) O 1.00 2.00 O O O O O O O O O							5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 0 1 6. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							5. 51
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					-	1	5. 99
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0	6. 00						6. 00
7.00 Total Medicare program liability (see instructions) 0 949,598 7. Contractor Number (Mo/Day/Yr) 0 1.00 2.00							6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							6. 02
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)			-		7. 00
					Number	(Mo/Day/Yr)	
	8. 00	Name of Contractor)	1.00	2.00	8. 00

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69.00

68 00

69.00

70 00

71.00

100.00 TOTAL

THRIFT STORE*

NURSING FACILITY ROOM & BOARD*

OTHER NONREIMBURSABLE (SPECIFY)*

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

See instructions. Do not transfer the amounts in column 7 to Wkst.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	CENEDAL CEDVICE COCT CENTERS	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	o	12, 000		1.00
2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP*	0	74, 798		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	74, 770		3.00
4. 00	ADMINISTRATIVE & GENERAL*	0	92, 635		4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	15, 769		5.00
6. 00	LAUNDRY & LINEN SERVICE*	o	13, 707		6.00
7. 00	HOUSEKEEPI NG*	o	o		7.00
8. 00	DI ETARY*	0	0		8.00
9. 00	NURSI NG ADMI NI STRATI ON*	o	13, 290		9.00
10. 00	ROUTI NE MEDI CAL SUPPLI ES*	o	8, 920		10.00
11. 00	MEDI CAL RECORDS*	ő	0, 720		11.00
12. 00	STAFF TRANSPORTATION*	ő	0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	ő	0		13. 00
14. 00	PHARMACY*	ő	o		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	ő	0		15. 00
16. 00	OTHER GENERAL SERVICE*	ő	o		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	Ŭ	Ĭ		17. 00
.,. 00	DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0		25. 00
26. 00	PHYSICIAN SERVICES**	O	63, 925		26. 00
27. 00	NURSE PRACTITIONER**	Ö	0		27. 00
28. 00	REGI STERED NURSE**	0	339, 843		28. 00
29. 00	LPN/LVN**	O	0		29.00
30.00	PHYSI CAL THERAPY**	0	o		30.00
31.00	OCCUPATIONAL THERAPY**	O	o		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	o		32.00
33.00	MEDICAL SOCIAL SERVICES**	O	90, 047		33.00
34.00	SPIRITUAL COUNSELING**	o	30, 016		34.00
35.00	DI ETARY COUNSELI NG**	o	ol		35.00
36.00	COUNSELING - OTHER**	0	o		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	89, 507		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	o		38.00
39.00	PATI ENT TRANSPORTATI ON**	0	10, 282		39.00
40.00	IMAGING SERVICES**	o	o		40.00
41.00	LABS & DIAGNOSTICS**	0	o		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	3, 194		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	2, 788		46.00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64. 00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	-58	0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69.00	THRI FT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00		-58	847, 014		100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	62, 304	26.00
27. 00	NURSE PRACTITIONER	0	0	27.00
28. 00	REGI STERED NURSE	0	331, 228	28.00
29. 00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	87, 764	33.00
34.00	SPIRITUAL COUNSELING	0	29, 255	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	87, 238	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATIENT TRANSPORTATION	0	10, 022	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	3, 113	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 717	46.00
100.00	TOTAL *	0	613, 641	100.00

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14, 305

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613, 641

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613, 641 100. 00

2,717

45.00

46.00

45.00

46.00

100.00 TOTAL *

PALLIATIVE CHEMOTHERAPY

OTHER PATIENT CARE SERVICES (SPECIFY)

