Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		Inlie	eu of Form CMS-	2552-10
	eport is required by law (42 USC 1395g; 42 CF			ort can result			
	ts made since the beginning of the cost report					OMB NO. 0938- EXPI RES 05-31	0050
HOSPI T/	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	RT CERTIFICATIO	ON Provider CC	CN: 15-0065	Peri od:	Worksheet S	
AND SE	ITLEMENT SUMMARY				From 01/01/2017	Parts I-III	
					To 12/31/2017	Date/Time Pre 5/23/2018 2:0	
DADT I	- COST REPORT STATUS					572372016 2.0	5 pill
Provi de		ort			Date: 5/23/20)18 Time: 2	2:05 pm
use on					Date. 3/23/20	To Thile. 2	1.05 pm
000 011	3. [0] If this is an amended report		er of times the	e provider re	submitted this c	ost report	
	4. [F] Medicare Utilization. Enter "	F" for full or	"L" for low.			lost report	
Contra	ctor 5. [1]Cost Report Status 6. Date	Recei ved:		10. N	PR Date:		
use on	v (1) As Submitted 7. Contr	actor No.		11. C	ontractor's Vend	or Code:	4
	(2) Settled without Audit 8. [N]	Initial Report	for this Provi	der CCN 12. [
	(3) Settled with Audit 9. [N]	Final Report f	or this Provide	er CCN	number of ti	mes reopened =	0-9.
	(4) Reopened						
	(5) Amended						
DADT I							
	- CERTIFICATION						
	RESENTATION OR FALSIFICATION OF ANY INFORMATI						
	STRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
	ED OR PROCURED THROUGH THE PAYMENT DIRECTLY O		- A KICKBACK UR	WERE OTHERW	ISE ILLEGAL, CRI	MINAL, CIVIL AN	1D
ADMINI:	STRATIVE ACTION, FINES AND/OR IMPRISONMENT MA						
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	R ADMI NI STRATOR	OF PROVIDER(S)				
	I HEREBY CERTIFY that I have read the above	e certification	statement and	that I have	examined the acc	ompanyi ng	
	electronically filed or manually submitted	cost report and	d the Balance S	Sheet and Sta	tement of Revenu	e and	
	Expenses prepared by SCHNECK MEDICAL CENTER						
	ending 12/31/2017 and to the best of my kno	wledge and beli	ief, this repor	t and statem	ent are true, co	rrect,	
	complete and prepared from the books and re	ecords of the p	rovider in acco	ordance with	applicable instr	uctions,	
	except as noted. I further certify that I	am familiar wi	th the laws and	d regulations	regarding the p	rovision of	
	health care services, and that the services	s identified in	this cost repo	ort were prov	ided in complian	ce with such	
	laws and regulations.						
	[]I have read and agree with the above of	contification s	tatement I cer	ctify that I	intend my electr	oni c	
	signature on this certification state						
	Signatare on this certification states		0 9	g equivarent	or my orriginar a	n gha cur e.	
		(Si gn			turter of Durit	1 ()	
			UTTIC	er or adminis	strator of Provid	der(s)	
			Title				
			nue				
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			bato				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	339, 702	176, 1		0	
2.00	Subprovider - IPF	0	0		0	0	
3.00	Subprovider - IRF	0	0		0	0	
5.00	Swing bed - SNF	0	0		0	0	5.00
6.00	Swing bed - NF	0				0	6.00

200.00 Total 0 339, 702 176, 172 0 200. 00 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

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9.00

HOME HEALTH AGENCY I

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	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provio	ler CCN: 1	5-0065	Period: From 01/01		Part	I	et S-2	
						To 12/31	/2017				pared: 30 am
	1.00	2.00		3.00			4.00				
00	Hospital and Hospital Health Care Co Street: 411 WEST TIPTON STREET	PO Box:									 1. C
00	City: SEYMOUR	State: IN	Zip Cod	e: 47274-	Coun	ty: JACKSON					2.0
		Component Name	CCN	CBSA	Provi dei	Date	Paym	ent S			
			Number	Number	Туре	Certified		<u>, 0,</u>			-
		1.00	2.00	3.00	4.00	5.00	V 6. 00	XVI) 7.(XI X 8.00	-
	Hospital and Hospital-Based Componer	1	2.00	0.00	1.00	0.00	1 0. 00	////	00 [0.00	
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00 00	Subprovi der – I PF Subprovi der – I RF										4.0
00	Subprovider - (Other)										6.0
00	Swing Beds - SNF	SCHNECK MEDICAL CENTE	R 15U065	99915		03/04/199		P	>	Ν	7.
00	Swing Beds - NF	SCHNECK MEDICAL CENTE	R 15U065	99915		03/04/199	9 N			0	8.
00 . 00	Hospital-Based SNF Hospital-Based NF										9. 10.
. 00	Hospi tal -Based OLTC										11.
. 00	Hospital-Based HHA	JACKSON COUNTY HOME	157155	99915		07/01/198	5 N	P	>	0	12.0
00	Separately Cortified ASC	HEALTH									13. (
. 00 . 00	Separately Certified ASC Hospital-Based Hospice	HOSPICE OF MEMORIAL	151529	99915		12/09/199	4				14.0
		HOSPITAL									
. 00	Hospital-Based Health Clinic - RHC										15.0
. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. (
. 00	Renal Dialysis										18. 0
. 00	Other										19. (
						From 1.0			To: 2.00	<u></u>	-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/3			31/2		20.
. 00	Type of Control (see instructions)					8					21.
. 00	Inpatient PPS Information Does this facility qualify and is it	currently, receiving	anymonts for	disprop	ortionato	e Y			N		22.
. 00	share hospital adjustment, in accord								IN		22.0
	for yes or "N" for no. Is this facil			2.106(c)	(2) (Pi ckl	е					
01	amendment hospital?) In column 2, en			s cost n	enortina	v			v		22 (
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)SPI T.	Financial Systems SCHNEC AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		CAL CENTER Provider CC	1	Period: From 01/01/20 Fo 12/31/20	17 Part 17 Date	ksheet	S-2 Prep	ared:
					Urban/Rural		e of G		
5.00	Enter your standard geographic classification (not wa	ge) sta	atus at the bed	ginning of the	1.00	2	2.00		26.0
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not way reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If ap	d of the cost oplicable,		2			27.0
	enter the effective date of the geographic reclassific If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35. C
					Begi nni ng:	E	indi ng	:	
	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00		2.00		36. (
	of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter is in offset in the cost properties period		umber of period	ds MDH status		0			37. (
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37. (
	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/N 1.00		Y/N 2.00		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mile with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re	i)? Enter in co equirements in	olumn 1 "Y" accordance	Y Y		Y		39. (
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	er 1. I	Enter "Y" for y		. N		Ν		40.
			,		1			XI X 5. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for (di sproporti onat	te share in ac	cordance	N	N	N	45.
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.					N	N	N	46.
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS ca Is the facility electing full federal capital payment?						N N	N N	47. 48.
	Teaching Hospitals Is this a hospital involved in training residents in a	approv	ed GME programs	s? Enter "Y"	for yes	N			56.
	or "N" for no. If line 56 is yes, is this the first cost reporting pr GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y' "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	yes o h of tl ", comp	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period?	column 1 Enter "Y"				57.
	If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15–1, chapter 21, §2148? If yes, o			ans' services	as	N			58.
	Are costs claimed on line 100 of Worksheet A? If yes,	•		1	Worksheet	N Docr	s-Thro	ugh	59.
				NAHE 413.85 Y/N	Li ne #	Qual	i fi ca eri on	tion	
00	Are you claiming nursing and allied health education	(NAHE)	costs for	1.00 N	2.00		3.00		60.
	any programs that meet the criteria under §413.85? (s			Direct GME	IME	Dir	rect G	ME	50.
		1.00	2.00	3.00	4.00		5.00		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		2.00			. 00	0100	0.00	61.
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								61.
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see								61.

		CAL CENTER			eu of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΓA	Provider CO		Period: From 01/01/2017 To 12/31/2017		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary. 						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name		e Unweighted IME FTE Count	Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		
 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00	0.00	61.20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser				riad for which	0.00	(2.00
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	tions)					62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s	see instructio		o your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63.00
, · · · · · · · · · · · · · · · ·			Unwei ghted FTEs	Unweighted FTEsin	Ratio (col. 1/	
			Nonprovi der Si te	Hospi tal	(col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	nnrovi	dar Sattings	1.00	2.00	3.00	
period that begins on or after July 1, 2009 and befor	•	0				
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	-priman all nor non-pr	ry care nprovider rimary care	0.0	0. 00	0. 000000	64.00
resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see						
Program Name		ogram Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te		.,,,	
1.00		2.00	3.00	4.00	5.00	

SPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ATA Provider (eriod:		Worksheet	S-2
			Fi To	rom 01/01/ o 12/31/	2017	Part I Date/Time	Prepared
	Program Name	Program Code	Unweighted	Unwei ght		5/18/2018 Ratio (col.	<u>10:30 am</u>
	Program Name	Program code	FTEs	FTEs i		(col. 3 + c	
			Nonprovi der	Hospi ta	al	4))	
	1.00	2.00	Si te 3. 00	4.00		5.00	
.00 Enter in column 1, if line 63	1.00	2.00	0.00		0.00		000 65.0
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 divided by (column 3 + column 4)). (see instructions)							
			Unweighted	Unwei ght		Ratio (col.	
			FTEs Nonprovi der	FTEs i Hospita		(col. 1 + c 2))	:01 .
			Si te 1.00	2.00		3.00	
Section 5504 of the ACA Current		n Nonprovider Settin					
. 00 Enter in column 1 the number of		ry care resident	0.00)	0.00	0.000	000 66.
FTEs attributable to rotations o Enter in column 2 the number of							
Fils attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweight FTEs i Hospita	n (Ratio (col. (col. 3 + c 4))	
Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site	FTES i Hospita	n (al	(col. 3 + c 4))	
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + 	unweighted non-prima al. Enter in column _column 2)). (see in	ry care resident 3 the ratio of structions)	FTĔs Nonprovi der	FTES i Hospi ta 4.00	n (al	(col. 3 + c 4)) 5.00	:01.
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES i Hospi ta 4.00	n (al	(col. 3 + c 4)) 5.00	
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u>	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES i Hospi ta 4.00	n (al	(col . 3 + c 4)) 5.00 0.000	iol . 1000 67. (
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u>	ry care resident 3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES i Hospi ta 4.00	n (al 0.00	(col . 3 + c 4)) 5.00 0.000	000 67. 0
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + 0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u>	ry care resident 3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES i Hospi ta 4.00	n ((col . 3 + c 4)) 5.00 0.000	000 67. 0
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + 	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	ry care resident 3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach	FTES i Hospi ta 4.00	n (al 0.00	(col . 3 + c 4)) 5.00 0.000 0.000	000 67. 0 000 67. 0 00 70. 0
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + 	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	ry care resident 3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	FTES i Hospi ta 4.00	n (al 0.00	(col . 3 + c 4)) 5.00 0.000 0.000	xol . 10000 67. (10000 70. (70. (71. (
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + ame associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility P 100 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no 100 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.</u>	ry care resident 3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi y (IRF), or does it of	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	FTES i Hospita 4.00	n (al 0.00	(col . 3 + c 4)) 5.00 0.000 2.00 3.	000 67. (000 67. (00 70. (

Heal th	Financial Systems SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0065	Peri od:	Worksheet S-	2
				From 01/01/2017 To 12/31/2017	Part I Date/Time Pr	epared:
					5/18/2018 10	: <u>30 am</u>
					1.00	-
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes				N	80.00
81.00	Is this a LTCH co-located within another hospital for part of	or all of the o	cost reportin	g period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Providers					-
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)) TEFRA? Ente	r "Y" for yes	or "N" for no.	N	85.00
	Did this facility establish a new Other subprovider (exclude	ed unit) under	42 CFR Secti	on		86.00
	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospita		under costi en		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		under section		IN IN	07.00
				V	XI X	
				1.00	2.00	_
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	al services? Fi	nter "V" for	N	Y	90.00
	yes or "N" for no in the applicable column.			IN IN	1	70.00
91.00	Is this hospital reimbursed for title V and/or XIX through t			N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appl				N	02.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		ION)? (See		IN	92.00
93.00	Does this facility operate an ICF/IID facility for purposes	of title V and	d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column.					
	Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes	s or "N" for n	o in the	N	N	96.00
	applicable column.			0.00	0.00	97.00
	If line 96 is "Y", enter the reduction percentage in the app Does title V or XIX follow Medicare (title XVIII) for the in			0.00 Y	0.00 Y	97.00
70.00	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1					/0.00
	column 1 for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98.01
	title XIX.	trev, and m				
	Does title V or XIX follow Medicare (title XVIII) for the ca			Y	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of far title VIV	or "N" for no	in column 1			
	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit	tical access h	ospital (CAH)	N	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye					
	for title V, and in column 2 for title XIX.		111 6			00.04
	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98.04
	in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) and add ba				Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.	column 1 for t	itle V, and i	n		
	Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	r Wkst. D.	Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column					
	column 2 for title XIX. Rural Providers					-
	Does this hospital qualify as a CAH?			N		105.00
	If this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of paymen			106.00
	for outpatient services? (see instructions)					
	If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column			N		107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col.			t		
	reimbursed. If yes complete Wkst. D-2, Pt. II.		0			
	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.00
	CIR Section 9412. IIS(C). Litter 1 Tor yes of N Tor no.	Physi cal	Occupati ona	I Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
	If this hospital qualifies as a CAH or a cost provider, are	Ν	N	N	N	109. 00
	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
			ı			
446.07				1101	1.00	110.05
	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter '				N	110.00
	complete Worksheet E, Part A, lines 200 through 218, and Wor					
	appl i cabl e.					

Health Financial Systems SCHNECK MEDICAL CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	CN: 15-0065	Period: From 01/01/	/2017	u of For Workshe Part I	eet S-2	2
		To 12/31/	/2017	Date/Ti 5/18/20	me Pre 018 10:	epared: :30 am
		1.00		2. (00	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N		2.0		111.00
			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 is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t Pub. 15-1, chapter 22, §2208.1.	is "E", enter rm care (incl he definitior	in column udes	N		0	115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N 117.00 s this facility legally-required to carry malpractice insurance? Enter " no.		"N" for	N N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	is	1			118.00
	Premi ums	Losse	S	Insur	ance	
	1.00	2.00		3. (-
118.01 List amounts of malpractice premiums and paid losses:	1, 194, 8	808	0		1	0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other	+h +h -	1.00 N	1	2.0	00	118.02
Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	vision in ACA " for yes or he Outpatient			Y	,	119. 00 120. 00
121.00Did this facility incur and report costs for high cost implantable device	s charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente the Worksheet A line number where these taxes are included.				5.0	00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the certi	fication date	•				126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ication date					127.00
10 column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certif lin column 1 and termination date, if applicable, in column 2.	ication date					128.00
129.00 If this is a Medicare certified lung transplant center, enter the certificol umn 1 and termination date, if applicable, in column 2.	cation date i	n				129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on					130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the c date in column 1 and termination date, if applicable, in column 2.	erti fication					131.00
132.00 If this is a Medicare certified islet transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.	ication date					132.00
133.00 If this is a Medicare certified other transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ïcation date					133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	in column 1					134.00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		S N				140. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		DICAL CENTER Provider CC	CN: 15-0065			u of Form CMS- Worksheet S- Part I Date/Time Pr 5/18/2018 10	2 epared:
1.00	2	. 00			3.00	371072010 10	<u>. 50 am</u>
If this facility is part of a chai	n organization, enter o	n lines 141 throu		name ar		of the	
home office and enter the home off		contractor numbe					
41.00Name: 42.00Street:	Contractor's Name: PO Box:		Contrac	ctor's N	umber:		141.0
42.00 Street. 43.00 Ci ty:	State:		Zip Coo	1e∙			142.0
10.00 of ty.			21 p 000				110.0
						1.00	
44.00 Are provider based physicians' cos	sts included in Workshee [.]	t A?				Y	144.0
					1.00	0.00	_
45.00 If costs for renal services are cl	aimed on Wkst A line	71 are the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio for no in column 2.	in column 1. lf c on for this cost	column 1 is reporting				143.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c	gy changed from the previ n column 1. (See CMS Pub.	iously filed cost 15–2, chapter 4	t report? 40, §4020)	lf	Ν		146. 0
						1.02	_
17 00 Was there a change in the statist	cal basis? Enton "V" for	r vor or "N" for	20			1.00 N	147.0
47.00Was there a change in the statisti 48.00Was there a change in the order of						N N	147. C
49.00 Was there a change to the simplifi				or no.		N	149.0
	<u>_</u>	Part A	Part B		Title V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or ' 55.00Hospital	N TOP NO FOP each comp	N	And Part B	. (See 4	<u>42 CFR 9413</u> N	N	155. 0
56. 00 Subprovi der – TPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158. C
59.00 SNF		N	N		N	N	159.0
60.00HOME HEALTH AGENCY 61.00CMHC		N	N		N	N	160.0
			N		N	N	161. C
						1.00	_
Multicampus							
65.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campu	uses in dif	ferent C	BSAs?	N	165. C
Enter "Y" for yes or "N" for no.	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	-
56.00 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)							00 166. 0
						1.00	-
Health Information Technology (HI	C) incentive in the Amer	ican Recovery and	d Reinvestm	ent Act		1.00	
57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter D5 is "Y") and is a meani	"Y" for yes or " ingful user (line	'N" for no.		er the	Y	167. (0168. (
58.01 If this provider is a CAH and is r	not a meaningful user, do	bes this provider			dshi p		168.0
exception under §413.70(a)(6)(ii)?							
69.00 If this provider is a meaningful ι		nd is not a CAH (line 105 is	s "N"),	enter the	9.9	99169. C
transition factor. (see instruction	ons)			B	egi nni ng	Endi ng	
					1. 00	2.00	-
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	peginning date and ending	g date for the re	eporting	01	/01/2017	12/31/2017	170. 0
					1.00	2.00	-
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r					N		0171.0

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0065	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2017 To 12/31/2017		
				Y/N	5/18/2018 10): 30 an
				1.00	Date 2.00	-
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ent			-
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	corumn 2. (see	Y/N) Date	V/I	-
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F	Program? If	N	2.00	0.00	2.
	yes, enter in column 2 the date of termination and in colum					
~~	vol untary or "I" for invol untary.					
. 00	Is the provider involved in business transactions, includin		N			3.
	contracts, with individuals or entities (e.g., chain home contracts, with home contracts, wit					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	-
00	Financial Data and Reports	tified Dublie	Y	С		
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		ř	L		4.
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfves is th	ne provider i	s N		6.0
. 00	the legal operator of the program?	11 yes, 15 ti		3 11		0.
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7. (
. 00	Were nursing school and/or allied health programs approved		during the	N		8. (
	cost reporting period? If yes, see instructions.					
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. (
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		he current	Ν		10. (
0.00	cost reporting period? If yes, see instructions.			i v		10.
1.00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	_
	Ded Debte				1.00	-
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	ions		Y	12. (
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N	13. (
	period? If yes, submit copy.	sorr og ondinge e	anng this s	oot i opoi ti ng		
3.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see in	structions.	Ν	14.0
4.00	Bed Complement		VOC COO IDC	tructions	N	15. (
4.00	Bed Complement Did total beds available change from the prior cost reporti					
4.00		Par	rt A	Par		_
4.00		Par Y/N	t A Date	Par Y/N	Date	
4.00	Did total beds available change from the prior cost reporti	Par	rt A	Par		
4.00	Did total beds available change from the prior cost reporti	Par Y/N	t A Date	Par Y/N	Date	16.
4.00	Did total beds available change from the prior cost reporti	Par Y/N 1.00	t A Date	Par Y/N 3.00	Date	16.
4.00	Did total beds available change from the prior cost reporti PS&R Data 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	Par Y/N 1.00	t A Date	Par Y/N 3.00	Date	16.
4. 00 5. 00 5. 00	Did total beds available change from the prior cost reporti PS&R Data 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)	Par Y/N 1.00 N	Date 2.00	Par Y/N 3.00	Date 4.00	
4. 00 5. 00 6. 00	Did total beds available change from the prior cost reporti PS&R Data 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) Was the cost report prepared using the PS&R Report for	Par Y/N 1.00	t A Date	Par Y/N 3.00	Date	
4. 00 5. 00 6. 00	Did total beds available change from the prior cost reporti PS&R Data 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Par Y/N 1.00 N	Date 2.00	Par Y/N 3.00	Date 4.00	
4.00 5.00 6.00	Did total beds available change from the prior cost reporti PS&R Data 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) 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	Par Y/N 1.00 N	Date 2.00	Par Y/N 3.00	Date 4.00	
4. 00 5. 00 6. 00 7. 00	Did total beds available change from the prior cost reporti PS&R Data 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) 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)	Par Y/N 1.00 N	Date 2.00	Par Y/N 3.00	Date 4.00	17.
4. 00 5. 00 6. 00 7. 00	Did total beds available change from the prior cost reporti PS&R Data 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) 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	Par Y/N 1.00 N Y	Date 2.00	Par Y/N 3.00 N Y	Date 4.00	17.
4.00 5.00 6.00 7.00	Did total beds available change from the prior cost reporti PS&R Data 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R	Par Y/N 1.00 N Y	Date 2.00	Par Y/N 3.00 N Y	Date 4.00	17. (
4.00 5.00 6.00 7.00 8.00	Did total beds available change from the prior cost reporti PS&R Data 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) 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) 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.	Par Y/N 1.00 N Y N	Date 2.00	Par Y/N 3.00 N Y N	Date 4.00	16. (17. (18. (
4.00 5.00 6.00 7.00	Did total beds available change from the prior cost reporti PS&R Data 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) 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) 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	Par Y/N 1.00 N Y	Date 2.00	Par Y/N 3.00 N Y	Date 4.00	17.