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

Health Financial Systems	SCHNECK MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC		Provi der CC	N: 15-0065	Peri od:	Worksheet 0-3	
RESPITE CARE		Hospi ce CCN	: 15-1529	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared:
				Hospi ce I	072072017 7. 1	2 4111
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED	0	0		0 0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	715	14	72	29 0	729	26.00
27. 00 NURSE PRACTITIONER	0	0		0 0	0	27. 00
28. 00 REGI STERED NURSE	3, 875	0	3, 87	75 0	3, 875	28. 00
29. 00 LPN/LVN	0	0		0 0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	1, 027	0	1, 02	27 0	1, 027	33.00
34. 00 SPIRITUAL COUNSELING	342	0	34	12 0	342	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36. 00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	1, 021	0	1, 02	21 0	1, 021	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00 PATIENT TRANSPORTATION	0	117	11	17 0	117	39. 00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41. 00 LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	36	3	36 0	36	42.00
43. 00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	32	О	3	32 0	32	46.00
100. 00 TOTAL *	7, 012	167	7, 17	79 0	7, 179	100.00
* Transfor the amount in column 7 to Wket 0.5 col	ump 1 line E2					

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

		ADJUSTMENTS	TOTAL (col. 5	
		/ 00	± col . 6)	
	DIRECT PATIENT CARE SERVICE COST CENTERS	6. 00	7.00	
25. 00	INPATIENT CARE-CONTRACTED		0	25. 00
26. 00	PHYSI CLAN SERVI CES	0	729	26.00
27. 00	NURSE PRACTITIONER	0	127	27.00
		0	2 075	
28. 00 29. 00	REGISTERED NURSE	0	3, 875	28.00
30.00	PHYSICAL THERAPY	0	0	29.00
		0	0	30.00
31. 00 32. 00	OCCUPATIONAL THERAPY	0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	1 007	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1, 027	33.00
34.00	SPIRITUAL COUNSELING	0	342	34.00
35. 00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1, 021	37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN	_		38.00
39. 00	PATI ENT TRANSPORTATI ON	0	117	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	36	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	32	46. 00
100.00	TOTAL *	0	7, 179	100.00

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

Health Financial Systems	SCHNECK MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provi der CC	N: 15-0065	Peri od:	Worksheet 0-4	
I NPATI ENT CARE		Hospi ce CCN	: 15-1529	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 9:4	pared:
				Hospi ce I	0, 20, 201, 711	
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED	0	0		0	0	25.00
26. 00 PHYSI CI AN SERVI CES	875	17	89	0	892	
27. 00 NURSE PRACTITIONER	0	0		0	0	27.00
28. 00 REGI STERED NURSE	4, 740	0	4, 74	0	4, 740	1
29. 00 LPN/LVN	0	0		0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0		0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	1, 256	0	1, 25	66 0	1, 256	33.00
34. 00 SPIRITUAL COUNSELING	419	0	41	9 0	419	34.00
35. 00 DI ETARY COUNSELING	0	0		0	0	35.00
36. 00 COUNSELING - OTHER	0	0		0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	1, 248	0	1, 24	18 0	1, 248	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00 PATIENT TRANSPORTATION	0	143	14	13 0	143	39.00
40.00 I MAGING SERVICES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	45	4	15 0	45	42.00
43.00 OUTPATIENT SERVICES	O	O		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	o	O		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	O		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	39	O	3	0	39	46.00
100. 00 TOTAL *	8, 577	205	8, 78	32 0	<u>8,</u> 782	100.00
* Transfor the amount in column 7 to Wkst 0.5 col	ump 1 line E2	· · · · · · · · · · · · · · · · · · ·	·	·		_

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26. 00	PHYSI CI AN SERVI CES	0	892	26.00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	4, 740	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1, 256	33.00
34.00	SPI RI TUAL COUNSELI NG	0	419	34.00
35. 00	DI ETARY COUNSELI NG	0	0	35.00
36. 00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1, 248	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39. 00	PATI ENT TRANSPORTATION	0	143	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	45	42.00
43. 00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	39	46.00
100.00	TOTAL *	0	8, 782	100.00

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

COST A	Financial Systems SCHNECK MEDI	Provi der Co	CN: 15-0065	Period:	u of Form CMS-2 Worksheet 0-5	
	SES FOR ALLOCATION	Hospi ce CCI		From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
				Hospi ce I	5/23/2017 9: 4	.2 am
	Descriptions		HOSPI CE	GENERAL	TOTAL	
	beschiptions		DI RECT	SERVI CE	EXPENSES (sum	
				ee EXPENSES FROM	of cols. 1 +	
				s) WKST B PART I	2)	
				(see	,	
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		12, 0		41, 529	1
2.00	CAP REL COSTS-MVBLE EQUIP		74, 7		74, 798	1
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 185, 099	185, 099	1
4.00	ADMINISTRATIVE & GENERAL		92, 6		301, 177	
5. 00	PLANT OPERATION & MAINTENANCE		15, 7	·	62, 589	
6.00	LAUNDRY & LINEN SERVICE			0 0	0	
7.00	HOUSEKEEPI NG			0 14, 689	14, 689	
8.00	DI ETARY		12.2	0 0	12 200	
9. 00 10. 00	NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES		13, 2		13, 290 9, 210	
11. 00	MEDICAL RECORDS		8, 9	0 13,770	13, 770	1
12.00	STAFF TRANSPORTATION			0 13,770	13,770	1
13. 00	VOLUNTEER SERVI CE COORDI NATI ON			0	0	1
14. 00	PHARMACY			0 0	0	
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	1
16. 00	OTHER GENERAL SERVICE			0 0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	1
	LEVEL OF CARE					1
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		613, 6	41	613, 641	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		7, 1		7, 179	1
53.00	HOSPICE GENERAL INPATIENT CARE		8, 7	82	8, 782	53.00
	NONREI MBURSABLE COST CENTERS		-			
60.00	BEREAVEMENT PROGRAM			0	0	1
61.00	VOLUNTEER PROGRAM			0	0	
62.00	FUNDRAI SI NG			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	
64.00	PALLIATIVE CARE PROGRAM			0	0	1
65. 00 66. 00	OTHER PHYSICIAN SERVICES			0	0	
67.00	RESI DENTI AL CARE ADVERTI SI NG			0	0	1
68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRIFT STORE			0	0	
70.00	NURSING FACILITY ROOM & BOARD			0	0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	
99.00	NEGATIVE COST CENTER			0	0	

			Hospi ce cc	N: 15-1529 10	0 12/31/2016	5/23/2017 9:4	pared: 2 am
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	41, 529	41, 529				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	74, 798		74, 798			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	185, 099	0	0	185, 099		3.00
4.00	ADMINISTRATIVE & GENERAL	301, 177	7, 802	0	11, 706	320, 685	4.00
5.00	PLANT OPERATION & MAINTENANCE	62, 589	0	0	0	62, 589	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPI NG	14, 689	0	0	0	14, 689	7.00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	13, 290	2, 571	0	3, 668	19, 529	9.00
10.00	ROUTINE MEDICAL SUPPLIES	9, 210	1, 079	74, 798	0	85, 087	10.00
11.00	MEDI CAL RECORDS	13, 770	0	0	0	13, 770	11.00
12.00	STAFF TRANSPORTATION	l	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	ol	0	0	0	0	13.00
14. 00	PHARMACY	l ol	0	Ō	0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	أما	11, 236	0	0	11, 236	15.00
16. 00	OTHER GENERAL SERVICE		5, 142		0	5, 142	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	l j	3, 811		Š,	3, 811	17. 00
.,, 00	LEVEL OF CARE	<u> </u>	5,011	<u> </u>		3,011	.,,,,,,
50.00	HOSPICE CONTINUOUS HOME CARE	O			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	613, 641			165, 423	779, 064	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	7, 179	0	0	1, 935	9, 114	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	8, 782	0	_		11, 149	53.00
00.00	NONREI MBURSABLE COST CENTERS	0,,02			2,007	,	00.00
60.00	BEREAVEMENT PROGRAM	0	9, 888	0	0	9, 888	60.00
61. 00	VOLUNTEER PROGRAM	l ol	0		0	0	61.00
62. 00	FUNDRAI SI NG	l ol	0	Ō	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	l ol	0	Ō	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	أما	0	Ō	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES		0	Ö	0	0	65.00
66. 00	RESI DENTI AL CARE		0	Ö	0	0	66.00
67. 00	ADVERTI SI NG		0	٥	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	٥	0	0	68.00
69. 00	THRI FT STORE		0	Ŏ	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		O		٥	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER		0		0	O	99.00
	TOTAL	1, 345, 753	41, 529	74, 798	185, 099	1, 345, 753	
100.00	7101712	1, 545, 755	+1, JZ7	1 77,770	100, 077	1, 545, 755	1.00.00