	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-0065	Period: From 01/01/2017 To 12/31/2017		Prepared
		Descrip	tion	Y/N	Y/N	
		0		1.00	3.00	
	f line 16 or 17 is yes, were adjustments made to PS&R			Ν	N	20.0
R	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00 W	Vas the cost report prepared only using the provider's	N	2.00	N	11 00	21.0
	records? If yes, see instructions.					
					1.00	
C	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS HOS	PLTALS)		1.00	
	apital Related Cost	T ON EDICENS HOS	TTTAE5)			
	lave assets been relifed for Medicare purposes? If yes, see	instructions				22. (
	lave changes occurred in the Medicare depreciation expense of		s made dur	ing the cost		23.
	reporting period? If yes, see instructions.					
	Were new leases and/or amendments to existing leases entered	d into during th	iis cost re	eporting period?		24.0
	f yes, see instructions Have there been new capitalized leases entered into during t	the cost reporti	na neriod?	Plfves see		25.
	instructions.	the cost report	ng periou:	11 yes, see		20.
	Vere assets subject to Sec. 2314 of DEFRA acquired during the	e cost reportino	, period?∣	fyes, see		26.
	nstructions.		· •	5		
	las the provider's capitalization policy changed during the	cost reporting	period? If	°yes, submit		27.
	copy.					_
	nterest Expense Vere new Loans, mortgage agreements or letters of credit ent	tered into durir	a the cost	reporting		28.
	period? If yes, see instructions.		ig the cost	. Tepor tring		20.
	Did the provider have a funded depreciation account and/or k	bond funds (Debt	Service R	Reserve Fund)		29.
t	reated as a funded depreciation account? If yes, see instru	uctions		,		
	las existing debt been replaced prior to its scheduled matur	rity with new de	bt? If yes	s, see		30.
	nstructions.	ouenee of new de	h+2 lf voo			21
	Has debt been recalled before scheduled maturity without is nstructions.	suance of new de	bt? IT yes	s, see		31.0
	urchased Services					
2.00 H	lave changes or new agreements occurred in patient care serv	vi ces furni shed	through co	ontractual		32.
	arrangements with suppliers of services? If yes, see instruc					
	fline 32 is yes, were the requirements of Sec. 2135.2 appl	lied pertaining	to competi	tive bidding? If		33.
	no, see instructions.					
	rovider-Based Physicians Are services furnished at the provider facility under an arm	rangement with r	vrovi der-ba	ased physicians?	1	34.
	f yes, see instructions.		novi dei -ba			54.1
1	fline 34 is yes, were there new agreements or amended exis	sting agreements	s with the	provi der-based		35.
p	physicians during the cost reporting period? If yes, see ins	structions.		•		
				Y/N	Date	
	ama Offica Casta			1.00	2.00	_
	ome Office Costs Were home office costs claimed on the cost report?					36.
	fline 36 is yes, has a home office cost statement been pre	epared by the ho	me office?	>		37.
	f yes, see instructions.	opulou og tilo lie				0,11
	fline 36 is yes, was the fiscal year end of the home offi	ice different fr	om that of	-		38. (
	the provider? If yes, enter in column 2 the fiscal year end					
9.00 1	f line 36 is yes, did the provider render services to other	r chain componer	its? If yes	5,		39. (
	see instructions. fline 36 is yes, did the provider render services to the H	homo offico? If				40.0
	nstructions.		yes, see			40.0
D. 00 I						
D. 00 I			j	2.	00	
0. 00 I i		1.00				
0.00 i	ost Report Preparer Contact Information					
0.00 i .00 E	nter the first name, last name and the title/position	JORDAN		ROSE		41.
D. 00 I i 1. 00 E h	nter the first name, last name and the title/position . neld by the cost report preparer in columns 1, 2, and 3,			ROSE		41.0
0. 00 I i 1. 00 E h r	nter the first name, last name and the title/position neld by the cost report preparer in columns 1, 2, and 3, respectively.	JORDAN		ROSE		41. (
0. 00 1. 00 E 2. 00 E	Enter the first name, last name and the title/position neld by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report		C	ROSE		41. (
0. 00 1. 00 E h 2. 00 E p	Enter the first name, last name and the title/position neld by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	JORDAN	.C	ROSE	0. COM	

Heal th	Financial Systems SCHNECK	MEDI C	CAL CENTER		In Lieu	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0065		eriod: com 01/01/2017	Worksheet S-2 Part II	
				To			pared: 30 am
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	S	SENFOR ACCOUNTANT				41.00
	held by the cost report preparer in columns 1, 2, and 3	,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cos	t					43.00
	report preparer in columns 1 and 2, respectively.						

^{5/18/2018 10:30} am

	Financial Systems	SCHNECK MEDIC				eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	al data	Provider CC		Period: From 01/01/2017 To 12/31/2017		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	85	31, 02	. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF		05			0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		85	31, 02	0.00	0	7.00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00	7	2, 55	55 0.00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	43.00	92	33, 58	0.00	0 0 0	12.00 13.00 14.00 15.00
17.00 18.00 19.00 20.00 21.00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						17.00 18.00 19.00 20.00 21.00
22. 00 23. 00 24. 00 24. 10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	101. 00 116. 00 30. 00	1	36	55	0	22.00 23.00 24.00 24.10
25.00 26.00 26.25 27.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	93			0	25.00 26.00 26.25 27.00
28.00 29.00 30.00 31.00 32.00 32.01	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		0	0	28.00 29.00 30.00 31.00 32.00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/18/2018 10:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	3, 074	1, 708	8, 31	9		1.00
. 00	HMO and other (see instructions)	770	467				2.00
. 00	HMO I PF Subprovi der	0	407				3.00
. 00	HMO I RF Subprovi der	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	115	0	18	2		5.00
. 00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	115	0	8			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	3, 189	1, 708	8, 58			7.00
. 00	INTENSI VE CARE UNI T	439	60	1, 08	R		8.00
. 00	CORONARY CARE UNI T	437	00	1,00	5		9.00
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL INTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)		000	4 (0			12.0
3.00	NURSERY	0 (00	822	1, 63		047.04	13.0
4.00	Total (see instructions)	3, 628	2, 590	11, 30		817.01	
5.00	CAH visits	0	0		D		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18. C
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	4, 384	203	8, 72	B 0.00	17.35	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE	279	20	32	1 0.00	9.29	24.0
4.10	HOSPICE (non-distinct part)	0	0		C		24.1
5.00	CMHC - CMHC						25. C
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26.2
7.00	Total (sum of lines 14-26)				0.00	843.65	27.0
8.00	Observation Bed Days		405	2, 19	7		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				D		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	80	15	-		32.0
2.00	Total ancillary labor & delivery room	0	00		0		32.0
∠. ∪ I	outpatient days (see instructions)						JZ. C
3.00	LTCH non-covered days	0					33.0
5.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	SCHNECK MEDICA	Provi der C	CN: 15-0065	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Prej 5/18/2018 10:3	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		74 501	2, 708	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)			1.	132		2.00
3.00	HMO I PF Subprovider				0		3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	8.	74 501	2, 708	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						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 29.00	Observation Bed Days Ambulance Trips						28.00 29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detroit)						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				0		33.00
33.01	LTCH site neutral days and discharges				0		33.01

PI T.	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/18/2018 10:	pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200. 00	60, 836, 103	0	60, 836, 103	3 1, 754, 813. 45	34. 67	1.
0	instructions) Non-physician anesthetist Part		0	0		0.00	0.00	2.
0	A Non-physician anesthetist Part		0	360, 911	360, 911	4, 227. 00	85. 38	3
0	B Physician-Part A -		228, 754	0	228, 754	1, 098. 00	208. 34	4
1	Administrative Physicians - Part A - Teaching		0	0		0.00	0.00	4
0	Physician and Non		8, 622, 675	-	8, 622, 675			
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services		O	0) (0.00	0. 00	6
0	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
1	approved program) Contracted interns and residents (in an approved programs)		C	0		0.00	0.00	7
0	Home office and/or related		0	0	0	0.00	0.00	8
0	organization personnel SNF	44.00	0	0		0.00	0.00	Ģ
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		10, 994, 611	773	10, 995, 384	4 287, 137. 33	38. 29	10
00	Contract Labor: Direct Patient		1, 114, 707	0	1, 114, 707	13, 842. 92	80. 53	11
00	Care Contract Labor: Top Level management and other management and administrative		0	0	0 0	0. 00	0. 00	12
00	services Contract Labor: Physician-Part		239, 000	0	239, 000	1, 732. 00	137.99	13
00	A - Administrative Home office and/or related orgainzation salaries and		C	0) (0.00	0.00	14
01	wage-related costs Home office salaries		0	0		0.00	0.00	14
02 00	Related organization salaries Home office: Physician Part A		0	-		0.00		
	- Administrative		-	_				
00	Home office and Contract <u>Physicians Part A - Teaching</u> WAGE-RELATED COSTS		0	0		0.00	0.00	16
00	Wage-related costs (core) (see instructions)		12, 558, 636	0	12, 558, 636	ò		17
00	Wage-related costs (other) (see instructions)		0	0	0	D		18
00 00	Excluded areas Non-physician anesthetist Part		2, 803, 659	0	2, 803, 659			19
	Non-physician anesthetist Part A Non-physician anesthetist Part		59, 935		59, 935			20
	B Physician Part A -		28, 226		28, 226			21
00	Administrative Physician Part A - Teaching		20, 220		20, 220			22
00	Physician Part B		1, 087, 435	0	1, 087, 435	5		23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0)		24 25
50	approved program) Home office wage-related		C	0	C	þ		25
51	(core) Related organization		C	o				25
52	wage-related (core) Home office: Physician Part A - Administrative -		0	o	0			25
53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		O	0) (25
00	OVERHEAD COSTS - DIRECT SALARIE		E14 FOF		E44 F05	10 700 70	40.00	
	Employee Benefits Department Administrative & General	4.00 5.00	511, 535 7, 555, 431					

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2017 Fo 12/31/2017		
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		947, 876	0	947, 87	6 4, 150. 43	228. 38	28.00
29.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 355, 165	0	1, 355, 16	5 47, 859. 55	28. 32	30.00
31.00	Laundry & Linen Service	8.00	45, 165	0	45, 16	5 3, 396. 80	13.30	31.00
32.00	Housekeepi ng	9.00	928, 035	0	928, 03	5 66, 314. 55	13.99	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.00
34.00	Dietary	10.00	700, 610	-546, 667	153, 94	8, 912. 94	17. 27	34.00
35.00	Dietary under contract (see instructions)		0	0		0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	546, 667	546, 66	7 31, 651. 00	17. 27	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 147, 535	-773	2, 146, 76	2 61, 254. 43	35.05	38.00
39.00	Central Services and Supply	14.00	713, 952	0	713, 95	2 36, 412. 59	19.61	39.00
40.00	Pharmacy	15.00	1, 197, 000	0	1, 197, 00	29, 565. 19	40. 49	40.00
41.00	Medical Records & Medical Records Library	16.00	979, 311	0	979, 31	1 44, 374. 00	22. 07	41.00
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	369, 423	0	369, 42	7, 452. 90	49.57	43.00

Heal th	Financial Systems	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2017	Worksheet S-3	
						To 12/31/2017		pared:
							5/18/2018 10:	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
					(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-		
1.00	Net salaries (see		53, 161, 304	-360, 911	52, 800, 39	3 1, 709, 547. 88	30. 89	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 994, 611	773	10, 995, 38	4 287, 137. 33	38. 29	2.00
	instructions)							
3.00	Subtotal salaries (line 1		42, 166, 693	-361, 684	41, 805, 00	9 1, 422, 410. 55	29. 39	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 353, 707	0	1, 353, 70	7 15, 574. 92	86. 92	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 586, 862	0	12, 586, 86	2 0.00	30. 11	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		56, 107, 262	-361, 684	55, 745, 57	8 1, 437, 985. 47	38. 77	6.00
7.00	Total overhead cost (see		17, 451, 038	-773	17, 450, 26	5 590, 903. 48	29. 53	7.00
	instructions)							

^{5/18/2018 10:30} am

Heal th	Financial Systems	SCHNECK MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
	FAL WAGE RELATED COSTS		Provi der	CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Pre 5/18/2018 10:	pared:
						Amount	
						Reported 1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see in					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst	,				1, 137, 524	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	rgani zati on)					
5.00	401K/TSA Plan Administration fees					0	
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00
7.00	Employee Managed Care Program Administration I	Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					10, 724, 838	
8.01	Health Insurance (Self Funded without a Third					0	
8.02	Health Insurance (Self Funded with a Third Par	rty Administrato	r)			0	
8.03	Health Insurance (Purchased)					0	
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	
11.00	Life Insurance (If employee is owner or benefi					77, 929	
12.00	Accident Insurance (If employee is owner or be					0	
13.00	Disability Insurance (If employee is owner or		、 、			511, 785	
14.00	Long-Term Care Insurance (If employee is owned	r or beneticiary)			10, 529	
15.00	'Workers' Compensation Insurance				L L FACD 10/	53, 778	
16.00	Retirement Health Care Cost (Only current year Non cumulative portion)	r, not the extra	ordinary ad	ccruai require	ed by FASB 106.	0	16.00
	TAXES						
17.00	FICA-Employers Portion Only					3, 912, 312	17.00
18.00	Medicare Taxes - Employers Portion Only					3, 912, 312	
19.00	Unemployment Insurance					0	
20,00						0	
20.00	OTHER					0	20.00
21.00	Executive Deferred Compensation (Other Than Re instructions))	etirement Cost R	eported on	lines 1 throu	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					109, 196	
24.00						16, 537, 891	
	Part B - Other than Core Related Cost						1
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	SCHNECK MEDI CAL	CENTER	In Lie	u of Form CMS-2	2552-10
H0SPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0065	Peri od:	Worksheet S-3	
				From 01/01/2017 To 12/31/2017		norod.
				To 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Cost Center Description		· ·	Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identif	i cati on:				
1.00	Total facility's contract labor and benefit c	ost		1, 114, 707	16, 537, 891	1.00
2.00	Hospi tal			1, 114, 707	16, 537, 891	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	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

IDDEF IDDEF IDDEF Particized Deparent Particized Departicized Deparent Particized Depart	Heal th	Financial Systems	SCHNECK MEDIC	CAL CENTER		In Lie	eu of Form CMS-:	2552-10
Nome Hear Heat Person	HOME H	IEALTH AGENCY STATI STI CAL DATA				From 01/01/2017	Date/Time Pre	pared:
O County Title V Title XVII. Title XIX Other Total 0.0; 1.00 2.00 3.00 4.00 5.00 2.00 3.00 4.00 5.00 2.01 Inner IRALTH ACHILY STATISTICAL PATA 0.0; 3.00 4.00 5.00 2.771 1.0; 2.02 Inner IRALTH ACHILY STATISTICAL PATA 0.0; 4.40 5.00 2.771 1.0; 2.03 Inner IRALTH ACHILY STATISTICAL PATA 0.0; 4.40 5.0 2.771 1.0; 2.03 Inner IRALTH ACHILY - MURRER OF EMMOYEES 0 1.00 2.00 3.00 0.0; 0.0; 3.00 3.00 Addit instrator and Assistant Admin strator(5) 40.00 0.00 0.00 0.00 0.00 3.00 3.00 Proving Spervice 0.00 0.00 0.00 0.00 0.00 1.00 3.00 3.00 Proving Spervice 0.00 0.00 0.00 0.00 1.00 3.00 2.18 0.00 2.18 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><u>30 alli</u></td>								<u>30 alli</u>
0.00 County Title V Title XVIII Title XVIII Title XX Other Factor 0.00 Mode HALTH ADDRY SIATSTICAL DATA 3.00 4.00 5.00 4.00 5.00							00	-
Title V Title VIII Title XX Under Total 1.00 2.00 3.00 4.00 5.00 2.00 Immunolity (Addedy Statistical bala immunolity) (Addedy Statistical bala bala bala bala bala bala bala b	0.00	County				1.	00	0,00
Note HALTH AGENCY STATISTICAL DATA 1.00 Home HaLTH Ade licers 0 449 0 2.735 2.773 1.00 2.00 Himbugh Latted Consus Count (see instructions) 0.00 449.00 35.00 2.703 2.00 2.00 Number of Employees (Full The Equivalent) Enter the number of hours in your nombel nork week Staff Centract Total -			Title V	Title XVIII	Title XIX	Other	Total	
1.00 Hene Heal th Aide Hours 0 449 0 2.33 2.721 1.00 2.00 Undupit Cated Census Count (see Instructions) 0.00 448.00 95.00 97.00 558.00 2.00 2.00 Undupit Cated Census Count (see Instructions) 0.00 448.00 97.00 558.00 2.00 50.00 2.00 50.00 2.00 50.00 2.00 50.00 2.00 50.00 2.00 3.00 3.00 Administrator and Assistant Administrator(s) 0 1.00 2.00 3.00 40.00 0.00 0.00 0.00 40.00 5.00 Other Administrative Personal 8.80 0.00 1.00 2.16 0.00 1.00			1.00	2.00	3.00	4.00	5.00	
2.00 Unduplicated Census Count (see instructions) 0.00 448.00 33.00 97.00 580.00 2.00 Image: Construct in your normal work week 0 1.00 2.00 3.00 - Nome: HeALTH AGENCY - NUMBER OF EMPLOYEES 0 1.00 2.00 3.00 - Addin Instructor and Assistant Administrator(s) 40.00 0.00			,				-	
Image: constraint of the set of								
Inter-the number of hours in your normal work week Staff Contract Iotal 1.00 1.00 2.00 3.00 4.00 0.00 0.00 0.00 4.00 0.00 0.00 4.00 3.98 0.00 3.98 5.00 1.00 2.00 3.98 6.00 1.00 2.00 3.98 6.00 0.00 4.00 0.00 0.00 4.00 0.00 1.00 2.00 1.00 0.00 0.00 0.00 1.00 2.00 1.00 0.00 0.00 0.00 1.00 1.00 0.00 0.00 1.00 1.00 1.00 0.00 0.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	2.00	Undupilcated Census Count (see Instructions)	0.00	448.00				2.00
your normal work week under Name s. 00 3.00 3.00 Administrator and Assistant Administrator (s) 0 0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
your normal work week under Name s. 00 3.00 3.00 Administrator and Assistant Administrator (s) 0 0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
OME IAME IAME <thiame< th=""> IAME IAME I</thiame<>					Staff	Contract	Total	
HARE HEALTH ARENCY - MURRER OF EMPLOYEES .00 Addministrator and Assistant Administrator(s) 40.00 0.00 0.00 0.00 0.00 3.00 4.00 Director(s) and Assistant Administrator(s) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 3.08 5.00 0.00 Director(s) and Assistant Administrator(s) 0.00			your normai	WOLK WEEK				
HARE HEALTH ARENCY - MURRER OF EMPLOYEES .00 Addministrator and Assistant Administrator(s) 40.00 0.00 0.00 0.00 0.00 3.00 4.00 Director(s) and Assistant Administrator(s) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 3.08 5.00 0.00 Director(s) and Assistant Administrator(s) 0.00			0		1.00	2.00	3.00	
3.00 Admini strator and Assistant Administrator(s) 40.00 0		HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	. 0			2.00	0.00	
5.00 0 ther. Administrative Personnel 3.98 0.00 3.98 0.00 3.98 6.00 00 Direct Hursing Supervisor 8.80 0.00 8.80 0.00 8.80 0.00 8.80 0.00 8.80 0.00 2.15 0.00 2.15 0.00 2.15 0.00 2.15 0.00 2.15 0.00 2.15 0.00 11.00 0.00 0.00 0.00 11.00 0.00	3.00			40.00	0.			•
6.00 Di rect Nursing Service 8.80 0.00 8.80 6.00 7.00 Nursing Supervisor 1.00 0.00 7.00 0.00 2.15 0.00 7.00 0.00 7.00 0.00 7.00 0.00 2.15 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00								
7.00 Nursing SuperVisor 1.00 0.00 1.00 7.00 8.00 Physical Therapy Service 2.15 0.00 1.00 1.00 1.00 1.00 1.00 0.00					1			
8.00 Physical Therapy Service 2.15 0.00 0.00 2.15 8.00 9.00 Physical Therapy Supervisor 0.00 0.0		5			1			•
9.00 Physical Therapy Supervisor 0.00 <					1			•
11.00 Cccupational Therap's Supervisor 0.00 0.00 0.00 0.00 0.00 0.00 11.00 12.00 Speech Pathol ogy Supervisor 0.00 0.00 0.00 0.00 18.00 0.00 0.00 0.00 0.00 18.00 13.00 Speech Pathol ogy Supervisor 0.00 0.00 0.00 0.00 0.00 0.00 18.00 0.00 0.00 0.00 18.00 0.00 0.00 0.00 0.00 13.1 16.00 0.00 0.00 0.00 0.00 18.00 0.00 0.00 0.00 0.00 10.00 17.00 18.00 0.00 0.00 0.00 10.00 18.00 0.00 0.00 0.00 0.00 10.00		Physical Therapy Supervisor						•
12.00 Speech Pathology Supervisor 0.18 0.00 0.00 0.01 12.00 13.00 Speech Pathology Supervisor 0.00 0.00 0.00 0.00 13.00 15.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 13.00 15.00 Medical Social Service Supervisor 0.00 0.00 0.00 1.31 16.00 16.00 Other (specify) 0.00 0.00 0.00 0.00 1.30 17.00 Home Healt H Aide Supervisor 0.00 0.00 0.00 0.00 1.30 18.00 Other (specify) Enter in column 1 the number of CBSAs where propring period. 3 3 20.00 18.00 20.01 Contains the first code). 31140 20.01 20.00 20.00 20.01 20.02 Etil Epi sodes PEP Onl y Total (cols. 1.40 1.67 21.00 21.00 Skilled Nursing Visit ts 1.508 298 59 14 1.67 21.00	10.00				2.	18 0.00	2.18	10.00
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17.00 Home Healt th Aide Supervisor 0.00 0.00 0.00 0.00 17.00 18.00 HOME HEALTH AGENCY CBSA CODES 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 18.00 19.00 Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. 99915 3 19.00 20.01 20.01 Contains the first code). 31140 20.01 20.01 20.00 20.00 20.01 20.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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	37 00			1 4		1	17	37 00
			10, 606			74 165		

	Financial Systems SCHNECK	MEDICAL CENTER	CCN: 15-0065	P	In Lie eriod:	u of Form CMS-2 Worksheet S-7	
110011					rom 01/01/2017		
						5/18/2018 10:	30 am
					1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all or was there no Medicare utilization? Enter "Y" for yes						1.00
	complete the rest of this worksheet.						
2.00	Does this hospital have an agreement under either secti swing beds? Enter "Y" for yes or "N" for no in column						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 4.00		RUX RUL		0			
5.00		RVX		0	0	0	5.00
6.00 7.00		RVL RHX		0	0 0		
8.00		RHL		0	0		
9.00		RMX		0			
10.00 11.00		RML RLX		0	0 0		10.00 11.00
12.00		RUC		0	0	0	12.00
13.00 14.00		RUB RUA		0			
15.00		RVC		0	0		15.00
16.00		RVB		0			
17.00 18.00		RVA RHC		0	0 0		17.00 18.00
19.00		RHB		0	0	0	19.00
20.00 21.00		RHA RMC		0 0	0 0		20.00 21.00
22.00		RMB		0	0		
23.00		RMA		0			
24.00 25.00		RLB RLA		0 0	0 0		
26.00		ES3		0	0	0	26.00
27.00 28.00		ES2 ES1		0	0 0		27.00 28.00
29.00		HE2		0	0		29.00
30.00 31.00		HE1 HD2		0 0	0 0		30.00 31.00
32.00		HD2 HD1		0			
33.00		HC2		0	0		33.00
34.00 35.00		HC1 HB2		0	0		34.00 35.00
36.00		HB1		0	0	0	36.00
37.00 38.00		LE2 LE1		0	0		
39.00		LD2		0	0	Ŭ	
40.00		LD1		0	0	0	
41.00 42.00		LC2 LC1		0	0		41.00 42.00
43.00		LB2		0	0		43.00
44.00 45.00		LB1 CE2		0	0 0		44.00 45.00
46.00		CE1		0	0	0	46.00
47.00 48.00		CD2 CD1		0	0 0		47.00 48.00
49.00		CC2		0	0		49.00
50.00		CC1		0			
51.00 52.00		CB2 CB1		0 0	0 0		51.00 52.00
53.00		CA2		0	0	0	53.00
54.00 55.00		CA1 SE3		0	0 0		54.00 55.00
56.00		SE2		0	0	0	56.00
57.00 58.00		SE1 SSC		0 0	0 0		57.00 58.00
58.00 59.00		SSB		0	0		58.00
60.00		SSA		0	0	0	60.00
61.00 62.00		I B2 I B1		0	0		61.00 62.00
63.00		I A2		0	0	0	63.00
64.00		I A1		0 0	0		64.00
65.00 66.00		BB2 BB1		0	0 0		65.00 66.00
67.00		BA2		0	0	0	67.00
68.00		BA1		0	0	0	68.00

Health Financial Systems SCHNECK	MEDICAL CENTER		Inlie	eu of Form CMS-	2552-10
PROSPECTI VE PAYMENT FOR SNF STATI STI CAL DATA		CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet S-7 Date/Time Pre	epared:
	Group	SNF Days	Swing Bed SNF Days	5/18/2018 10: Total (sum of col. 2 + 3)	<u>30 am</u>
	1.00	2.00	3.00	4.00	
69.00	PE2		0 0	0	69.00
70.00	PE1		0 0	0	70.00
71.00	PD2		0 0	0	71.00
72.00	PD1		0 0	0	72.00
73.00	PC2		0 0	0	73.00
74.00	PC1		0 0	0	74.00
75.00	PB2		0 0	0	75.00
76.00	PB1		0 0	0	76.00
77.00	PA2		0 0	0	77.00
78.00	PA1		0 0	0	78.00
199.00	AAA		0 115	115	199.00
200. 00 TOTAL			0 115	115	200.00
			CBSA at	CBSA on/after	
			Beginning of	October 1 of	
			Cost Reporting	the Cost	
			Peri od	Reporting	
				Period (if	
				applicable)	
			1.00	2.00	
SNF SERVICES			00045	00015	
201.00 Enter in column 1 the SNF CBSA code or 5 character non-			99915	99915	201.00
in effect at the beginning of the cost reporting period in effect on or after October 1 of the cost reporting p					
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, N					
payments beginning 10/01/2003. Congress expected this i					
expenses. For lines 202 through 207: Enter in column 1					
column 2 the percentage of total expenses for each cate					
line 7, column 3. In column 3, enter "Y" for yes or "N"			ts increases ass	ociated	
with direct patient care and related expenses for each	category. (see ins	Tructions)	0 0.00		202.00
202. 00 Staffing 203. 00 Recruitment			0 0.00		202.00
203.00 Retention of employees			0 0.00		203.00
204. 00 Retention of employees 205. 00 Training					204.00
205. 00 (Training 206. 00 (OTHER (SPECIFY)			0 0.00 0 0.00		205.00
200.00[0]HER (SPECIFY) 207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, colum	n 2)		0 0.00		206.00
201. OUTOTAL SNF LEVELUE (WOLKSHEEL G-2, PALL I, TIME 7, COLUM	11 37	1	U C	1	1207.00

	Financial Systems		SCHNECK MEDI				u of Form CMS-2	
HOSPI 1	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CC	CN: 15-0065 N: 15-1529	Period: From 01/01/2017 To 12/31/2017		GH IV pared:
						Hospi ce I		
		Undupl i cated						
		Days Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
		II LI E XVIII	II LIE XIX	Skilled	Nursing	All Other	cols. 1, 2 &	
				Nursing	Facility		5)	
				Facility	Facility		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO					3.00	0.00	
1.00	Hospice Continuous Home Care				2010			1 1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6.00
	hospi ce care							
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
3.00	Average Length of Stay (line 5							8.00
	/line 6)							
9.00	Unduplicated census count							9.00
IOTE:	Parts I and II, columns 1 and 2	also include t	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN		ER OCTOBER 1,		-	
10.00				0		0 0	0	1 .0.00
11.00				8, 115		31 25		11.00
12.00	The second secon			238		15 6		12.00
13.00				41	-	5 16		
14.00	Total Hospice Days			8, 394		51 47		14.00
	PART IV - CONTRACTED STATISTICA	L DATA FOR COS	I REPORTING PE	1	G ON OR AFTER			
15.00	The second secon			0		0 0		1 .0.00
	Hospice General Inpatient Care			0		0 0	0	16.00

Heal th	Financial Systems SCHNECK MEDICAL	CENTER		In Lie	eu of Form CMS-	2552-10		
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0065	Period: From 01/01/2017	Worksheet S-1	0		
				To 12/31/2017	Date/Time Pre 5/18/2018 10:			
					1.00			
1 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by Li		. 0)	0. 284752	1 00		
1.00	Medicaid (see instructions for each line)	/ided by II		1 8)	0. 284752	1.00		
2.00	Net revenue from Medicaid				11, 365, 584	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payment	s from Medica	ni d?	N	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	om Medicai	d		1, 151, 276 58, 735, 552			
6.00								
7.00	Medicaid cost (line 1 times line 6)	16, 725, 066						
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	•		ies 2 and 5; IT	4, 208, 206	8.00		
0.00	Children's Health Insurance Program (CHIP) (see instructions for	or each line	e)			0.00		
9.00 10.00	Net revenue from stand-al one CHIP				0			
10.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0			
12.00	Difference between net revenue and costs for stand-alone CHIP	line 11 mi	nus line 9 [.] i	f < zero then	0			
12100	enter zero)			2010 11011		12:00		
	Other state or local government indigent care program (see inst				-			
13.00	Net revenue from state or local indigent care program (Not incl				0			
14.00	Charges for patients covered under state or local indigent card	e program (Not included	in lines 6 or	0	14.00		
15.00	10) State or local indigent care program cost (line 1 times line 14	1)			0	15.00		
16.00	Difference between net revenue and costs for state or local inc		program (lir	ne 15 minus line	0			
	13; if < zero then enter zero)		p 9 (_			
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state	e/local indig	jent care program	ns (see			
17.00	Private grants, donations, or endowment income restricted to fu	undi ng char	ity care		63, 239	17.00		
18.00	Government grants, appropriations or transfers for support of I				27, 071			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent	care programs	s (sum of lines	4, 208, 206	19.00		
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	patients 2.00	+ col. 2) 3.00			
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts for the entire fac	cility	4, 684, 60)7 1, 474, 687	6, 159, 294	20.00		
	(see instructions)	,						
21.00	Cost of patients approved for charity care and uninsured disconinstructions)	unts (see	1, 333, 9	51 1, 474, 687	2, 808, 638	21.00		
22.00	Payments received from patients for amounts previously written charity care	off as		0 26, 239	26, 239	22.00		
23.00	5		1, 333, 9	1, 448, 448	2, 782, 399	23.00		
					1.00			
24.00	Does the amount on line 20 column 2, include charges for paties	nt days bey	ond a length	of stay limit	N	24.00		
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		care program	n's length of	0	25.00		
	stay limit	-		-				
26.00	Total bad debt expense for the entire hospital complex (see ins	,			15, 677, 785			
27.00 27.01	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s				230, 026			
27.01 28.00	Non-Medicare bad debt expense (see instructions)	see instruc	LI UNS)		353, 885 15, 323, 900			
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see	instructions		4, 487, 370			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(000			7, 269, 769			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			11, 477, 975	31.00		

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	SCHNECK MEDICA	L CENTER Provider CC		eri od:	u of Form CMS-2 Worksheet A	2552-10
				F T	rom 01/01/2017 p 12/31/2017	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	5/18/2018 10: Reclassified Trial Balance (col. 3 +-	30 am
						col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		7, 908, 050	7, 908, 050	-2, 822, 772	5, 085, 278	1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAPITAL RELATED COSTS		0 0	0 0	3, 731, 884 0	3, 731, 884 0	2.00 3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	511, 535 7, 555, 431	16, 940, 641 14, 883, 312	17, 452, 176 22, 438, 743	-69 -170, 457	17, 452, 107 22, 268, 286	4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT	1, 355, 165	2, 223, 247	3, 578, 412	-170, 437	3, 578, 412	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	45, 165	286, 914	332, 079	0	332, 079	8.00
9.00	00900 HOUSEKEEPI NG	928, 035	303, 638	1, 231, 673	0	1, 231, 673	
10.00	01000 DI ETARY	700, 610	583, 786 0	1, 284, 396	-1, 002, 767	281, 629	•
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 2, 147, 535	0 745, 627	0 2, 893, 162	1, 000, 093 -773	1, 000, 093 2, 892, 389	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	713, 952	6, 236, 912	6, 950, 864	-6, 022, 379	928, 485	14.00
15.00	01500 PHARMACY	1, 197, 000	8, 577, 675	9, 774, 675	-6, 651, 559	3, 123, 116	
16.00	01600 MEDICAL RECORDS & LIBRARY	979, 311	275, 025	1, 254, 336	0	1, 254, 336	16.00
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE	369, 423	16, 716	386, 139	0	386, 139	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	360, 911	360, 911	19.00
30.00	03000 ADULTS & PEDIATRICS	6, 758, 239	1, 405, 092	8, 163, 331	-2, 222, 380	5, 940, 951	30.00
31.00	03100 I NTENSI VE CARE UNI T	1,023,174	359, 742	1, 382, 916	-166, 316	1, 216, 600	
43.00	04300 NURSERY	0	0	0	566, 192	566, 192	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,844,898	3, 282, 959	6, 127, 857 491, 820	-1, 234, 166		50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	447, 270 0	44, 550 0	491, 820 0	-5, 186 1, 068, 748	486, 634 1, 068, 748	
53.00	05300 ANESTHESI OLOGY	3, 183, 406	117, 776	3, 301, 182	-360, 992	2, 940, 190	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 372, 739	1, 451, 695	3, 824, 434	-79, 762	3, 744, 672	
54.01	03630 ULTRA SOUND	268, 371	73, 046	341, 417	-34, 405	307, 012	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	82, 125	160, 456	242, 581	-112, 280	130, 301	54.02
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	275, 749 183, 153	466, 585 186, 389	742, 334 369, 542	-155, 982 -33, 107	586, 352 336, 435	57.00 58.00
60.00	06000 LABORATORY	1, 550, 063	3, 171, 130	4, 721, 193	-1, 527, 627	3, 193, 566	•
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	281, 382	281, 382	0	281, 382	63.00
64.00	06400 I NTRAVENOUS THERAPY	244, 749	18, 579	263, 328	-12, 564	250, 764	64.00
65.00	06500 RESPI RATORY THERAPY	1, 376, 407	387, 131	1, 763, 538	-183, 388	1, 580, 150	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 068, 805 366, 033	58, 070 34, 402	1, 126, 875 400, 435	-9, 583 -23, 467	1, 117, 292 376, 968	
68.00	06800 SPEECH PATHOLOGY	228, 916	8, 626	237, 542	-23, 407 -3, 488	234, 054	68.00
69.00	06900 ELECTROCARDI OLOGY	132, 854	170, 784	303, 638	-66, 019	237, 619	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	3, 491	3, 491	8, 160, 046	8, 163, 537	71.00
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0	0	0	2, 370, 603	2, 370, 603	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	6, 850, 088	6, 850, 088	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	221, 658	53, 031	274, 689	-42, 923	231, 766	
76.02	03951 CASE MANAGEMENT	522, 589	15, 385	537, 974	67	538, 041	•
	03950 PALN MANAGEMENT	1, 294, 878	263, 965	1, 558, 843	-32, 255		
/0.9/	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	415, 732	10, 582	426, 314	-3, 980	422, 334	76.97
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 PALLI ATI VE HEALTH	264, 577	16, 398	280, 975	-9	280, 966	
90.02	09002 VEIN CENTER	360, 355	46, 079	406, 434	-10, 669	395, 765	90.02
90.03	09003 OBGYN	2, 268, 790	336, 560	2, 605, 350	-260, 554	2, 344, 796	90.03 91.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 068, 716	504, 701	5, 573, 417	-103, 276	5, 470, 141	91.00
	04952 BEHAVI ORAL HEALTH	514, 084	10, 595	524, 679	-30	524, 649	
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 321, 346	140, 262	1, 461, 608	773	1, 462, 381	101.00
113.00	11300 I NTEREST EXPENSE		754, 221	754, 221	-754, 221	0	113.00
	11600 HOSPI CE	630, 020	177, 378	807, 398	0	807, 398	
118.00		51, 792, 858	72, 992, 585	124, 785, 443	0	124, 785, 443	118.00
100.00	NONREI MBURSABLE COST CENTERS					2	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 2, 979, 491	0 389, 519	0 3, 369, 010	0	0 3, 369, 010	190.00
	07950 WELLNESS	2, 7, 7, 471	007,019	3, 30 7 , 010 N	0		192.00
	07951 JACKSON MOB	õ	597, 467	597, 467	0	597, 467	
194.02	07952 EXTERNAL SVCS MARKETING	198, 789	759, 063	957, 852	0	957, 852	194. 02
	07953 WASHI NGTON CLI NI C	197, 375	0	197, 375	0	197, 375	
	07954 PHYSI CLAN OFFICES	790, 430	157, 398	947, 828	0	947, 828	
	07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	370, 149 1, 061, 120	133, 440 83, 272	503, 589 1, 144, 392	0	503, 589 1, 144, 392	
	07957 PRI MARY CARE	2, 588, 355	785, 373	3, 373, 728		3, 373, 728	
5/18/2	018 10:30 am					-	-