			nospi ce cc	N. 13-1329	10 12/31/2010	5/23/2017 9:4	
					Hospi ce I	0, 20, 201, 71	<u></u>
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	r r r	E & GENERAL	OPERATION &	LINEN SERVIC			
			MAI NTENANCE				
		4. 00	5.00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	320, 685					4.00
5.00	PLANT OPERATION & MAINTENANCE	19, 581	82, 170				5.00
6.00	LAUNDRY & LINEN SERVICE	0	. 0		0		6.00
7. 00	HOUSEKEEPI NG	4, 595	0		19, 284		7. 00
8. 00	DI ETARY	0	0		0	l c	
9. 00	NURSI NG ADMI NI STRATI ON	6, 110	6, 263	:	1, 657		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	26, 619	2, 628		695		10.00
11. 00	MEDI CAL RECORDS	4, 308	_, =_0		0		11.00
12. 00	STAFF TRANSPORTATION	0	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14. 00	PHARMACY	0	0		0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	3, 515	27, 376		7, 244		15.00
16. 00	OTHER GENERAL SERVICE	1, 609	12, 527		3, 314		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	1, 192	9, 286		0,011		17. 00
17.00	LEVEL OF CARE	1, 172	7, 200	1			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	243, 724					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	2, 851	0		0 0	l c	
53. 00	HOSPICE GENERAL INPATIENT CARE	3, 488	0	1	0 0		
00.00	NONREI MBURSABLE COST CENTERS	0, 100		1	<u> </u>		30.00
60.00	BEREAVEMENT PROGRAM	3, 093	24, 090		6, 374		60.00
61. 00	VOLUNTEER PROGRAM	0	,	1	0	l .	61.00
62. 00	FUNDRAI SI NG	0	0		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66. 00	RESI DENTI AL CARE	0	0		0 0		
67. 00	ADVERTI SI NG	0	0		0	ĺ	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68.00
69. 00	THRI FT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD	J	Ö			1	70.00
	OTHER NONREIMBURSABLE (SPECIFY)		0		0		•
99. 00	NEGATI VE COST CENTER		n		o o		
	TOTAL	320, 685	82, 170		0 19, 284	1	100.00
100.00	7.5	320,000	52, 170	1	17, 204	,	1.50.00

Health Financial S	Systems		SCHNECK MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
COST ALLOCATION -	HOSPI TAL-BASED	HOSPICE GENERAL	SERVI CE COSTS	Provi der CCN: 15-0065	Peri od:	Worksheet 0-6

From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 9: 42 am Hospi ce CCN: 15-1529 Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATIO SERVI CE COORDI NATI ON SUPPLI ES Ν N 11.00 9.00 10.00 12.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 33, 559 9.00 ROUTINE MEDICAL SUPPLIES 115, 029 10.00 10.00 11.00 MEDICAL RECORDS 0 18,078 11.00 12.00 STAFF TRANSPORTATION 0 12.00 0 VOLUNTEER SERVICE COORDINATION 0 13.00 0 13.00 0 14.00 PHARMACY 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 OTHER GENERAL SERVICE 0 16.00 16.00 0 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 50.00 0 0 51.00 HOSPICE ROUTINE HOME CARE 10,067 112,828 17, 732 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 10, 068 1, 182 186 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 10,068 1,019 160 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 60.00 3, 356 0 0 0 0 0 0 0 0 0 61.00 0 0 61.00 62.00 FUNDRAI SI NG 62.00 0000000 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 PALLIATIVE CARE PROGRAM 64.00 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 66.00 67 00 ADVERTI SI NG Ω 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 Ω 71.00 99.00 99. 00 NEGATI VE COST CENTER 0 0