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period: From 01/01/2017	Worksheet A	
				o 12/31/2017	Date/Time Pre 5/18/2018 10:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.08 07958 EMPLOYER CLINIC	729, 533	176, 191	905, 724	0	905, 724	194.08
194.0907959UROLOGY PROF	128, 003	534, 700	662, 703	0	662, 703	194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	60, 836, 103	76, 609, 008	137, 445, 111	0	137, 445, 111	200. 00

^{5/18/2018 10:30} am

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCI	I: 15-0065	Period: From 01/01/2017	Worksheet A
					To 12/31/2017	Date/Time Prepar
	Cost Center Description	Adjustments	Net Expenses		_	5/18/2018 10: 30
			or Allocation			
	GENERAL SERVICE COST CENTERS	6.00	7.00			
00	00100 CAP REL COSTS-BLDG & FIXT	-828, 892	4, 256, 386			
00	00200 CAP REL COSTS-MVBLE EQUIP	020,072	3, 731, 884			
00	00300 OTHER CAPITAL RELATED COSTS	0	0			
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-362, 797	17, 089, 310			
00	00500 ADMINI STRATI VE & GENERAL	-7, 825, 110	14, 443, 176			
00	00700 OPERATION OF PLANT	0	3, 578, 412			
00	00800 LAUNDRY & LINEN SERVICE	0	332, 079			
00	00900 HOUSEKEEPI NG	0	1, 231, 673			
	01000 DI ETARY	-27, 739	253, 890			1
	01100 CAFETERI A	-390, 435	609, 658			1
	01300 NURSING ADMINISTRATION	-1, 750	2, 890, 639			1
	01400 CENTRAL SERVICES & SUPPLY	0	928, 485			1
		0	3, 123, 116 1, 233, 783			1
	01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE	-20, 553 -4, 090	382, 049			1
	01900 NONPHYSICIAN ANESTHETISTS	-360, 911	362, 049			1
00	INPATIENT ROUTINE SERVICE COST CENTERS	-300, 711	U			
00	03000 ADULTS & PEDIATRICS	-691, 949	5, 249, 002			3
	03100 I NTENSI VE CARE UNI T	-62, 285	1, 154, 315			3
	04300 NURSERY	0	566, 192			4
	ANCI LLARY SERVICE COST CENTERS					
00	05000 OPERATI NG ROOM	-558, 249	4, 335, 442			5
00	05100 RECOVERY ROOM	0	486, 634			5
	05200 DELIVERY ROOM & LABOR ROOM	0	1, 068, 748			5
00	05300 ANESTHESI OLOGY	-3, 393, 787	-453, 597			5
00	05400 RADI OLOGY-DI AGNOSTI C	-666, 154	3, 078, 518			5
	03630 ULTRA SOUND	0	307, 012			5
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	130, 301			5
	05700 CT SCAN	-6, 664	579, 688			5
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	336, 435			5
	06000 LABORATORY	-22, 261	3, 171, 305			6
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	281, 382			6
	06400 I NTRAVENOUS THERAPY	0	250, 764			6
		-466, 617	1, 113, 533			6
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	-2, 544 -147	1, 114, 748			6
	06800 SPEECH PATHOLOGY	- 147	376, 821 234, 005			6
	06900 ELECTROCARDI OLOGY	-1,679	235, 940			6
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 163, 537			7
	07200 I MPLANTABLE DEVICES CHARGED TO	0	2, 370, 603			7
00	PATIENTS	Ū	2,0,0,000			
00	07300 DRUGS CHARGED TO PATIENTS	-165, 933	6, 684, 155			7
00	03952 WOUND CARE (DIABETES CENTER)	-98	231, 668			7
	03951 CASE MANAGEMENT	-504, 151	33, 890			7
	03950 PALN MANAGEMENT	-904, 173	622, 415			7
97	07697 CARDI AC REHABI LI TATI ON	0	422, 334			7
	OUTPATIENT SERVICE COST CENTERS	1				
		0	0			9
	09001 PALLI ATI VE HEALTH	-223, 673	57, 293			9
		-243, 594	152, 171			9
	09003 OBGYN 09100 EMERGENCY	-2,081,751	263, 045 2, 757, 419			9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 712, 722	2, 757, 419			9
	04952 BEHAVIORAL HEALTH	-267, 229	257, 420			9
00	OTHER REIMBURSABLE COST CENTERS	-207,229	237, 420			
. 00	10100 HOME HEALTH AGENCY	0	1, 462, 381			10
	SPECIAL PURPOSE COST CENTERS		.,,			
8. 00	11300 I NTEREST EXPENSE	0	0			11
	11600 HOSPI CE	0	807, 398			11
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-22, 797, 986	101, 987, 457			11
	NONREI MBURSABLE COST CENTERS					
). 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			19
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 369, 010			19
	07950 WELLNESS	0	0			19
	07951 JACKSON MOB	0	597, 467			19
	07952 EXTERNAL SVCS MARKETING	0	957, 852			19
	07953 WASHI NGTON CLI NI C	0	197, 375			19
	07954 PHYSI CI AN OFFI CES	0	947, 828			19
	07955 I NTEGRATED MEDI CI NE	0	503, 589			19
	07956 SURGI CAL PROFESSI ONAL	0	1, 144, 392			19
	07957 PRIMARY CARE	0	3, 373, 728			19
	07958 EMPLOYER CLINIC	0	905, 724			19
	07959 UROLOGY PROF		662, 703			19

Health Financial Systems	SCHNECK MEDIC	AL CENTER		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-0065	Period: From 01/01/2017	Worksheet A
					Date/Time Prepared: 5/18/2018 10:30 am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) F	or Allocation			
	6.00	7.00			
200.00 TOTAL (SUM OF LINES 118 through 199)	-22, 797, 986	114, 647, 125			200.00

^{5/18/2018 10:30} am

	Financial Systems IFICATIONS			Provider CCN: 15-006	55 Period: From 01/01/20	Worksheet A-6
					To 12/31/20	17 17 Date/Time Prepare 5/18/2018 10:30 au
		Increases				
_	Cost Center 2.00	Line # 3.00	Salary 4.00	0ther 5.00		
	A - DEPRECIATION	3.00	4.00	5.00		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 685, 953		1.
- H	TOTALS B - PROPERTY INSURANCE		0	3, 685, 953		
	CAP REL COSTS-BLDG & FIXT	1.00	0	108, 960		1.
	CAP REL COSTS-MVBLE EQUIP		<u>0</u>	45,931		2.
	TOTALS C - CAFETERIA		0	154, 891		
0	CAFETERI A		<u>546, 6</u> 67	453, 426		1.
	TOTALS D - BOND INTEREST		546, 667	453, 426		
- E	CAP REL COSTS-BLDG & FIXT	1.00	0	754, 221		1.
Ē	TOTALS		0	754, 221		
	E - NURSERY NURSERY	43.00	516, 716	49, 476		1.
	DELIVERY ROOM & LABOR ROOM	52.00	975, 357	93, 391		2.
	TOTALS		1, 492, 073	142, 867		
	F - NONPHYSICIAN ANESTHETIST NONPHYSICIAN ANESTHETISTS	19.00	360, 911	0		1.
F	TOTALS	T	360, 911	<u>0</u>		
	G - HOME HEALTH SOCIAL WORKER HOME HEALTH AGENCY	101.00	773	0		1.
Ē	TOTALS			- <u> </u>		1.
Į	H - IMPLANTABLE DEVICES	1				
	I MPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	2, 370, 603		1.
Ē	TOTALS		o	2, 370, 603		
- 64	I - DRUGS DRUGS CHARGED TO PATIENTS	73.00	0	6, 850, 088		1.
	LABORATORY	60.00	0	41		2.
		0.00	0	0		3.
		0.00 0.00	0	0		4. 5.
		0.00	0	0		6.
		0.00 0.00	0	0		7.
		0.00	0	0		8.
		0.00	0	0		10.
		0.00 0.00	0	0		11.
l		0.00	0	0		13.
		0.00	0	0		14.
+	TOTALS		0	0 6, 850, 129		15.
ļ	J - MEDICAL SUPPLIES	1				
	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	10, 530, 649		1.
	CASE MANAGEMENT	76.02	0	67		2.
		0.00 0.00	0	0		3.
		0.00	0	0		4. 5.
		0.00	0	0		6.
		0.00 0.00	0	0		7.
		0.00	0	0		9.
		0.00	0	0		10.
		0.00 0.00	0	0		11.
		0.00	0	0		13.
		0.00	0	0		14.
		0.00 0.00	0	0		15. 16.
		0.00	0	0		17.
		0.00	0	0		18.
		0.00 0.00	0 0	0		19. 20.
		0.00	0	0		21.
		0.00 0.00	0	0		22.
		0.00	0	0		23. 24.
				- 1		
		0.00	0	0		25.
		0.00 0.00 0.00	0 0 0	0 0 0		25. 26. 27.

Health Financial Systems			SCHNECK MEDI	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS				Provider (CCN: 15-0065	Peri od:	Worksheet A-	6	
						From 01/01/2017 To 12/31/2017	Date/Time Pr 5/18/2018 10	epared: 30 am	
		Increases							
	Cost Center	Line #	Sal ary	0ther					
	2.00	3.00	4.00	5.00					
29.00		0.00	0	0				29.00	
30.00		0.00	0	0				30.00	
	TOTALS		0	10, 530, 716					
500.00	Grand Total: Increases		2, 400, 424	24, 942, 806				500.00	

th Financial Systems ASSIFICATIONS		SCHNECK MEDI CAL		CN: 15-0065	Period:	u of Form CMS-255 Worksheet A-6
					From 01/01/2017 To 12/31/2017	Date/Time Prepar
	Decreases					5/18/2018 10: 30
Cost Center	Line #	Salary		Wkst. A-7 Ref		
	7.00	8.00	9.00	10.00		
A - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	0	3, 685, 953		9	
TOTALS		0	3, 685, 953		<u>×</u>	
B - PROPERTY INSURANCE	,					
ADMI NI STRATI VE & GENERAL	5.00	0	154, 891	1.		1
	0.00	0	0	1	2	2
TOTALS C - CAFETERIA		0	154, 891			
DI ETARY	10.00	546, 667	453, 426	-	0	1
TOTALS		546, 667	453, 426			
D - BOND INTEREST	1	I				
INTEREST EXPENSE	1 <u>13.00</u>	0	754, 221	1	1	1
TOTALS E - NURSERY		0	754, 221			
ADULTS & PEDIATRICS	30.00	1, 492, 073	142, 867		0	1
	0.00	0	0		0	2
TOTALS		1, 492, 073	142, 867			
F - NONPHYSICIAN ANESTHETIST	52.00	0(0,011				
ANESTHESIOLOGY	53.00		0		0	1
G - HOME HEALTH SOCIAL WORKE	R	300, 911	0			
NURSI NG ADMI NI STRATI ON	13.00	773	0		0	1
TOTALS		773	0 0		1	
H - IMPLANTABLE DEVICES	1				1	
MEDI CAL SUPPLI ES CHARGED TO	71.00	0	2, 370, 603		0	1
PATI ENTS	\vdash $$ $+$		2, 370, 603		-	
I - DRUGS	<u> </u>		2,070,000			
ADMI NI STRATI VE & GENERAL	5.00	0	13, 793		0	1
PHARMACY	15.00	0	6, 488, 881		0	2
ADULTS & PEDIATRICS	30.00 50.00	0	29, 682 224		0	3
OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00	0	224 17, 789		0	2
 RADI OLOGY-DI AGNOSTI C NUCLEAR MEDI CI NE - 	54.02	0	111, 738		0	
DI AGNOSTI C			,			
CT SCAN	57.00	0	63, 815		o	7
MAGNETIC RESONANCE IMAGING	58.00	0	26, 735		0	8
(MRI) RESPIRATORY THERAPY	65.00	0	5, 615		0	c
0 PHYSICAL THERAPY	66.00	0	51		0	10
0 ELECTROCARDI OLOGY	69.00	0	40, 920		o	11
WOUND CARE (DIABETES CENTER)	76.00	0	585		0	12
O PAIN MANAGEMENT	76.03	0	23, 811		0	13
O OBGYN O EMERGENCY	90.03 91.00	0	24, 431 2, 059		0	12
TOTALS	<u> </u>	0	6, 850, 129			
J - MEDICAL SUPPLIES	· ·					
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	69		0	1
ADMI NI STRATI VE & GENERAL	5.00	0	1,773		0	2
DI ETARY CENTRAL SERVICES & SUPPLY	10.00 14.00	0	2, 674 6, 022, 379		0	
PHARMACY	15.00	0	162, 678		0	Ę
ADULTS & PEDIATRICS	30.00	0	557, 758		0	e
INTENSIVE CARE UNIT	31.00	0	166, 316		o	7
OPERATING ROOM	50.00	0	1, 233, 942		0	8
RECOVERY ROOM	51.00	0	5, 186 81		0	10
0 ANESTHESI OLOGY 0 RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	81 61, 973		ol	10
0 ULTRA SOUND	54.00	ŏ	34, 405		0	12
0 NUCLEAR MEDICINE -	54.02	О	542		o	13
DI AGNOSTI C	F7 65		00 1/-			
0 CT SCAN 0 MAGNETIC RESONANCE IMAGING	57.00	0	92, 167		ol	14
<pre>0 MAGNETIC RESONANCE IMAGING (MRI)</pre>	58.00	۷	6, 372			15
0 LABORATORY	60.00	0	1, 527, 668		o	16
0 INTRAVENOUS THERAPY	64.00	o	12, 564		o	17
0 RESPIRATORY THERAPY	65.00	0	177, 773		0	18
0 PHYSICAL THERAPY	66.00	0	9, 532		0	19
0 OCCUPATIONAL THERAPY 00 SPEECH PATHOLOGY	67.00 68.00	0	23, 467 3, 488		0	20
0 ELECTROCARDI OLOGY	69.00	0	3, 488 25, 099		ol	22
WOUND CARE (DIABETES CENTER)	76.00	0	42, 338		0	23
PAIN MANAGEMENT	76.03	0	8, 444		o	24
O CARDIAC REHABILITATION	76.97	o	3, 980		o	25

Health Financial Systems			SCHNECK MED	CHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS				Provi der (CCN: 15-0065	Period: From 01/01/2017	Worksheet A-	6	
					_		Date/Time Pr 5/18/2018 10	epared: 30 am	
		Decreases							
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref				
	6.00	7.00	8.00	9.00	10.00				
26.00	PALLIATIVE HEALTH	90.01	0	ç		0		26.00	
27.00	VEIN CENTER	90.02	0	10, 669		0		27.00	
28.00	OBGYN	90.03	0	236, 123	6	0		28.00	
29.00	EMERGENCY	91.00	0	101, 217	,	0		29.00	
30.00	BEHAVI ORAL HEALTH	93.00	0	30)	0		30.00	
	TOTALS		0	10, 530, 716)]			
500.00	Grand Total: Decreases		2, 400, 424	24, 942, 806				500.00	

Health Financial Systems	SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0065		iod: m 01/01/2017 12/31/2017		pared:
			Acqui si ti on	s _			
	Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			_				
1.00 Land	8, 026, 498	478, 633		0	478, 633	0	1.00
2.00 Land Improvements	3, 962, 746	562, 628		0	562, 628	9, 243	2.00
3.00 Buildings and Fixtures	83, 617, 904	6, 401, 627		0	6, 401, 627	600, 503	3.00
4.00 Building Improvements	0	3, 999, 418		0	3, 999, 418	0	4.00
5.00 Fixed Equipment	5, 325, 703	29, 848		0	29, 848	64, 107	5.00
6.00 Movable Equipment	46, 411, 272	5, 666, 159		0	5, 666, 159	3, 406, 395	6.00
7.00 HIT designated Assets	3, 775, 424	0		0	0	46, 652	7.00
8.00 Subtotal (sum of lines 1-7)	151, 119, 547	17, 138, 313		0	17, 138, 313	4, 126, 900	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	151, 119, 547	17, 138, 313		0	17, 138, 313	4, 126, 900	10.00
	Endi ng Bal ance			-			
	5	Depreciated					
		Assets					
	6.00	7.00	1				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		•				
1.00 Land	8, 505, 131	0					1.00
2.00 Land Improvements	4, 516, 131	0					2.00
3.00 Buildings and Fixtures	89, 419, 028	0					3.00
4.00 Building Improvements	3, 999, 418						4.00
5.00 Fixed Equipment	5, 291, 444						5.00
6.00 Movable Equipment	48, 671, 036						6.00
7.00 HIT designated Assets	3, 728, 772						7.00
8.00 Subtotal (sum of lines 1-7)	164, 130, 960						8.00
9.00 Reconciling Items	0	0					9,00
10.00 Total (line 8 minus line 9)	164, 130, 960	0					10.00
		-					

^{5/18/2018 10:30} am

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0065	Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017		narod
					10 12/31/2017	5/18/2018 10:	30 am
			SL	JMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
			10.00	11.00		instructions)	
	DADT LL DEGONOLLLATION OF ANOUNTO FROM WOR	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			na 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	7, 908, 050	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, 908, 050			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7, 908, 050				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7, 908, 050				3.00

^{5/18/2018 10:30} am

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017 Fo 12/31/2017		bared: 30 am	
	COM	PUTATION OF RAT	[10S	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio (col. 1 - col. 2)	instructions)			
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 CAP REL COSTS-BLDG & FIXT	115, 459, 924		115, 459, 924		0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	48, 671, 036		48, 671, 030		0	2.00	
3.00 Total (sum of lines 1-2)	164, 130, 960		<u>164, 130, 960</u>		0	3.00	
	ALLUCA	TION OF OTHER (APITAL	SUMMARY O	F CAPITAL		
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
		d Costs	through 7)				
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE		-					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(4, 222, 097	-74, 671	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(3, 685, 953		2.00	
3.00 Total (sum of lines 1-2)	0	0	(7, 908, 050	-74, 671	3.00	
		SL	JMMARY OF CAPI	IAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
		instructions)	instructions)		of cols. 9		
				d Costs (see	through 14)		
				instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE		100.0/0			1.05/.00/		
1.00 CAP REL COSTS-BLDG & FIXT	0			0 0	4, 256, 386	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0			0	3, 731, 884	2.00	
3.00 Total (sum of lines 1-2)	0	154, 891	(0 0	7, 988, 270	3.00	

Health Financial Systems	SCHNECK MEDICAL CENTER	In Lie
AD HISTMENTS TO EXPENSES	Provider CCN: 15-0065 P	ari od:

Li eu	of	Form	CMS-2552-10

ADJUSTMENTS TO EXPENSES		SCHNECK MEDI	Provi der CCN: 15-0065	Period:	Worksheet A-8	2552-11
				From 01/01/2017 To 12/31/2017		
			Expense Classification o To/From Which the Amount is			JU UIII
Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref.	
1.00 Investment income - CAP REL	1.00 A		CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
COSTS-MVBLE EQUIP (chapter 2) 1 nvestment income - other		0		0.00	0	3.00
.00 (chapter 2) .00 Trade, quantity, and time		0		0.00	0	4.00
di scounts (chapter 8) .00 Refunds and rebates of	В	-65, 081	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
expenses (chapter 8) .00 Rental of provider space by	В		CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
suppliers (chapter 8) .00 Telephone services (pay	A		ADMI NI STRATI VE & GENERAL	5.00		7.00
stations excluded) (chapter 21)		1,070		5.00	0	7.00
. 00 Tel evi si on and radi o servi ce		0		0.00	0	8.00
(chapter 21) 0.00 Parking Lot (chapter 21)		0		0.00		9.00
0.00 Provi der-based physician adjustment	A-8-2	-11, 947, 467			0	10.00
1.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
2.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
3.00 Laundry and linen service 4.00 Cafeteria-employees and guests	s B	0 -390, 435	CAFETERI A	0.00 11.00		13.00 14.00
5.00 Rental of quarters to employed and others		0		0.00		15.00
6.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
7.00 Sale of drugs to other than patients	В	-1, 797	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
8.00 Sale of medical records and	В	-20, 553	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
9.00 Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
books, etc.) 20.00 Vending machines 21.00 Income from imposition of interest, finance or penalty	В	-6, 704 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		20.00 21.00
2.00 Interest expense on Medicare overpayments and borrowings to	þ	0		0.00	0	22. 0
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
Limitation (chapter 14) 4.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 0
limitation (chapter 14) 5.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 0
(chapter 21) 6.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 0
7.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBLE EQUIP 8.00 Non-physician Anesthetist	А	-360, 911	NONPHYSICIAN ANESTHETISTS	19.00		28. 0
9.00 Physicians' assistant0.00 Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 0 30. 0
limitation (chapter 14) 0.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
instructions) 1.00 Adjustment for speech pathology costs in excess of	A-8-3		SPEECH PATHOLOGY	68.00		31.00
Iimitation (chapter 14) 32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest 33.00 HOSPITAL ASSESSMENT FEE	А	-5, 216, 041	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER	Inlie	eu of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES			Provi der CCN: 15-0065	Peri od: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Pre	pared:
			Expense Classification c To/From Which the Amount is		5/18/2018 10:	<u>30 am</u>
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MARKETING DIETARY	A	-118	DI ETARY	10.00	0	33.01
33.02 MARKETING PHYS PRACTICE	A	-4, 090	PHYSICIAN PRIVATE PRACTICE	18.00	0	33. 02
34.00 MARKETING A&P	A	-1, 923	ADULTS & PEDIATRICS	30.00	0	34.00
35.00 MARKETING OPERATING ROOM	A		OPERATING ROOM	50.00		
36.00 MARKETING RADIOLOGY	A		RADI OLOGY-DI AGNOSTI C	54.00		00.00
37.00 MARKETING PHYSICAL THERAPY	A		PHYSICAL THERAPY	66.00		
37.01 MARKETING OCCUPATIONAL THERAPY			OCCUPATI ONAL THERAPY	67.00		
37.02 MARKETING SPEECH THERAPY	A		SPEECH PATHOLOGY	68.00		
37. 03 MARKETING WOUND CARE	A		WOUND CARE (DI ABETES CENTER			
37. 04 MARKETING BARIATRIC	A		CASE MANAGEMENT	76.02		
37. 05 MARKETING PAIN MANAGEMENT	A		PAIN MANAGEMENT	76.03		
37.06 MARKETING OB GYN	A	-1, 909		90.03		
37.07 MARKETING EMERGENCY ROOM 37.08 PHYSICAN RECRUITMENT	A			91.00		
37.08 PHYSICAN RECRUITMENT 37.09 MISC INCOME - DIETERY	A B		ADMI NI STRATI VE & GENERAL DI ETARY	5.00 10.00		
37. 10 MISC INCOME - DIETERT	В		DRUGS CHARGED TO PATIENTS	73.00		
38.00 MISC INCOME - ADMIN & GENERAL	В		ADMI NI STRATI VE & GENERAL	5.00		
39. 00 MI SC I NCOME - RESPI RATORY THERAPY	B		RESPI RATORY THERAPY	65.00		
39. 01 LOBBYING DUES	A	-7, 702	ADMI NI STRATI VE & GENERAL	5.00	0	39.01
39.02 TELEPHONE OPERATOR BENEFITS	A	-135	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	39.02
39.03 CRNA OFFSET - BENEFITS	A	-73, 048	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	39.03
39.04 APRN OFFSET - GENERAL ADMIN	A	-378, 089	ADMINISTRATIVE & GENERAL	5.00	0	39.04
39.05 APRN OFFSET - A&P	A		ADULTS & PEDIATRICS	30.00	0	39.05
39.06 APRN OFFSET - RADIOLOGY	A	-14, 216	RADI OLOGY-DI AGNOSTI C	54.00	0	39.06
39.07 APRN OFFSET - BARIATRIC	A	-115, 484	CASE MANAGEMENT	76.02	0	39.07
39.08 APRN OFFSET - PAIN MANAGEMENT	A		PAIN MANAGEMENT	76.03		
39.09 APRN OFFSET - PALLIATIVE	A		PALLIATIVE HEALTH	90.01		
39.10 APRN OFFSET - OBGYN	A	-100, 341		90.03		
39. 11 APRN OFFSET - EMERGENCY ROOM	A		EMERGENCY	91.00		-
39. 12 APRN OFFSET - MENTAL HEALTH	A		BEHAVI ORAL HEALTH	93.00		
39. 13 APRN OFFSET - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	0 / 0
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-22, 797, 986				50.00
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste		SCHNECK MED	ICAL CENTER			eu of Form CMS-	
PROVIDE	R BASED PHYSIC	IAN ADJUSIMENT		Provider (1	Period: From 01/01/2017		
						Γο 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	28, 409	28, 409	0	211, 500	0	1.00
2.00		ADMINISTRATIVE & GENERAL	47, 861	4, 875	42, 986			2.00
3.00		NURSING ADMINISTRATION	1, 750					3.00
4.00 5.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	601, 636 62, 285					4.00 5.00
5.00 6.00		OPERATING ROOM	557,850					6.00
7.00		ANESTHESI OLOGY	3, 393, 787	3, 393, 787	0			7.00
8.00		RADI OLOGY-DI AGNOSTI C	771, 746		232, 071	271, 900		8.00
9.00		CT SCAN	6, 664		0	211, 500	0	9.00
10.00		LABORATORY	230, 000				1, 660	10.00
11.00			465, 792			211, 500	0	11.00
12.00 13.00		ELECTROCARDI OLOGY CASE MANAGEMENT	9, 000 388, 577	0 388, 577	9, 000 0			12. 00 13. 00
14.00		PAIN MANAGEMENT	723, 939					14.00
15.00		PALLIATIVE HEALTH	10, 822		0			15.00
16.00	90. 02	VEIN CENTER	243, 594	243, 594	0	211, 500	0	16.00
17.00		OBGYN	1, 979, 501	1, 979, 501	0			17.00
18.00		EMERGENCY	2, 524, 916		0	211, 500		18.00
19.00 200.00	93.00	BEHAVIORAL HEALTH	253, 196					19.00
	Wkst. A Line #	Cost Center/Physician	12, 301, 325 Unadj usted RCE		514,057 Cost of	Provi der	2,830 Physician Cost	200.00
	WRSt. A EINC #	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1.00	1.00	2.00 EMPLOYEE BENEFITS DEPARTMENT	8.00	9.00	12.00	13.00	14.00	1.00
2.00		ADMI NI STRATI VE & GENERAL	16, 574	-			-	2.00
3.00		NURSING ADMINISTRATION	0	0			0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00		INTENSIVE CARE UNIT	0	0			0	5.00
6.00		OPERATING ROOM	0	0	-	0	0	6.00
7.00 8.00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	122, 224	0 6, 111	0	0	0	7.00 8.00
9.00		CT SCAN	122, 224	0, 111	0	0	0	9.00
10.00		LABORATORY	207, 739	10, 387	0	0	0	10.00
11.00	65.00	RESPI RATORY THERAPY	0	0	0	0	0	11.00
12.00		ELECTROCARDI OLOGY	7, 321	366			0	12.00
13.00		CASE MANAGEMENT	0	0			0	13.00
14.00 15.00		PAIN MANAGEMENT PALLIATIVE HEALTH	0	0	-		0	14. 00 15. 00
16.00		VEIN CENTER		0			0	16.00
17.00		OBGYN	0	0	-	0	Ő	17.00
18.00		EMERGENCY	0	0	0	0	0	18.00
19.00	93.00	BEHAVIORAL HEALTH	0	-				
200.00			353, 858			-	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adj ustment		
			Share of col.		bi sui i onunce			
			14					
1.00	1.00	2.00 EMPLOYEE BENEFITS DEPARTMENT	15.00 0	16.00	17.00	18.00 28,409		1.00
1.00 2.00		ADMINISTRATIVE & GENERAL						2.00
3.00		NURSI NG ADMI NI STRATI ON	0	0	0	1, 750		3.00
4.00		ADULTS & PEDIATRICS	0	0	0			4.00
5.00		INTENSIVE CARE UNIT	0	0	0			5.00
6.00		OPERATING ROOM	0	0	0			6.00
7.00		ANESTHESI OLOGY	0	-	0	-,,		7.00
8.00 9.00		RADI OLOGY-DI AGNOSTI C CT SCAN	0	122, 224	109, 847	649, 522 6, 664	1 1	8.00 9.00
10.00		LABORATORY	0	207, 739	22, 261	22, 261		10.00
11.00		RESPI RATORY THERAPY	0	0	0	465, 792		11.00
12.00	69.00	ELECTROCARDI OLOGY	0	7, 321	1, 679	1, 679		12.00
13.00		CASE MANAGEMENT	0	0	0	388, 577		13.00
14.00		PALN MANAGEMENT	0	0	-			14.00
15.00		PALLIATIVE HEALTH	0	0	0			15.00
16.00 17.00		VEIN CENTER OBGYN		0	-			16. 00 17. 00
18.00		EMERGENCY	0	0	-	.,,		18.00
19.00		BEHAVIORAL HEALTH	0	0	0	253, 196		19.00
200.00			0	353, 858	160, 199	11, 947, 467		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI	CAL CENTER Provider CO		eriod: rom 01/01/2017	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/18/2018 10:	pared:
			CAPI TAL REL	ATED COSTS		571872018 10.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	1 05/ 00/	4 95 4 99 4				
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	4, 256, 386 3, 731, 884	4, 256, 386	3, 731, 884			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	17, 089, 310	20, 175				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	14, 443, 176	389, 572	363, 600		17, 339, 253	5.00
7.00	00700 OPERATION OF PLANT	3, 578, 412	242, 684	1, 589, 889		5, 795, 345	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	332,079	14, 816	831	12, 810	360, 536	8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY	1, 231, 673 253, 890	22, 165 85, 009	1, 793 20, 371	263, 215 43, 662	1, 518, 846 402, 932	•
11.00	01100 CAFETERI A	609, 658	85,009	20, 371		402, 932 764, 707	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 890, 639	92, 723	60, 678		3, 652, 918	•
14.00	01400 CENTRAL SERVICES & SUPPLY	928, 485	79, 615	53, 647	202, 495	1, 264, 242	
15.00	01500 PHARMACY	3, 123, 116	33, 412	18, 778		3, 514, 806	•
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 233, 783	21, 765	5, 178		1, 538, 484	16.00
18.00 19.00	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	382, 049 0	0	0		486, 827 102, 364	18.00 19.00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	102, 304	102, 304	1 19.00
30. 00	03000 ADULTS & PEDIATRICS	5, 249, 002	725, 544	213, 800	1, 493, 622	7, 681, 968	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 154, 315	68, 968	76, 330	290, 199	1, 589, 812	31.00
43.00	04300 NURSERY	566, 192	9, 516	0	146, 554	722, 262	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	4, 335, 442	303, 962	437, 741	806, 887	5, 884, 032	50.00
50.00	05100 RECOVERY ROOM	4, 335, 442 486, 634	59, 676	437, 741 870		5, 884, 032 674, 037	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 068, 748	69, 651	0,0		1, 415, 036	•
53.00	05300 ANESTHESI OLOGY	-453, 597	1, 013	40, 436	800, 533	388, 385	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 078, 518	305, 222	399, 168		4, 455, 878	•
54.01	03630 ULTRA SOUND	307,012	12, 272	16, 924		412, 325	•
54.02 57.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	130, 301 579, 688	5, 323 14, 486	74 31, 843		158, 991 704, 227	54.02 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	336, 435	14, 480	2, 803		401, 396	•
60.00	06000 LABORATORY	3, 171, 305	66, 672	55, 957		3, 733, 572	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	281, 382	6, 207	448		288, 037	63.00
64.00	06400 I NTRAVENOUS THERAPY	250, 764	48, 240	34, 258		402, 679	
65.00		1, 113, 533	59, 935	21, 411	390, 385	1, 585, 264	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 114, 748 376, 821	147, 476 5, 853	11, 623 86		1, 576, 988 486, 576	
68.00	06800 SPEECH PATHOLOGY	234,005	4, 640	686		304, 258	
	06900 ELECTROCARDI OLOGY	235, 940	16, 229	15, 897		305, 747	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 163, 537	0	1, 360		8, 164, 897	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	2, 370, 603	0	0	0	2, 370, 603	72.00
73.00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	6, 684, 155	0	о	0	6, 684, 155	73.00
76.00	03952 WOUND CARE (DI ABETES CENTER)	231, 668	24, 520	687	-	319, 743	
76. 02	03951 CASE MANAGEMENT	33, 890	25, 039	235		207, 384	
	03950 PALN MANAGEMENT	622, 415	63, 292	2, 584		1, 055, 552	•
76. 97	07697 CARDI AC REHABI LI TATI ON	422, 334	25, 922	5, 405	117, 912	571, 573	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.00 90.01	09001 PALLI ATI VE HEALTH	57, 293	3, 710	0		136, 044	
90. 02	09002 VEIN CENTER	152, 171	2, 933	4, 293	102, 206	261, 603	90.02
90. 03	09003 OBGYN	263, 045	83, 949	77, 797		1, 068, 279	•
91.00	09100 EMERGENCY	2, 757, 419	170, 996	23, 853	1, 437, 620	4, 389, 888	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	257 420	14 451	6, 544	145 000	424 422	92.00 93.00
7 3.00	OTHER REIMBURSABLE COST CENTERS	257, 420	14, 651	0, 344	145, 808	424, 423	93.00
101.00	10100 HOME HEALTH AGENCY	1, 462, 381	19, 904	881	374, 987	1, 858, 153	101.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE	0.07 0.00			470 (00		113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	807, 398 101, 987, 457		0 3, 598, 880			
110.00	NONREIMBURSABLE COST CENTERS	101, 707, 437	5, 405, 154	5, 570, 880	14, 344, 700	70, 430, 321	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 992	0	0	13, 992	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 369, 010	314, 962	45, 357		4, 574, 390	192.00
	07950 WELLNESS	0	0	0	0		194.00
	07951 JACKSON MOB	597, 467	0	0	-	597, 467	
	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	957, 852 197, 375	22, 730 49, 712	335 0		1, 037, 299 303, 068	
174.03	07954 PHYSI CI AN OFFICES	947, 828		5, 342		1, 231, 143	
194.04		94/ 0/0	0.0 / 0/				1174.04

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre	pared:
					5/18/2018 10:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
194. 06 07956 SURGI CAL PROFESSI ONAL	1, 144, 392	31, 669	96	6 300, 961	1, 477, 988	194.06
194. 07 07957 PRI MARY CARE	3, 373, 728	236, 277	50, 87	734, 125	4, 395, 009	194.07
194.0807958 EMPLOYER CLINIC	905, 724	61, 219	1, 35	9 206, 915	1, 175, 217	194.08
194.0907959UROLOGY PROF	662, 703	24, 485	27, 08	36, 305	750, 573	194.09
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	114, 647, 125	4, 256, 386	3, 731, 88	17, 109, 606	114, 647, 125	202.00

^{5/18/2018 10:30} am

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDIC	CAL CENTER Provider CO		<u>In Lie</u> Period: From 01/01/2017 To 12/31/2017	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/18/2018 10:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	17 000 050					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	17, 339, 253 1, 032, 673	6, 828, 018				5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	64, 244	28, 070		D		8.00
9.00	00900 HOUSEKEEPI NG	270, 643	41, 994				9.00
10.00	01000 DI ETARY	71, 798	161, 057		43, 709	679, 496	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	136, 263 650, 913	0 175, 672		0 0 0 47,675	0	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	225, 275	150, 838		40, 935	0	14.00
15.00	01500 PHARMACY	626, 303	63, 303		0 17, 179	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	274, 142	41, 235		0 11, 191	0	16.00
18.00 19.00	01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	86, 748 18, 240	0			0	18.00 19.00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10,240	0		0	0	19.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 368, 850	1, 374, 609	246, 61	5 373, 050	601, 272	30.00
31.00	03100 I NTENSI VE CARE UNI T	283, 289	130, 667	21, 99		78, 224	31.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	128,700	18, 029	10, 30	1 4, 893	0	43.00
50.00	05000 OPERATING ROOM	1, 048, 476	575, 883	46, 59	3 156, 287	0	50.00
51.00	05100 RECOVERY ROOM	120, 107	113, 061		30, 683	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	252, 145 69, 206	131, 961		3 35, 812 0 521	0	52.00 53.00
53.00 54.00	05400 RADI OLOGY -DI AGNOSTI C	793, 993	1, 919 578, 271	38, 58		0	54.00
54.01	03630 ULTRA SOUND	73, 472	23, 250		6, 310	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	28, 331	10, 086		2, 737	0	54.02
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	125, 486 71, 525	27, 445 19, 346		0 7,448 0 5,250	0	57.00 58.00
60.00	06000 LABORATORY	665, 285	126, 315		34, 280	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	51, 325	11, 759		0 3, 191	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	71, 753	91, 395		24, 803	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	282, 478 281, 003	113, 552 279, 407	22, 25	0 30, 817 6 75, 827	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	86, 703	11,090		3, 010	0	67.00
68.00	06800 SPEECH PATHOLOGY	54, 216	8, 791		2, 386	0	68.00
69.00	06900 ELECTROCARDI OLOGY	54, 481	30, 748			0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	1, 454, 865 422, 418	0			0	71.00
72.00	PATIENTS	422,410	0		0	0	/2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 191, 050	0		0 0	0	
	03952 WOUND CARE (DI ABETES CENTER)	56,975	46, 456		0 12,608 0 12,874	0	
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT	36, 954 188, 089	47, 438 119, 912		0 12,874 0 32,542	0	
	07697 CARDI AC REHABI LI TATI ON	101, 849	49, 112		13, 328	0	
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 PALLIATIVE HEALTH	24, 242	0 7, 029		0 0 0 1,907	0	90.00 90.01
90.02	09002 VEIN CENTER	46, 615	5, 556		1, 508	0	90.02
	09003 OBGYN	190, 357	159, 049		0 43, 164	0	90.03
91.00	09100 EMERGENCY	782, 234	323, 966	40, 06	6 87, 920	0	91.00
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 04952 BEHAVI ORAL HEALTH	75, 628	27, 758		7, 533	0	92.00 93.00
75.00	OTHER REIMBURSABLE COST CENTERS	73,020	27,730		7,000	0	/3.00
101.00	10100 HOME HEALTH AGENCY	331, 104	37, 709	(0 10, 234	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS			1			112 00
	11600 HOSPI CE	180, 559	51, 544		0 13, 988	0	113.00 116.00
118.00		14, 451, 005	5, 215, 282			679, 496	
	NONREI MBURSABLE COST CENTERS	I I		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	2,493	26, 508		0 7, 194 0 161, 943		190.00 192.00
	07950 WELLNESS	815, 111 0	596, 724 0		0 161, 943 0 0		192.00
194.01	07951 JACKSON MOB	106, 463	0		o o	0	194.01
	07952 EXTERNAL SVCS MARKETING	184, 836	43, 065		0 11, 687		194.02
	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES	54, 004 219, 377	94, 184 101, 905		0 25, 560 0 27, 656		194.03 194.04
	07955 I NTEGRATED MEDI CI NE	116, 297	80, 328		21,800		194.04
194.06	07956 SURGI CAL PROFESSI ONAL	263, 363	60, 000	(0 16, 283	0	194.06
	07957 PRI MARY CARE	783, 147	447, 649		0 121, 486		194.07
	07958 EMPLOYER CLINIC 07959 UROLOGY PROF	209, 412 133, 745	115, 984 46, 389		0 31, 477 0 12, 589		194. 08 194. 09
200.00		100,740	40, 307		12, 307	0	200.00
	018 10:30 am	· ·		•			·

Health Fin	ancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLO	CATI ON – GENERAL SERVI CE COSTS		Provider C	F	Period: From 01/01/2017 Fo 12/31/2017		
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	C	(0 0	C	201.00
202.00	TOTAL (sum lines 118 through 201)	17, 339, 253	6, 828, 018	452, 850	1, 834, 016	679, 496	202.00

^{5/18/2018 10:30} am

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI	CAL CENTER Provider CC		eriod: com 01/01/2017	u of Form CMS-: Worksheet B Part I Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/18/2018 10: MEDI CAL RECORDS & LI BRARY	30 am
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A	900, 970					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	40, 967	4, 568, 145	1 007 401			13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	24, 353 19, 773	220, 788 179, 266	1, 926, 431 2, 732	4, 423, 362		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	29, 678	0	2,867	0	1, 897, 597	16.00
18.00	01850 PHYSICIAN PRIVATE PRACTICE	4, 985	0	307	о	0	18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS I NPATIENT ROUTINE SERVICE COST CENTERS	2, 827	0	0	0	0	19.00
30.00	03000 ADULTS & PEDIATRICS	119, 534	1, 083, 698	13, 375	0	48, 430	30.00
31.00	03100 I NTENSI VE CARE UNI T	23, 281	211, 062	974	Ō	8, 315	
43.00	04300 NURSERY	10, 717	97, 161	0	0	5, 948	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	64, 982	589, 124	25, 509	0	497, 413	50.00
51.00	05100 RECOVERY ROOM	8, 786	0	304	0	50, 813	
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 228	183, 389	0	О	40, 431	52.00
53.00	05300 ANESTHESI OLOGY	9, 934	0	375	0	35, 032	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	44, 069 4, 393	399, 526 0	3, 794 259	0	104, 797 25, 672	54.00 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 342	0	25	0	10, 628	
57.00	05700 CT SCAN	5, 153	0	463	О	210, 805	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 503	0	30	0	54, 864	58.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	44, 905 0	407, 111 0	5, 629 0	0	277, 124 4, 160	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	5, 028	Ő	835	Ő	7, 785	64.00
65.00	06500 RESPI RATORY THERAPY	27, 400	0	1, 824	0	35, 370	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	26, 439 6, 907	239, 700 0	1, 864 616	0	26, 880 13, 216	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	4,030	0	264	0	4, 599	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 900	26, 291	440	О	41, 081	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 364, 631	0	48, 403	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	396, 275	0	29, 101	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	4, 423, 362	121, 948	
	03952 WOUND CARE (DIABETES CENTER)	4, 464	0	395	0		76.00
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT	4, 691 17, 518	0	228 361	0	1, 117 17, 049	
76.97		8, 384	0	282	0	1, 533	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 PALLIATIVE HEALTH	0 4, 036	0	0 33	0	0 325	
90.01		5, 098	0	574	0	10, 353	
90.03	09003 OBGYN	24, 295	0	4, 242	О	8, 525	
91.00	09100 EMERGENCY	78, 553	712, 157	4, 852	0	120, 353	
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 04952 BEHAVI ORAL HEALTH	5, 776	0	499	0	3 050	92.00 93.00
70.00	OTHER REIMBURSABLE COST CENTERS	0,,,0	0		0	0,000	70.00
101.00	10100 HOME HEALTH AGENCY	24, 142	218, 872	1, 589	0	14, 089	101.00
112 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	12, 925	о	1, 760	о	12, 470	116.00
118.00		745, 996		1, 838, 207	4, 423, 362	1, 897, 597	
400.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 40, 332	0	0 28, 508	0		190. 00 192. 00
194.00	07950 WELLNESS	0, 332	0	20, 000	0		192.00
	07951 JACKSON MOB	0	0	0	0		194. 01
	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	4, 173 7, 940	0	1, 376	0		194. 02 194. 03
	07954 PHYSI CI AN OFFI CES	13, 883	0	4, 759	0		194.03
194.05	07955 INTEGRATED MEDICINE	3, 814	Ō	19, 948	0	0	194.05
	07956 SURGI CAL PROFESSI ONAL	7,933	0	819	0		194.06
	07957 PRIMARY CARE 07958 EMPLOYER CLINIC	55, 382 16, 214	0	20, 631 7, 464	0		194. 07 194. 08
	07959 UROLOGY PROF	5, 303	0	4, 719	0		194.08
	018 10:30 am					-	·

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				rom 01/01/2017		
			1	o 12/31/2017	Date/Time Pre	pared:
					5/18/2018 10:	<u>30 am</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 20	1) 900, 970	4, 568, 145	1, 926, 431	4, 423, 362	1, 897, 597	202.00

Cast Center Description OTHER GENERAL PRIVATE		Financial Systems LLOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI	CAL CENTER Provider CO		Period:	u of Form CMS-: Worksheet B	2552-10
Cost Center Duscription Difference Discussion Cost Center Duscription Cost Center Duscription 0 Definition Definition Definition Definition Definition 10 Definition Definition Definition Definition Definition Definition 10 Definition Definitio							Part I Date/Time Pre	pared:
Cost Center Rescription Struct PROLICE PROVINCA PROVINE PROVIN			ATUER OFNERAL				5/18/2018 10:	30 am
Cost Center Description PROVINCE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE PROVINCE NOMENTICE			· · · ·					
PMACING All STILL IS IS Rest dents cost with an intervention of the second sec		Cost Center Description		NONPHYSI CI AN	Subtotal	Intern &	Total	
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66:00 06600 PHSTICAL THERAPY 0 0 2,530,364 0 2,530,364 66.0 00 06700 OCCUPATIONAL THERAPY 0 0 6608,118 0 6608,118 0 6608,118 0 6608,118 0 6608,118 0 6608,118 0 6607,00 6000 PHSTLENTS 0 0 378,544 0 378,544 68.0 66.00 6000 MEDICAL SUPLIES CHARGED TO PATIENTS 0 0 1,032,796 0 1,032,796 0 3,218,397 72.0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 12,420,515 0 12,420,515 73.0 73.00 03950 PAIN MANAGEMENT 0 0 1446,559 66.0 76.00 76.00 10,666 0 146,015 0 16.01 746,061 76.90 190,02 146,015 0 16.01 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00<	64.00		0	0				1
67:00 067:00 0CUPATIONAL THERAPY 0 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0 608, 118 0	65.00	06500 RESPI RATORY THERAPY	0	0	2, 076, 70	5 0	2, 076, 705	65.00
66:00 068:00 SPEECH PATHOLOGY 0 378, 544 0 378, 544 68.00 69:00 06900 ELECTROCARDIOLOGY 0 0 490, 260 0 490, 260 69.00 69.00 0 490, 260 0 490, 260 69.00 111, 032, 796 0 111, 032, 796 0 111, 032, 796 0 3, 218, 397 0 3, 218, 397 72.00 0 0 3, 218, 397 0 3, 218, 397 72.00 0 0 446, 559 0 12, 420, 515 0 12, 420, 515 73.00 76.00 0 0 310, 686 0 310, 686 76.00 76.00 0 0 1446, 559 0 1446, 559 0 1446, 559 0 1446, 559 0 1446, 559 0 1446, 559 0 1446, 559 0 146, 051 0 160.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66.00		0	0				
69:00 06900 ELECTROCARDIOLOGY 0 490.260 99.0 490.260 99.0 11.032.796 11.032.796 11.032.796 97.0 97.0 97.00 77.00 <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></th<>			0	0				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11. 032, 796 0 11. 032, 796 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 3, 218, 397 0 3, 218, 397 0 3, 218, 397 72. 00 73. 00 DRUGS CHARGED TO PATIENTS 0 0 12, 420, 515 0 12, 420, 515 73. 00 76. 02 03951 CASE MANAGEMENT 0 0 310, 686 0 310, 686 76. 00 76. 02 03950 PAIN MANAGEMENT 0 0 746, 061 0 1, 431, 023 76. 70 70. 07 OTGOV CARDIA C REHABILI TATI ON 0 0 746, 061 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
72: 00 072:00 1MPLANTABLE DEVICES CHARGED TO PATLENTS 0 3, 218, 397 0 3, 218, 397 72: 0 73: 00 07300 DRUGS CHARGED TO PATLENTS 0 0 12, 420, 515 0 12, 420, 515 73: 0 73: 00 03952 WOUND CARE (DLABETES CENTER) 0 0 446, 559 0 446, 559 76: 00 76: 00 76: 00 76: 00 76: 00 76: 00 0 130, 686 0 130, 686 76: 00 90: 00 90: 00 90: 00 76: 00 90: 00 90: 00 90: 00 90: 00 90: 00 90: 00				-				
PATI ENTS O			0	-				
76.00 03952 WOUND CARE (DI ABETES CENTER) 0 446,559 0 446,559 76.02 03951 CASE MANAGEMENT 0 0 310,686 0 310,686 76.02 300,686 0 310,686 76.02 300,686 0 310,686 76.02 76.02 0 1,431,023 0 1,431,023 0 1,431,023 0 1,431,023 0 1,431,023 0 1,431,023 0 1,431,023 0 1,431,023 0			-	_	-,,	-		
76. 02 03951 CASE MANAGEMENT 0 0 310,686 0 310,686 76. 02 76. 02 03950 PAIN MANAGEMENT 0 0 1,431,023 0 1,431,023 76. 02 76. 02 70. 70 776. 97 (776.97) CARDIAC REHABILITATION 0 0 746. 061 0 746. 061 746. 061 76. 09 00.00 090001 PALLIATIVE HEALTH 12, 399 0 186, 015 90. 00 90. 00 90. 00 346, 970 0 346, 970 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 6, 539, 989 0 6, 539, 989 91. 00 91. 00 91. 00 92. 00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.44, 667 0 2, 495, 892 0 2, 495, 892 10. 0 93. 00 101.00 10000 IMERGENCY 0 0 2, 495, 892 0 2, 495, 892 <td>73.00</td> <td></td> <td>0</td> <td>0</td> <td>12, 420, 51</td> <td>5 0</td> <td></td> <td></td>	73.00		0	0	12, 420, 51	5 0		
76. 03 03950 PAIN MANAGEMENT 0 0 1, 431, 023 0 1, 431, 023 76. 07 OUTPATI ENT SERVICE COST CENTERS 0 0 746, 061 0 746, 061 0 746, 061 746, 061 746, 061 76. 0 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90. 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>			0	0				
76. 97 07697 CARDI AC REHABI LI TATI ON 0 746, 061 0 746, 061 746, 061 746, 061 746, 061 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0000 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>			0	0				
OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td></td><td></td></t<>			0	-				
90.00 09000 CLINIC 0	70. 77		0	0	740,00	1 0	740,001	/0. //
90.01 09001 PALLI ATI VE HEALTH 12,399 0 186,015 0 186,015 90.0 90.0 90.02 VEIN CENTER 15,663 0 346,970 0 346,970 90.0 90.0 90.00 90.00 90.00 90.00 346,970 90.0 90.0 90.00 90.00 90.00 346,970 90.0 90.0 90.00	90.00		0	0	(0 0	0	90.00
90.03 09003 0BGYN 74,646 0 1,572,557 0 1,572,557 90.0 91.00 09100 EMERGENCY 0 0 6,539,989 0 6,539,989 91.0 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 6,539,989 91.0 93.00 04952 BEHAVI ORAL HEALTH 0 0 0 544,667 93.0 0THER REI MBURSABLE COST CENTERS 0 0 2,495,892 0 2,495,892 101.00 HOME HEALTH AGENCY 0 0 1,286,540 0 1,286,540 113.00 INTEREST EXPENSE 0 1,286,540 0 1,286,540 118.0 NONREI MBURSABLE COST CENTERS 113.0 118.0 92,780,305 92,780,305 118.0 NONREI MBURSABLE COST CENTERS 0 0 50,187 0 6,340,929 0 6,340,929 194.03,092 194.03,092 194.03,092 194.03,092 194.03,092 194.03,092 194.03,092 194.03,092 0<	90.01	09001 PALLI ATI VE HEALTH	12, 399	0	186, 01			
91.00 09100 EMERGENCY 0 0 6, 539, 989 0 6, 539, 989 91.0 92.0 92.00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 544, 667 0 544, 667 92.0 93.00 04952 BEHAVI ORAL HEALTH 0 0 0 544, 667 0 544, 667 93.0 01100 HOME HEALTH AGENCY 0 0 2, 495, 892 0 2, 495, 892 101.0 10100 HOME HEALTH AGENCY 0 0 2, 495, 892 0 2, 495, 892 110.0 113.00 INTEREST EXPENSE 0 1, 286, 540 0 1, 286, 540 116.0 118.00 11600 HONSPI CE 0 123, 431 92, 780, 305 92, 780, 305 118.0 118.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50, 187 190.0 192.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 123, 921 0 6, 340, 929 6, 340, 929 194.0 194.0 194.00 07950 WELINESS 0 <td>90.02</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	90.02							
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 93.0 92.0 93.0	90.03		74, 646					
93.00 04952 BEHAVI ORAL HEALTH 0 0 544, 667 93.0 93.0 0THER REI MBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY 0 0 2, 495, 892 0 2, 495, 892 101.0 2, 495, 892 101.0 2, 495, 892 0 2, 495, 892 101.0 2, 495, 892 101.0 2, 495, 892 0 2, 495, 892 101.0 101.0 10100 HOME HEALTH AGENCY 0 0 2, 495, 892 0 2, 495, 892 101.0 101.0 101.0 101.0 101.0 113.00 113.00 113.00 113.00 113.00 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td>6, 539, 989</td><td>9 0</td><td>6, 539, 989</td><td></td></td<>			0	0	6, 539, 989	9 0	6, 539, 989	
OTHER REI MBURSABLE COST CENTERS 101.00 HOME HEALTH AGENCY 0 0 2, 495, 892 0 2, 495, 892 101.0 SPECIAL PURPOSE COST CENTERS 113.0 113.00 11300 INTEREST EXPENSE 113.0 113.0 116.00 11600 HOSPICE 0 1, 286, 540 0 1, 286, 540 16.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 102, 708 123, 431 92, 780, 305 0 92, 780, 305 116.0 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50, 187 190.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 123, 921 0 6, 340, 929 0 6, 340, 929 192.0 194.00 07950 WELLNESS 0 0 0 0 194.0 194.02 07951 JACKSON MOB 0 0 703, 930 0 703, 930 <td< td=""><td></td><td></td><td>0</td><td></td><td>E11 44</td><td>7 0</td><td>E11 447</td><td></td></td<>			0		E11 44	7 0	E11 447	
101.00 HOME HEALTH AGENCY 0 0 2,495,892 0 2,495,892 101.0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.0 113.00 11300 HOSPICE 0 1,286,540 0 1,286,540 116.0 NONREL MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50,187 0 50,187 190.0 192.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194.0 0 194.0 194.0 194.0 0 0 0 0 194.0 194.0 195.2 1,282.3 0 1,295,259 0 1,295,259 194.0 194.00 0752 EXTENAL SVCS MARKETING 124,396 0 509,152 0 1,295,259 194.0 194.0 194.0 1,295,259 0 1,295,259 194.0 194.0 194.0 194.0 194.0 194.0 1,295,259 0 1,295,259 194.0 194.0 </td <td>73.00</td> <td></td> <td>0</td> <td>0</td> <td>544,00</td> <td>0</td> <td>544,007</td> <td>93.00</td>	7 3.00		0	0	544,00	0	544,007	93.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 116.00 HOSPI CE 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 1, 286, 540 0 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 102, 708 123, 431 92, 780, 305 0 92, 780, 305 0 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 192.00 19200 192.00 19200 194.00 07950 WELLNESS 0 0 0 194.01 07951 JACKSON MOB 0 194.02 07952 EXTENAL SVCS MARKETING 12, 823 0 1, 295, 259	101.00		0	0	2, 495, 892	2 0	2, 495, 892	101.00
113.00 11300 INTEREST EXPENSE 113.00 116.00 1000 HOSPI CE 0 1, 286, 540 0 1, 286, 540 116.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 102, 708 123, 431 92, 780, 305 0 92, 780, 305 118.0 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50, 187 0 6, 340, 929 192.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 123, 921 0 6, 340, 929 0 6, 340, 929 192.0 194.00 07950 WELLNESS 0 0 0 0 0 194.0 194.02 07951 JACKSON MOB 0 0 703, 930 0 703, 930 194.0 194.02 07952 EXTERNAL SVCS MARKETING 12, 823 0 1, 295, 259 0 1, 295, 259 194.0 194.03 07953 WASHI NGTON CLINI C 24, 396 509, 152 0 509, 152 194.0 194.04 07954 PHYSI CI AN OFFI CES 42, 6		SPECIAL PURPOSE COST CENTERS						1
SUBTOTALS SUBTOTALS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>113.00</td></t<>								113.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50, 187 0 50, 187 190. 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 123, 921 0 6, 340, 929 0 6, 340, 929 192. 0 194. 00 07950 WELLNESS 0 0 0 0 194. 0 194. 01 07951 JACKSON MOB 0 0 703, 930 0 703, 930 194. 0 194. 02 07952 EXTERNAL SVCS MARKETI NG 12, 823 0 1, 295, 259 0 1, 295, 259 194. 0 194. 03 07953 WASHI NGTON CLI NI C 24, 396 0 509, 152 0 509, 152 194. 0 194. 04 07954 PHYSI CI AN OFFICES 42, 654 0 1, 641, 377 0 1, 641, 377 194. 0			0	100.101				
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 50, 187 190.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 123, 921 0 6, 340, 929 0 6, 340, 929 192.0 194.00 07950 WELLNESS 0 0 0 0 0 194.0 194.01 07951 JACKSON MOB 0 0 703, 930 0 703, 930 194.0 194.02 07952 EXTERNAL SVCS MARKETING 12, 823 0 1, 295, 259 0 1, 295, 259 194.0 194.03 07954 WASHI NGTON CLI NI C 24, 396 509, 152 0 509, 152 194.0 194.04 07954 PHYSI CI AN OFFICES 42, 654 0 1, 641, 377 194.0	118.00		102, 708	123, 431	92, 780, 30	0 0	92, 780, 305	1118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 123, 921 0 6, 340, 929 0 6, 340, 929 192.0 194.00 07950 WELLNESS 0 0 0 0 194.0 194.01 07951 JACKSON MOB 0 0 0 703, 930 703, 930 194.0 194.02 07952 EXTERNAL SVCS MARKETING 12, 823 0 1, 295, 259 0 1, 295, 259 194.0 194.03 07953 WASHI NGTON CLINIC 24, 396 0 509, 152 509, 152 194.0 194.04 07954 PHYSI CI AN OFFICES 42, 654 0 1, 641, 377 0 1, 641, 377 194.0	100 00		0	0	FO 10	7	FO 197	190 00
194. 00 07950 WELLNESS 0 0 0 194. 0 194. 0 194. 0 0 0 0 194. 0 194. 0 194. 0 0 0 0 0 194. 0 194. 0 194. 0 0 0 0 0 703, 930 194. 0 194. 0 0 703, 930 194. 0 194. 0 12, 823 0 1, 295, 259 0 1, 295, 259 194. 0 194. 0 194. 0 24, 396 0 509, 152 0 509, 152 194. 0 </td <td></td> <td></td> <td>123 921</td> <td>0 0</td> <td></td> <td></td> <td></td> <td></td>			123 921	0 0				
194. 01 07951 JACKSON MOB 0 703, 930 703, 930 194. 0 194. 02 07952 EXTERNAL SVCS MARKETING 12, 823 0 1, 295, 259 0 1, 295, 259 14. 0			0	0	() 0		
194. 0207952EXTERNALSVCSMARKETING12, 82301, 295, 25901, 295, 259194. 0194. 0307953WASHI NGTONCLINIC24, 3960509, 1520509, 152194. 0194. 0407954PHYSI CI AN0FFICES42, 65401, 641, 37701, 641, 377194. 0			0	0	703, 930	o o		
194. 03 07953 WASHI NGTON CLINIC 24, 396 0 509, 152 0 509, 152 194. 0 194. 04 07954 PHYSI CI AN 0FFI CES 42, 654 0 1, 641, 377 0 1, 641, 377 194. 0	194.02	07952 EXTERNAL SVCS MARKETING					1, 295, 259	194. 02
					509, 152	2 0		
194. USIO 7955] INTEGRATED MEDICINE 11, 717 0 906, 562 0 906, 562 194. 0								
- /19 /2019 10, 20 cm			11, 717	0	906, 562	2 0	906, 562	194.05