33, 559

115, 029

18, 078

0 100.00

100.00 TOTAL

Heal th FinancialSystemsSCHNECK MECOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0065 | Period: | Worksheet 0-6 | From 01/01/2016 | Part | | Hospice CCN: 15-1529 | To 12/31/2016 | Date/Time Prepared: | Date/Time Prepared: | Part | Par Provider CCN: 15-0065

			nospi ce co	10 1027	0 12/01/2010	5/23/2017 9: 4	2 am
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	49, 371				15.00
16.00	OTHER GENERAL SERVICE	0		22, 592			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				14, 289		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	48, 427			1, 234, 002	
52.00	HOSPICE INPATIENT RESPITE CARE	0	507			31, 814	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	437	200	6, 615	33, 136	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		46, 801	60.00
61. 00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAI SI NG	0		0		0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	
67. 00	ADVERTI SI NG	0		0		0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRI FT STORE	0		0		0	
70. 00	NURSING FACILITY ROOM & BOARD					0	
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		_	0	71.00
99. 00	NEGATI VE COST CENTER	0	0	0	-	0	
100.00	TOTAL	0	49, 371	22, 592	14, 289	1, 345, 753	100.00

	Financial Systems	SCHNECK MEDI				u of Form CMS-	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der C		Peri od: From 01/01/2016	Worksheet 0-6 Part II	1
STATES	STICAL BASIS		Hospi ce CCI	N: 15-1529	To 12/31/2016	Date/Time Pre	pared:
						5/23/2017 9: 4	
					Hospi ce I		
	Cost Center Descriptions		CAP REL MVBLE		RECONCI LI ATI O		
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS SALARI ES)		COSTS)	
		1. 00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	44	4.00	
1. 00	CAP REL COSTS-BLDG & FLXT	2, 310		1			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2,0.0	66, 397				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0		670, 62	25		3.00
4.00	ADMINISTRATIVE & GENERAL	434	0	42, 41		1, 025, 068	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	, ,	0 0	62, 589	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPI NG	0	0		0 0	14, 689	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	143		13, 29	0 0	19, 529	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	60	66, 397		0	85, 087	10.00
11.00	MEDI CAL RECORDS	0	0	1	0	13, 770	
12.00	STAFF TRANSPORTATION	0	0	1	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	13.00
14. 00	PHARMACY	0	0		0	0	14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	625		1	0	11, 236	
16. 00	OTHER GENERAL SERVICE	286		1	0	5, 142	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	212	0		0	3, 811	17.00
EO 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE			1	0 0	0	50.00
50. 00 51. 00	HOSPICE CONTINUOUS HOME CARE			599, 33	-	1	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1			
53.00	HOSPICE GENERAL INPATIENT CARE						
33.00	NONREI MBURSABLE COST CENTERS		0	0,37	7 0	11, 147	33.00
60.00	BEREAVEMENT PROGRAM	550	0		0 0	9, 888	60.00
61. 00	VOLUNTEER PROGRAM	0		1	0 0	0	61.00
62. 00	FUNDRAI SI NG	0	l o	,	0 0	Ö	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	Ō		0 0	Ō	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68 NO	TELEHEALTH/TELEMONI TOPLNG	1	l o	d.		l o	68 00

41, 529 17. 977922 0

74, 798

1. 126527

0 0 0

185, 099 0. 276010

0 69.00 70.00 71.00

320, 685 100. 00 0. 312843 101. 00

68.00

99.00

TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der C	CN: 15-0065	Peri od:	Worksheet 0-6	
STATISTICAL BASIS				From 01/01/2016	Part II	
		Hospi ce CCI	N: 15-1529	To 12/31/2016		
		·			5/23/2017 9: 4	2 am
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET)) (IN-FACILITY	ADMI NI STRATI O	
	MALNITENANCE	(IN EACHLITY	1	DAVS	N	

						5/23/2017 9: 4	2 am
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE		(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY	(040/1112 / 221)	DAYS)	N	
			,		DATS)	(DI RECT NURS.	
		(SQUARE FEET)	DAYS)				
						HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE	1, 876					5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0				6.00
7. 00	HOUSEKEEPI NG	0		1, 664			7. 00
8. 00	DI ETARY	0		0	0		8.00
9. 00	NURSING ADMINISTRATION	143		143		100	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	60		60		0	10.00
11.00	MEDI CAL RECORDS	0		1 0		0	11.00
12. 00	STAFF TRANSPORTATION	0				0	
13. 00	VOLUNTEER SERVICE COORDINATION					0	
						_	
14.00	PHARMACY	0		0		0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	625		625		0	15. 00
16. 00	OTHER GENERAL SERVICE	286		286		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	212		0			17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					30	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	30	52.00
	HOSPICE GENERAL INPATIENT CARE	0		1	0	30	1
33. 00	NONREI MBURSABLE COST CENTERS		1	1		1 30	33.00
40.00	BEREAVEMENT PROGRAM	550	1	550		10	60.00
	1	1		1		1	
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62. 00	FUNDRAI SI NG	0		0		0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0		0		0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		1		0	68.00
69. 00	THRIFT STORE					0	1
							1
70.00	NURSING FACILITY ROOM & BOARD	_	_	_	_	_	70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0	0	0	0	0	
	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	82, 170	0	19, 284			100.00
101.00	UNIT COST MULTIPLIER	43. 800640	0. 000000	11. 588942	0.000000	335. 590000	101.00
	•	•	•	•	•	•	•

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	SCHNECK MEDICA	Provider C	CN: 15 0045	Period:	u of Form CMS- Worksheet 0-0	
	TICAL BASIS	ERVICE COSTS	Hospi ce CC		From 01/01/2016 Part II To 12/31/2016 Date/Tim		epared:
					Hospi ce I	5/23/2017 9:4	42 am
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	cost center bescriptions	MEDI CAL	RECORDS	TRANSPORTATI		(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON	(======================================	
		(PATIENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	T		T	1		
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00 5. 00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE						4. 00 5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES	8, 467					10.00
11.00	MEDICAL RECORDS		8, 467				11.00
12.00	STAFF TRANSPORTATION			84, 45	50		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	C	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	C	
16. 00	OTHER GENERAL SERVICE				0	C	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
F0 00	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0 205	0 205	l .	0 0	C	
51. 00 52. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	8, 305 87	8, 305 87		50 0 0 0	0	
53.00	HOSPICE GENERAL INPATIENT CARE	75	75		0 0		
55.00	NONREI MBURSABLE COST CENTERS	[75]	75	1	O O		33.00
60.00	BEREAVEMENT PROGRAM				0 0	C	60.00
61. 00	VOLUNTEER PROGRAM				0 0	Ċ	
62.00	FUNDRAI SI NG				0 0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	C	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	C	64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	C	65.00
66.00	RESI DENTI AL CARE				0 0	C	
67.00	ADVERTI SI NG				0	C	1
68. 00	TELEHEALTH/TELEMONI TORI NG				0 0	C	
69. 00	THRIFT STORE				0	C	
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	C	
	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	115, 029	18. 078			_	99.00

Health Financial Systems	SCHNECK MEDICAL	CENTER	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HO STATISTICAL BASIS		Provi der CCN: 15- Hospi ce CCN: 15	From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II Date/Time Prepared:

						5/23/2017 9:42 am
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(TIME	CARE SERVICES		
		(PATI ENT	SPENT)	(IN-FACILITY	'	
		DAYS)		DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS		,	,		
1.00	CAP REL COSTS-BLDG & FIXT					1.1
2.00	CAP REL COSTS-MVBLE EQUIP					2.
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.
4.00	ADMINISTRATIVE & GENERAL					4.
5.00	PLANT OPERATION & MAINTENANCE					5. (
6.00	LAUNDRY & LINEN SERVICE					6.
7.00	HOUSEKEEPI NG					7. (
8.00	DI ETARY					8.
9.00	NURSI NG ADMI NI STRATI ON					9. (
10.00	ROUTINE MEDICAL SUPPLIES					10.
11.00	MEDI CAL RECORDS					11.0
12.00	STAFF TRANSPORTATION					12.
13.00	VOLUNTEER SERVICE COORDINATION					13.
14.00	PHARMACY					14.
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	8, 467	1			15.
16.00	OTHER GENERAL SERVICE		8, 467			16.
17.00	PATIENT/RESIDENTIAL CARE SERVICES			16	2	17.
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.
51.00	HOSPICE ROUTINE HOME CARE	8, 305	8, 305			51.
52.00	HOSPICE INPATIENT RESPITE CARE	87	87	8	7	52.
53.00	HOSPICE GENERAL INPATIENT CARE	75	75	7	5	53.
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.
61.00	VOLUNTEER PROGRAM		0)		61.
62.00	FUNDRAI SI NG		0)		62.
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.
64.00	PALLIATIVE CARE PROGRAM		0			64.
65.00	OTHER PHYSICIAN SERVICES		0			65.
66.00	RESI DENTI AL CARE	0	0		0	66.
67.00	ADVERTI SI NG		0			67.
68.00	TELEHEALTH/TELEMONI TORI NG		0			68.
69.00	THRI FT STORE		0			69.
70.00	NURSING FACILITY ROOM & BOARD					70.
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	71.
99.00	NEGATI VE COST CENTER					99.
			1	1 11 20		
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 49, 371	22, 592	14, 28	9	100.