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017	Worksheet B Part I	
				Го 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: <u>30 am</u>
	OTHER GENERAL SERVI CE					
Cost Center Description	PHYSI CI AN PRI VATE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost	Total	
	PRACTICE	ANESTHETTSTS		& Post		
				Stepdown Adjustments		
	18.00	19.00	24.00	25.00	26.00	
194. 06 07956 SURGI CAL PROFESSI ONAL	24, 374	0	1, 850, 76	0 0	1, 850, 760	194.06
194. 07 07957 PRI MARY CARE	170, 162	0	5, 993, 46	5 0	5, 993, 466	194.07
194.08 07958 EMPLOYER CLINIC	49, 818	0	1, 605, 58	5 0	1, 605, 586	194.08
194. 09 07959 UROLOGY PROF	16, 294	0	969, 61	2 0	969, 612	194. 09
200.00 Cross Foot Adjustments		0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	578, 867	123, 431	114, 647, 12	5 0	114, 647, 125	202.00

^{5/18/2018 10:30} am

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI	Provi der CC		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/18/2018 10:	pared:
			CAPI TAL REL	ATED COSTS		5/18/2018 10:	30 am
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 1 00
16. 00 18. 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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	0 14, 270 11, 068 0 5, 493 3, 974 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20, 175 389, 572 242, 684 14, 816 22, 165 85, 009 0 92, 723 79, 615 33, 412 21, 765 0 0 0	60, 67 53, 64 18, 77 5, 17	0 767, 442 9 1, 843, 641 1 15, 647 3 29, 451 1 109, 354 0 0 8 153, 401 7 133, 262 8 52, 190	20, 296 2, 565 455 312 52 184 721 240 402 329 124 121	$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 18.\ 00\\ \end{array}$
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	7, 344 1, 606 0	725, 544 68, 968 9, 516	213, 80 76, 33		1, 769 344 174	31.00
50.00	ANCI LLARY SERVI CE COST CENTERS	183, 899	303, 962	437, 74	1 925, 602	956	50.00
51.00 52.00 53.00 54.01 54.01 54.02 57.00 58.00 60.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 71.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 0 0 0 0 0 135, 440 0 0 3, 275 0 0 0 2, 400 0 2, 400	59, 676 69, 651 1, 013 305, 222 12, 272 5, 323 14, 486 10, 211 66, 672 6, 207 48, 240 59, 935 147, 476 5, 853 4, 640 16, 200 0	87 40, 43 399, 16, 92 7 31, 84 2, 80 55, 95 44 34, 25 21, 41 11, 62 8 68 15, 89 1, 36	0 69, 651 6 41, 449 8 704, 390 4 29, 196 4 5, 397 3 46, 329 3 13, 014 7 258, 069 8 6, 655 8 82, 498 1 84, 621 3 159, 099 6 5, 939 6 5, 326 7 34, 526	150 328 948 797 90 28 93 62 521 0 82 462 359 123 77 45 0	$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 54.\ 02\\ 57.\ 00\\ 63.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ \end{array}$
72.00 73.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER)	0 0 11, 414	0 0 24, 520		o o o o	0 0 74	72.00 73.00
76.03	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0 0 0	25, 039 63, 292 25, 922	23 2, 58 5, 40	4 65, 876	176 435 140	76.03
92.00	09000 CLINIC 09001 PALLIATIVE HEALTH 09002 VEIN CENTER 09003 OBGYN 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	0 0 0 34 0	0 3, 710 2, 933 83, 949 170, 996 14, 651		7 161, 746 3 194, 883 0	0 89 121 762 1, 703 173	90. 01 90. 02 90. 03 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	19, 904	88	1 20, 785	444	101.00
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	61, 586 441, 803	27, 206 3, 405, 154	3, 598, 88	0 88, 792 0 7, 445, 837		113.00 116.00 118.00
192.00 194.00 194.01 194.02 194.03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS 07951 JACKSON MOB 07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	0 3, 330 0 0 0 0	13, 992 314, 962 0 22, 730 49, 712	45, 35 33	0 0 0 0 5 23, 065 0 49, 712	1, 001 0 67 66	190.00 192.00 194.00 194.01 194.02 194.03
194.05	07954 PHYSI CI AN OFFICES 07955 I NTEGRATED MEDI CI NE 07956 SURGI CAL PROFESSI ONAL	90 0 0	53, 787 42, 399 31, 669	5, 34 1, 68 96	6 44, 085	124	194. 04 194. 05 194. 06

Heal th Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017		pared: 30 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.07 07957 PRI MARY CARE	1, 319	236, 277	50, 87	9 288, 475	870	194.07
194.0807958 EMPLOYER CLINIC	0	61, 219	1, 35	9 62, 578	245	194.08
194.0907959UROLOGY PROF	0	24, 485	27, 08	0 51, 565	43	194.09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	446, 542	4, 256, 386	3, 731, 88	4 8, 434, 812	20, 296	202.00

^{5/18/2018 10:30} am

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113.00 1NTEREST EXPENSE 8,018 14,267 0 408 0 116.00 116.00 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 641,748 1,443,558 26,285 40,773 158,450 118.00 NONREI MBURSABLE COST CENTERS 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 111 7,337 0 210 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36,197 165,170 0 4,729 0 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 07952 EXTERNAL SVCS MARKETI NG 8,208 11,920 0 194.01 194.02 07952 EXTERNAL SVCS MARKETI NG 8,208 11,920 0 0 194.03 194.03 07954 WASHI NGTON CLI NI C 2,398 26,070 0 194.03 194.03 07954 WASHI NGTON CLI NI C 2,398 26,070 0 194.03 194.04 07954 WASHI NGTON CLI NI C 2,398 26,070 0 637 0 194.04 0494.03 04 0494.03	101.00		14, 704	10, 438	0	299	0	101.00
116.00 HOSPI CE 8,018 14,267 0 408 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 641,748 1,443,558 26,285 40,773 158,450 118.00 NONREL MBURSABLE COST CENTERS NONREL MBURSABLE COST CENTERS 111 7,337 0 210 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36,197 165,170 0 4,729 0 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.02 07952 EXTERNAL SVCS MARKETI NG 8,208 11,920 0 341 0 194.01 194.03 07953 WASHI NGTON CLI NI C 2,398 26,070 0 746 0 194.02 194.04 07954 PHYSI CI AN OFFICES 9,742 28,207 0 808 0 194.04 194.05 07955 INTEGRATED MEDI CI NE 5,164 22,234 0 637 0 <t< td=""><td></td><td></td><td></td><td></td><td>1</td><td></td><td></td><td></td></t<>					1			
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 641,748 1,443,558 26,285 40,773 158,450 118.00 NONREL MBURSABLE COST CENTERS 190.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 111 7,337 0 210 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 36,197 165,170 0 4,729 0 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.01 07951 JACKSON MOB 4,728 0 0 0 194.01 194.02 07952 EXTERNAL SVCS MARKETING 8,208 11,920 0 341 0 194.02 194.04 07954 PHYSI CI AN OFFI CES 9,742 28,207 0 808 0 194.04 194.05 07955 INTEGRATED MEDI CI NE 5,164 22,234 0 637 0 194.05 194.06 07955 INTEGRATED MEDI CI NE 5,164 <			0.010	44.0/7		100	0	
NONRE I MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 111 7,337 0 210 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 36,197 165,170 0 4,729 0 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.01 07951 JACKSON MOB 4,728 0 0 0 194.01 194.02 07952 EXTERNAL SVCS MARKETING 8,208 11,920 341 0 194.02 194.03 07953 WASHI NGTON CLINIC 2,398 26,070 0 746 0 194.02 194.04 07954 PHYSI CI AN OFFI CES 9,742 28,207 0 808 194.04 194.05 07955 INTEGRATED MEDI CI NE 5,164 22,234 0 637 0 194.05 194.06 07955 INGI CAL PROFESSI ONAL 11,695 16,608 475 0 194.06 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
192.00 PHYSI CI ANS' PRI VATE OFFICES 36, 197 165, 170 0 4, 729 0 192.00 194.00 07950 WELLNESS 0 0 0 0 0 194.00 194.01 07951 JACKSON MOB 4, 728 0 0 0 194.01 194.02 07952 EXTERNAL SVCS MARKETI NG 8, 208 11, 920 0 341 0 194.02 194.03 07953 WASHI NGTON CLI NI C 2, 398 26, 070 0 746 0 194.03 194.05 07954 PHYSI CI AN OFFI CES 9, 742 28, 207 0 808 0 194.04 194.05 07955 INTEGRATED MEDI CI NE 5, 164 22, 234 0 637 0 194.05 194.05 07955 INTEGRATED MEDI CI NE 51, 164 22, 234 0 637 0 194.05 194.06 07955 SURGI CAL PROFESSI ONAL 11, 695 16, 608 0 475 0 194.07 194.07 07957 PRI MARY CARE 34, 778 123, 907 <td>110.00</td> <td></td> <td></td> <td>1, 443, 330</td> <td>20,203</td> <td>40, 773</td> <td>130, 430</td> <td>110.00</td>	110.00			1, 443, 330	20,203	40, 773	130, 430	110.00
194.00 07950 WELLNESS 0 0 0 194.00 194.01 07951 JACKSON MOB 4,728 0 0 0 194.01 194.02 07952 EXTERNAL SVCS MARKETING 8,208 11,920 0 341 0 194.02 194.03 07953 WASHINGTON CLINIC 2,398 26,070 0 746 0 194.03 194.04 07954 PHYSI CI AN OFFICES 9,742 28,207 0 808 0 194.04 194.05 07955 INTEGRATED MEDICINE 5,164 22,234 0 637 0 194.05 194.06 07956 SURGI CAL PROFESSI ONAL 11,695 16,608 0 475 0 194.05 194.06 07957 PRI MARY CARE 34,778 123,907 0 3,547 0 194.07 194.09 07959 UROLOGY PROF 5,939 32,104 0 919.00 194.08 194.09 07959 UROLOGY PROF 5,939 12,840 0 368 0 194.09 <								
194.01 07951 JACKSON MOB 4,728 0 0 0 194.01 194.02 07952 EXTERNAL SVCS MARKETING 8,208 11,920 0 341 0 194.02 194.03 07953 WASHI NGTON CLINIC 2,398 26,070 0 746 0 194.03 194.04 07954 PHYSI CLAN OFFICES 9,742 28,207 0 808 0 194.04 194.05 07955 INTEGRATED MEDICINE 5,164 22,234 0 637 0 194.05 194.06 07956 SURGI CAL PROFESSI ONAL 11,695 16,608 0 475 0 194.05 194.08 07958 EMPLOYER CLINIC 9,299 32,104 0 919.07 194.08 194.09 07959 UROLOGY PROF 5,939 12,840 0 368 0 194.09 200.00 Cross Foot Adjustments 0 200.00 200.00 0 368 0 194.09								
194.02 07952 EXTERNAL SVCS MARKETING 8, 208 11, 920 0 341 0 194.02 194.03 07953 WASHINGTON CLINIC 2, 398 26, 070 0 746 0 194.03 194.04 07954 PHYSI CI AN OFFICES 9, 742 28, 207 0 808 0 194.04 194.05 07955 INTEGRATED MEDICINE 5, 164 22, 234 0 637 0 194.05 194.06 07956 SURGI CAL PROFESSI ONAL 11, 695 16, 608 0 475 0 194.06 194.06 07957 PRI MARY CARE 34, 778 123, 907 0 3, 547 0 194.06 194.09 07958 EMPLOYER CLINIC 9, 299 32, 104 0 919 0 194.08 194.09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194.09 200.00 Cross Foot Adjustments 0 368 0 194.09 200.00				0		0		
194.03 07953 WASHI NGTON CLINIC 2,398 26,070 0 746 0 194.03 194.04 07954 PHYSI CI AN OFFICES 9,742 28,207 0 808 0 194.04 194.05 07955 INTEGRATED MEDI CI NE 5,164 22,234 0 637 0 194.05 194.06 07956 SURGI CAL PROFESSI ONAL 11,695 16,608 0 475 0 194.06 194.07 07957 PRI MARY CARE 34,778 123,907 0 3,547 0 194.08 194.09 07958 EMPLOYER CLINIC 9,299 32,104 0 919 0 194.08 194.09 07959 UROLOGY PROF 5,939 12,840 0 368 0 194.09 200.00 Cross Foot Adjustments 200.00 0 368 0 194.09				0 11. 920		341		
194.05 07955 INTEGRATED MEDICINE 5, 164 22, 234 0 637 0 194.05 194.06 07956 SURGICAL PROFESSIONAL 11, 695 16, 608 0 475 0 194.06 194.07 07957 PRI MARY CARE 34, 778 123, 907 0 3, 547 0 194.07 194.09 07958 EMPLOYER CLINIC 9, 299 32, 104 0 919 0 194.08 194.09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194.09 200.00 Cross Foot Adjustments 200.00 0 200.00 0 200.00 0 0 200.00	194.03	07953 WASHINGTON CLINIC		26, 070	0		0	194. 03
194.06 07956 SURGI CAL PROFESSI ONAL 11, 695 16, 608 0 475 0 194.06 194.07 07957 PRI MARY CARE 34, 778 123, 907 0 3, 547 0 194.07 194.08 07958 EMPLOYER CLINIC 9, 299 32, 104 0 919 0 194.08 194.09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194.09 200.00 Cross Foot Adjustments 200.00 12, 840 0 368 0 194.09								
194. 07 07957 PRI MARY CARE 34, 778 123, 907 0 3, 547 0 194. 07 194. 08 07958 EMPLOYER CLINIC 9, 299 32, 104 0 919 0 194. 08 194. 09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194. 09 200. 00 Cross Foot Adjustments 200. 00 194. 08 200. 00 200. 00 12, 840 0 368 0 194. 09								
194.08 07958 EMPLOYER CLINIC 9, 299 32, 104 0 919 0 194.08 194.09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194.09 200.00 Cross Foot Adjustments 0 12, 840 0 368 0 194.09								
194. 09 07959 UROLOGY PROF 5, 939 12, 840 0 368 0 194. 09 200. 00 Cross Foot Adjustments 5, 939 12, 840 0 368 0 194. 09							0	194.08
	194.09	07959 UROLOGY PROF				368	0	
								200.00

Health Fir	nancial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATI O	N OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017 Fo 12/31/2017	Worksheet B Part II Date/Time Pre 5/18/2018 10:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	C)	0 0	(201.00
202.00	TOTAL (sum lines 118 through 201)	770, 007	1, 889, 955	26, 28	5 53, 553	158, 450	202.00

^{5/18/2018 10:30} am

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI	Provider CC		Period: From 01/01/2017	u of Form CMS-: Worksheet B Part II	
					0 12/31/2017	Date/Time Pre 5/18/2018 10:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11.00	01100 CAFETERI A	6, 235					11.00
13.00	01300 NURSING ADMINISTRATION	283					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	169	· · ·	197, 898			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	137 205		281 294		51, 686	15.00 16.00
18.00	01850 PHYSI CI AN PRI VATE PRACTI CE	34		32		0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	20	0	C		0	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.20		1 07/		1 000	
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	828 161		1, 374 100		1, 322 227	30.00 31.00
43.00	04300 NURSERY	74		C		162	•
	ANCI LLARY SERVI CE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	450 61	30, 091 0	2, 620		13, 459	50.00 51.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	140	-	31 C		1, 387 1, 104	
53.00	05300 ANESTHESI OLOGY	69		39		956	
54.00	05400 RADI OLOGY-DI AGNOSTI C	305		390		2, 861	54.00
54.01 54.02	03630 ULTRA SOUND	30 9		27 3		701 290	54.01 54.02
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	36		48		290 5, 755	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	24		3		1, 498	
60.00	06000 LABORATORY	311	20, 794	578		7, 566	•
63.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06400 I NTRAVENOUS THERAPY	0 35		C		114	63.00
64.00 65.00	06500 RESPIRATORY THERAPY	35 190		86 187		213 966	
66.00	06600 PHYSI CAL THERAPY	183		191		734	66.00
67.00	06700 OCCUPATIONAL THERAPY	48		63		361	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	28 20		27 45		126 1, 122	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20		140, 187		1, 122	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	40, 708		794	
72 00	PATIENTS	0			100,002	2 220	72.00
	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER)	0 31	0	C 41			73.00 76.00
	03951 CASE MANAGEMENT	32		23		30	
	03950 PALN MANAGEMENT	121		37		465	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	58	0	29	0	42	76.97
90.00	09000 CLINIC	0	0	C	0 0	0	90.00
90. 01	09001 PALLI ATI VE HEALTH	28		3	3 0	9	
90. 02 90. 03	09002 VEIN CENTER	35		59		283	
	09003 OBGYN 09100 EMERGENCY	168 544		436 498		233 3, 286	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	011	00,070	170		0,200	92.00
93.00	04952 BEHAVI ORAL HEALTH	40	0	51	0	83	93.00
101 00	OTHER REIMBURSABLE COST CENTERS	1/7	11 170	1/0		205	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	167	11, 179	163	8 0	385	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	89		181			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 163	233, 328	188, 835	108, 003	51, 686	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	279		2, 929	0	0	192.00
	07950 WELLNESS	0	0	C	0		194.00
	07951 JACKSON MOB 07952 EXTERNAL SVCS MARKETING	0 29	0	C 141			194. 01 194. 02
	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	55		141			194.02
194.04	07954 PHYSICIAN OFFICES	96		489	0	0	194. 04
	07955 I NTEGRATED MEDI CI NE	26		2, 049			194.05
	07956 SURGI CAL PROFESSI ONAL 07957 PRI MARY CARE	55 383		84 2, 119			194.06 194.07
	07957 PRIMARY CARE 07958 EMPLOYER CLINIC	383		2, 119 767			194.07
194.08							