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SER	VICE COSTS BY	Provi der Co	CN: 15-0065	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hooni oo CCI	U. 1E 1E20	From 01/01/2016		narad.
			HOSPI CE CCI	N: 15-1529	To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cook Cooker December the	F Wi+ C	0+ +-	HCHC	LIDUC	HI RC	
	Cost Center Descriptions	From Wkst. C,	Cost to	HUHU	HRHC	HIRC	
		Part I, Col. 9 line	Charge Ratio				
		0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS		1.00	2.00	0.00	1. 00	
1.00	PHYSI CAL THERAPY	66.00	0. 600626		0 0	0	1.00
2.00	OCCUPATI ONAL THERAPY	67.00	0. 269884		0 0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0. 658073		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 709503		0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0. 100415		0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1. 306593		0	0	7. 00
8.00	BEHAVI ORAL HEALTH	93.00	2. 367147		0	0	8. 00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9. 00
10.00	WOUND CARE (DIABETES CENTER)	76.00	0. 636455		0	0	10.00
10. 02	CASE MANAGEMENT	76. 02	1. 387015		0 0	0	10.02

Cost Center Descriptions From Wkst. C, Cost to HCHC HRHC HIRC		
Part I, Col. Charge Ratio		
9 line	_	
0 1.00 2.00 3.00 4.00		
ANCI LLARY SERVI CE COST CENTERS 1. 00 PHYSI CAL THERAPY 66. 00 0. 600626 0 0		1 00
	0	1.00
	0	2.00
3. 00 SPEECH PATHOLOGY 68. 00 0. 658073 0 0 0 4. 00 DRUGS CHARGED TO PATIENTS 73. 00 0. 709503 0 0	0	3. 00 4. 00
5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00	۷	4. 00 5. 00
6. 00 LABORATORY 60. 00 0. 100415 0	0	6.00
7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 1. 306593 0 0	0	7. 00
8. 00 BEHAVI ORAL HEALTH 93. 00 2. 367147 0	0	8.00
9. 00 RADI OLOGY-THERAPEUTI C 93. 00 2. 36/14/1 0 0	۷	9. 00
10. 00 WOUND CARE (DI ABETES CENTER) 76. 00 0. 636455 0	0	9. 00 10. 00
10. 00 WOUND CARE (DIABETES CENTER)	0	10.00
10. 02 CASE MANAGEMENT 76. 02 1. 387015 0 0 10. 03 PALN MANAGEMENT 76. 03 0. 656337 0 0	0	10. 02
10. 03 PATN WANAGEMENT	0	10. 03
11. 00 Totals (sum of lines 1-11)	۷	10. 97
Charges by Shared Service Costs by LOC		11.00
LOC (from		
Provi der		
Records)		
Cost Center Descriptions Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (co	1	
x col . 2) x col . 3) x col . 4) x col . 5)		
5.00 6.00 7.00 8.00 9.00		
ANCI LLARY SERVI CE COST CENTERS		
1.00 PHYSI CAL THERAPY 0 0 0 0	0	1.00
2. 00 OCCUPATI ONAL THERAPY 0 0 0 0	0	2.00
3.00 SPEECH PATHOLOGY O O O O	0	3.00
4.00 DRUGS CHARGED TO PATIENTS 0 0 0 0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED		5.00
6.00 LABORATORY 0 0 0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0	0	7.00
8. 00 BEHAVI ORAL HEALTH 0 0 0 0	0	8.00
9. 00 RADI OLOGY-THERAPEUTI C		9.00
10. 00 WOUND CARE (DIABETES CENTER) 0 0 0 0	0	10.00
10. 02 CASE MANAGEMENT 0 0 0	0	10.02
10. 03 PAIN MANAGEMENT 0 0 0 0		10.03
10. 97 CARDIAC REHABILITATION 0 0 0		10. 97
11.00 Totals (sum of lines 1-11) 0 0 0	0	11.00

Health Financial Systems	SCHNECK MEDICAL	CENTER		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provider CCN	I: 15-0065	Peri od: From 01/01/2016	Worksheet 0-8
		Hospi ce CCN:	15-1529		Date/Time Prepared:

		Hospi ce CCN	l: 15-1529 T	0 12/31/2016	Date/Time Pre 5/23/2017 9:4	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	3.00
4. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)	0	-		4.00
5.00	Program cost (line 3 times line 4)		0	0		5. 00
	HOSPICE ROUTINE HOME CARE					
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			1, 234, 002	6. 00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				8, 305	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				148. 59	8. 00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	8, 305			9. 00
10.00	Program cost (line 8 times line 9)		1, 234, 040	0		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	/, col. 8,			31, 814	11. 00
40.00	line 11)				0.7	40.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				87	12.00
13.00	Total average cost per diem (line 11 divided by line 12)	10)	0.7		365. 68	
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	87	0		14.00
15. 00	Program cost (line 13 times line 14)		31, 814	0		15.00
1/ 00	HOSPICE GENERAL INPATIENT CARE	7 0		I	22 12/	1/ 00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7 line 11)	7, COL. 9,			33, 136	16. 00
17 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				75	17. 00
	Total undupricated days (wkst. 3-9, col. 4, fine 13) Total average cost per diem (line 16 divided by line 17)				75 441. 81	18.00
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	20 12)	75		441.01	19.00
	Program cost (line 18 times line 19)	le 13)	33, 136	0		20.00
20.00	TOTAL HOSPICE CARE		33, 130	U		20.00
21 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 298, 952	21 00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)					22.00
	Average cost per diem (line 21 divided by line 22)				153. 41	
23.00	Average cost per drem (Time 21 drvided by Time 22)	1		l l	100.41	23.00

		DI CAL CENTER		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0065	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 9:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			563, 196	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			58, 611	2.00
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cos	st reporting period (see ins	tructions)	0 28. 69	
4. 00	Number of interns & residents (see instructions)	st reporting period (see this	tructrons)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0. 00	
6. 00	Indirect medical education adjustment (multiply line 5 by	y the sum of lines 1 and 1.0	1, columns 1 and	0	
	1.01) (see instructions)	•			
7.00	Percentage of SSI recipient patient days to Medicare Part	t A patient days (Worksheet	E, part A line	0. 00	7. 00
0.00	30) (see instructions)			0.00	0.00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		0. 00 0. 00	
10.00					
11. 00		0. 00 0	11.00		
12.00				621, 807	
	DART II DAVMENT UNDER REACONARIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00					4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circums			0	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2)				3. 00 4. 00
5.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)				5.00
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)				6.00
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				7.00
8.00	Capital minimum payment level (line 5 plus line 7)	`	,	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as a			0	9. 00
10.00	Current year comparison of capital minimum payment level			0	
11. 00	Carryover of accumulated capital minimum payment level own Worksheet L, Part III, line 14)	ver capital payment (from pr	ior year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capita	al payments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, e			0	13.00
14. 00	Carryover of accumulated capital minimum payment level ov			0	1
	(if line 12 is negative, enter the amount on this line)		Ŭ .		
15.00	Current year allowable operating and capital payment (see	,		0	
				^	1 1/ 00
16. 00	Current year operating and capital costs (see instruction Current year exception offset amount (see instructions)	ns)		0	