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2017	Part II	
				To 12/31/2017		
		l			5/18/2018 10:	<u>30 am</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 235	233, 328	197, 89	B 108, 003	51, 686	202.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part II	
					To 12/31/2017	Date/Time Pre	pared:
		OTHER GENERAL				5/18/2018 10:	30 am
		SERVI CE					
	Cost Center Description	PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total	
		PRI VATE PRACTI CE	ANESTHETI STS		Residents Cost & Post		
		TRACTICE			Stepdown		
					Adj ustments		
	GENERAL SERVICE COST CENTERS	18.00	19.00	24.00	25.00	26.00	
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						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
18.00	01850 PHYSI CLAN PRI VATE PRACTI CE	4,042					18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	951				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	[1			
30.00	03000 ADULTS & PEDIATRICS	0		1, 614, 01 227, 81		1, 614, 017	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0		227, 81	-	227, 817 26, 335	
10.00	ANCI LLARY SERVICE COST CENTERS			20,00	0 0	20,000	10.00
50.00	05000 OPERATING ROOM	0		1, 186, 40	7 0	1, 186, 407	50.00
51.00	05100 RECOVERY ROOM	0		99, 70		99, 700	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		129, 57		129, 573	•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C			47, 08 931, 29		47, 080 931, 292	•
54.01	03630 ULTRA SOUND	0		39, 92		39, 927	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0		9, 85		9, 857	54.02
57.00	05700 CT SCAN	0		65, 64		65, 648	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		23, 28		23, 285	•
60.00 63.00	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0		353, 34 12, 39		353, 347 12, 396	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0		112, 37		112, 122	•
65.00	06500 RESPI RATORY THERAPY	0		131, 30		131, 301	65.00
66.00	06600 PHYSI CAL THERAPY	0		266, 13	2 0	266, 132	66.00
67.00	06700 OCCUPATIONAL THERAPY	0		13, 54		13, 542	•
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		10, 49		10, 495	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			49, 44 207, 48		49, 449 207, 488	
	07200 I MPLANTABLE DEVICES CHARGED TO	0		60, 26	-	60, 261	•
	PATI ENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0		164, 22		164, 224	1
76.00	03952 WOUND CARE (DIABETES CENTER)	0		52, 68		52, 686	•
76.02 76.03	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT			40, 68 109, 42		40, 683 109, 428	
	07697 CARDI AC REHABI LI TATI ON	0		50, 10		50, 102	•
	OUTPATIENT SERVICE COST CENTERS	1	l	1			
90.00		0			0 0	0	
90. 01 90. 02	09001 PALLIATIVE HEALTH 09002 VEIN CENTER	87 109		7,00		7, 004 11, 485	1
	09003 0BGYN	521		217, 60		217, 603	•
91.00	09100 EMERGENCY	0		366, 59		366, 591	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04952 BEHAVI ORAL HEALTH	0		32, 80	3 0	32, 803	93.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	[58, 56	4 0	59 561	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0		1 36, 30	+I U	36, 364	
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0		112, 30		112, 307	116.00
118.00		717	0	6, 840, 95	1 0	6, 840, 951	118.00
100.00	NONREI MBURSABLE COST CENTERS	0		21.45	0 0	21 450	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 865		21, 65 574, 81		574, 819	190. 00 192. 00
	07950 WELLNESS	0			0 0		194.00
194.01	07951 JACKSON MOB	0		4, 72	8 0		194. 01
	07952 EXTERNAL SVCS MARKETING	90		43, 86			194. 02
	07953 WASHINGTON CLINIC	170		79, 21			194.03
	07954 PHYSI CI AN OFFI CES 07955 I NTEGRATED MEDI CI NE	298 82		99, 12 74, 40			194. 04 194. 05
	019. 10: 20. cm	1 02	I	1 74,40	·i 0	1 74,401	1174.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	pared [.]
				10 12/01/2017	5/18/2018 10:	<u>30 am</u>
	OTHER GENERAL					
	SERVI CE					
Cost Center Description	PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern &	Total	
	PRI VATE	ANESTHETI STS		Residents Cost		
	PRACTI CE			& Post		
				Stepdown		
				Adjustments		
	18.00	19.00	24.00	25.00	26.00	
194. 06 07956 SURGI CAL PROFESSI ONAL	170		62, 07	9 0	62, 079	194.06
194. 07 07957 PRI MARY CARE	1, 188		455, 26	7 0	455, 267	194.07
194.08 07958 EMPLOYER CLINIC	348		106, 37	2 0	106, 372	194.08
194.0907959UROLOGY PROF	114		71, 39	1 0	71, 391	194.09
200.00 Cross Foot Adjustments		951	95	1 0	951	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 042	951	8, 434, 81	2 0	8, 434, 812	202.00

^{5/18/2018 10:30} am

	Financial Systems LLOCATION - STATISTICAL BASIS	SCHNECK MEDI	CAL CENTER Provider CC		eri od:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/18/2018 10:	
		CAPI TAL REL	ATED COSTS	I		57 187 2018 10.	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	2/1 404					1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	361, 404	7, 795, 693				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 713	252	60, 324, 568			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	33, 078	759, 540	7, 555, 431		97, 307, 872	5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	20, 606 1, 258	3, 321, 186 1, 736	1, 355, 165		5, 795, 345 360, 536	
	00900 HOUSEKEEPING	1, 256	3, 745	45, 165 928, 035	-	1, 518, 846	•
	01000 DI ETARY	7, 218	42, 553	153, 943		402, 932	
	01100 CAFETERI A	0	0	546, 667		764, 707	
	01300 NURSI NG ADMI NI STRATI ON	7,873	126, 753	2, 146, 762		3, 652, 918	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 760 2, 837	112, 065 39, 226	713, 952 1, 197, 000		1, 264, 242 3, 514, 806	
	01600 MEDI CAL RECORDS & LI BRARY	1,848	10, 817	979, 311		1, 538, 484	
18.00	01850 PHYSI CLAN PRI VATE PRACTI CE	0	0	369, 423		486, 827	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	360, 911	0	102, 364	19.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	61, 605	446, 617	5, 266, 166	0	7, 681, 968	30.00
	03100 I NTENSI VE CARE UNI T	5, 856	159, 449	1, 023, 174		1, 589, 812	•
	04300 NURSERY	808	0	516, 716		722, 262	
	ANCI LLARY SERVI CE COST CENTERS				_		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	25, 809 5, 067	914, 415 1, 817	2, 844, 898 447, 270		5, 884, 032 674, 037	50.00
	05200 DELIVERY ROOM & LABOR ROOM	5,914	1, 817	975, 357	-	1, 415, 036	•
	05300 ANESTHESI OLOGY	86	84, 468	2, 822, 495		388, 385	
	05400 RADI OLOGY-DI AGNOSTI C	25, 916	833, 840	2, 372, 739		4, 455, 878	
	03630 ULTRA SOUND	1,042	35, 354	268, 371		412, 325	•
	03450 NUCLEAR MEDICINE – DIAGNOSTIC 05700 CT SCAN	452 1, 230	155 66, 519	82, 125 275, 749		158, 991 704, 227	54.02 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	867	5, 856	183, 153		401, 396	•
	06000 LABORATORY	5, 661	116, 892	1, 550, 063		3, 733, 572	
	06300 BLOOD STORING, PROCESSING, & TRANS.	527	935	0	0	288, 037	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 096 5, 089	71, 563 44, 727	244, 749 1, 376, 407		402, 679 1, 585, 264	•
	06600 PHYSI CAL THERAPY	12, 522	24, 279	1, 068, 805		1, 576, 988	•
	06700 OCCUPATI ONAL THERAPY	497	179	366, 033	0	486, 576	67.00
	06800 SPEECH PATHOLOGY	394	1, 433	228, 916		304, 258	•
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 378 0	33, 207 2, 842	132, 854 0		305, 747 8, 164, 897	•
	07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	0	2, 042	0	0	2, 370, 603	
	PATIENTS	_	-			_, _, _, _, _,	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	6, 684, 155	
	03952 WOUND CARE (DLABETES CENTER) 03951 CASE MANAGEMENT	2, 082 2, 126	1, 435 490	221, 658 522, 589		319, 743 207, 384	
	03950 PALN MANAGEMENT	5, 374	5, 398	1, 294, 878		1, 055, 552	1
76.97	07697 CARDI AC REHABI LI TATI ON	2, 201	11, 291	415, 732		571, 573	
	OUTPATIENT SERVICE COST CENTERS					0	
	09000 CLINIC 09001 PALLIATIVE HEALTH	0 315	0	C 264, 577	-	0 136, 044	
	09002 VEIN CENTER	249	8, 968	360, 355		261, 603	
90. 03	09003 OBGYN	7, 128	162, 514	2, 268, 790	0	1, 068, 279	90.03
	09100 EMERGENCY	14, 519	49, 827	5, 068, 716	0	4, 389, 888	
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 04952 BEHAVI ORAL HEALTH	1, 244	12 470	E14 094	0	121 122	92.00 93.00
	OTHER REIMBURSABLE COST CENTERS	1,244	13, 670	514, 084	. U	424, 423	73.00
	10100 HOME HEALTH AGENCY	1, 690	1, 840	1, 322, 119	0	1, 858, 153	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	2 210	0	420 020		1, 013, 294	113.00
118.00		2, 310 289, 127	7, 517, 853	630, 020 51, 281, 323		81, 099, 068	
	NONREI MBURSABLE COST CENTERS					., ., .,]
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	0	C	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	26, 743	94, 749	2, 979, 491	0	4, 574, 390	
	07950 WELLNESS 07951 JACKSON MOB	0	0	C	0	0 597, 467	194.00 194.01
		1 U	0	L	. 0		
194.01		1.930	699	198. 789		1,037.299	194.02
194.01 194.02	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	1, 930 4, 221	699 0	198, 789 197, 375		1, 037, 299 303, 068	194.03
194. 01 194. 02 194. 03 194. 04	07952 EXTERNAL SVCS MARKETING				0		194. 03 194. 04

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/18/2018 10:	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
194. 06 07956 SURGI CAL PROFESSI ONAL	2, 689				1, 477, 988	
194. 07 07957 PRI MARY CARE	20, 062	106, 284	2, 588, 35	5 0	4, 395, 009	194.07
194.0807958 EMPLOYER CLINIC	5, 198	2, 839	729, 533	3 0	1, 175, 217	194.08
194. 09 07959 UROLOGY PROF	2,079	56, 568	128, 003	3 0	750, 573	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 256, 386	3, 731, 884	17, 109, 600	5	17, 339, 253	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 777363	0. 478711	0. 283620	5	0. 178190	203.00
204.00 Cost to be allocated (per Wkst. B,			20, 296	5	770, 007	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0.000330	5	0.007913	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	SCHNECK MEDI	CAL CENTER Provider CO	°N: 15_0065 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
0051 A	LEGATION STATISTICAL DAGIS			F	From 01/01/2017	Date/Time Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/18/2018 10: CAFETERI A	
		PLANT (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(HOURS OF SERVICE)	
		FEET) 7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	20/ 007					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	306, 007 1, 258	529, 103				7.00
9.00	00900 HOUSEKEEPI NG	1, 882	2, 959	302, 867	7		9.00
10.00	01000 DI ETARY	7, 218	0	7, 218			10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 7, 873	0	7, 873		1, 347, 121 61, 254	1
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 760	0	6, 760		36, 413	1
15.00	01500 PHARMACY	2, 837	0	2, 837		29, 565	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 848	0	1, 848		44, 374	
	01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0			7, 453 4, 227	18.00 19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS				<u>, </u>	1, 22,	1 1 1 00
30.00	03000 ADULTS & PEDI ATRI CS	61, 605	288, 143			178, 727	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 856	25, 699			34,809	
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	808	12, 035	808	3 0	16, 024	43.00
50.00	05000 OPERATI NG ROOM	25, 809	54, 438	25, 809	9 0	97, 160	50.00
51.00	05100 RECOVERY ROOM	5, 067	0	5, 067		13, 136	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 914	4, 303	5, 914		30, 245	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	86 25, 916	45, 077	86 25, 916		14, 853 65, 891	
54.01	03630 ULTRA SOUND	1,042	0	1, 042		6, 568	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	452	0	452		2, 007	•
57.00	05700 CT SCAN	1, 230	0	1, 230		7, 705	•
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	867 5, 661	0	867 5, 661		5, 238 67, 142	58.00 60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	527	0	527		0,,112	63.00
64.00	06400 I NTRAVENOUS THERAPY	4, 096	0	4, 096		7, 518	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5,089	0 26, 004	5,089		40, 968	
67.00	06700 OCCUPATIONAL THERAPY	12, 522 497	20,004	12, 522 497		39, 532 10, 328	
68.00	06800 SPEECH PATHOLOGY	394	0	394		6, 026	
69.00	06900 ELECTROCARDI OLOGY	1, 378	23, 633	1, 378		4, 336	1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	0	0			0	
72.00	PATIENTS	0	0			0	/2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	0	73.00
	03952 WOUND CARE (DI ABETES CENTER)	2,082	0	2, 082		6, 674	
	03951 CASE MANAGEMENT 03950 PAIN MANAGEMENT	2, 126 5, 374	0	2, 126 5, 374		7, 014 26, 193	
	07697 CARDI AC REHABI LI TATI ON	2, 201	0			12, 535	
	OUTPATIENT SERVICE COST CENTERS						
		0	0	010		0	90.00
	09001 PALLIATIVE HEALTH 09002 VEIN CENTER	315 249	0	315 249		6, 034 7, 622	
	09003 OBGYN	7, 128	0	7, 128		36, 325	
91.00	09100 EMERGENCY	14, 519	46, 812	14, 519	9 O	117, 451	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 244	0	1.04/	1 0	0 () (92.00
	04952 BEHAVIORAL HEALTH OTHER REIMBURSABLE COST CENTERS	1, 244	0	1, 244	+ <u> </u>	8, 636	93.00
	10100 HOME HEALTH AGENCY	1, 690	0	1, 690	0 0	36, 097	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	2, 310	0	2, 310	0	10 326	113.00 116.00
118.00		233, 730	529, 103			1, 115, 406	
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 188	0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS	26, 743 0	0	26, 743		60, 304 0	192.00
	07951 JACKSON MOB	0	0	(-		194.00
194.01	07952 EXTERNAL SVCS MARKETING	1, 930	0	1, 930			194. 02
194.02			0	4, 221	0	11 872	194.03
194. 02 194. 03	07953 WASHINGTON CLINIC	4,221	0				•
194.02 194.03 194.04	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES	4, 567	0	4, 567	7 0	20, 757	194.04
194.02 194.03 194.04 194.05	07953 WASHINGTON CLINIC		0 0 0 0		7 O O O	20, 757 5, 702	•
194.02 194.03 194.04 194.05 194.06 194.07	07953 WASHINGTON CLINIC 07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE	4, 567 3, 600	0 0 0 0 0	4, 567 3, 600 2, 689 20, 062	7 0 0 0 2 0	20, 757 5, 702 11, 861 82, 807	194. 04 194. 05

Health Fin	ancial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1		
					From 01/01/2017 To 12/31/2017			
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A		
			LINEN SERVICE		(MEALS	(HOURS OF		
		(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVI CE)		
		FEET)	LAUNDRY)					
		7.00	8.00	9.00	10.00	11.00		
194.09079	59 UROLOGY PROF	2,079	0	2, 07	9 0	7, 929	194.09	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6, 828, 018	452, 850	1, 834, 01	6 679, 496	900, 970	202. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 313274	0. 855883	6. 05551	6 21.874771	0. 668811	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 889, 955	26, 285	53, 55	3 158, 450	6, 235	204. 00	
205.00	Unit cost multiplier (Wkst. B, Part II)	6. 176182	0. 049678	0. 17682	0 5. 100924	0. 004628	205.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

^{5/18/2018 10:30} am

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI	CAL CENTER Provider CC	CN: 15-0065	In Lie Period:	u of Form CMS- Worksheet B-1	
				From 01/01/2017 To 12/31/2017		
				10 12/31/2017	5/18/2018 10:	30 am
Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE (TI ME SEDENT)	
	13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	SPENT) 18.00	
GENERAL SERVICE COST CENTERS						
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 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 0900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01850 PHYSI CI AN ANESTHETI STS 19.00 01900 NONPHYSI CI AN ANESTHETI STS	753, 392 36, 413 29, 565 0 0 0	11, 524, 346 16, 342 17, 150 1, 838 0	10	00 0 325, 828, 440 0 0 0 0	281, 696 0	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	178, 727	80, 014		0 8, 315, 532	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	34, 809	5, 826		0 1, 427, 645		
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	16, 024	0		0 1, 021, 329	0	43.00
50. 00 05000 OPERATING ROOM	97, 160	152, 601		0 85, 412, 825	0	50.00
51.00 05100 RECOVERY ROOM	0	1, 816		0 8, 724, 749		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	30, 245	0 2, 244		0 6, 942, 173 0 6, 015, 026	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	65, 891	22, 698		0 17, 994, 065	0	54.00
54. 01 03630 ULTRA SOUND	0	1, 551		0 4, 407, 956		
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 57. 00 05700 CT SCAN	0	151 2, 769		0 1, 824, 897 0 36, 195, 829	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2,709		0 9, 420, 257	0	1
60. 00 06000 LABORATORY	67, 142	33, 673		0 47, 583, 069		
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 714, 330		
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	4, 995 10, 910		0 1, 336, 679 0 6, 073, 069		64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	39, 532	11, 149		0 4, 615, 420	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	3, 685		0 2, 269, 164	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	4, 336	1, 581 2, 635		0 789, 687 0 7, 053, 667	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 163, 537		0 8, 310, 973		1
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	2, 370, 603		0 4, 996, 653		72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	10	20, 938, 798	о	73.00
76.00 03952 WOUND CARE (DI ABETES CENTER)	0	2, 362		0 1, 016, 160		1
76. 02 03951 CASE MANAGEMENT	0	1, 365		0 191, 768		
76. 03 03950 PALN MANAGEMENT 76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 160 1, 686		0 2, 927, 328 0 263, 277		
OUTPATIENT SERVICE COST CENTERS		.,	1	2007277		
90. 00 09000 CLINIC 90. 01 09001 PALLIATIVE HEALTH	0	0		0 0	0	
90. 02 09002 VEIN CENTER	0	195 3, 432		0 55,773 0 1,777,642		1
90. 03 09003 0BGYN	0	25, 379		0 1, 463, 723		1
91.00 09100 EMERGENCY	117, 451	29, 025		0 20, 665, 030	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04952 BEHAVIORAL HEALTH	0	2, 984		0 523, 745	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	36, 097	9, 508		0 2, 419, 071	0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	10, 528		0 2, 141, 131	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	753, 392	10, 996, 572	10	325, 828, 440	49, 981	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	170, 542		0 0	60, 304	192.00
194.0007950WELLNESS 194.0107951JACKSONMOB	0	0		0 0		194.00
194.01 07951 JACKSON MOB 194.02 07952 EXTERNAL_SVCS_MARKETING		0 8, 231		0 0		194. 01 194. 02
194. 03 07953 WASHINGTON CLINIC	0	0		0 0	11, 872	194. 03
194. 04 07954 PHYSI CLAN OFFICES	0	28, 470		0 0		194.04
194. 05 07955 I NTEGRATED MEDI CI NE		119, 334	1	0 0	5, 702	194.05

Health Finar	cial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	FION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	
						OTHER GENERAL	
						SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PHYSI CI AN	
		ADMI NI STRATI ON		(COSTED	RECORDS &	PRI VATE	
			SUPPLY	REQUIS.)	LI BRARY	PRACTI CE	
		(DI RECT	(COSTED		(GROSS	(TIME	
		NRSING HRS)	REQUIS.)		CHARGES)	SPENT)	
		13.00	14.00	15.00	16.00	18.00	
	SURGI CAL PROFESSI ONAL	0	4, 897		0 0	11, 861	
	PRIMARY CARE	0	123, 421		0 0	82, 807	
	EMPLOYER CLINIC	0	44, 651		0 0	24, 243	
194.0907959	UROLOGY PROF	0	28, 228		0 0	7, 929	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 568, 145	1, 926, 431	4, 423, 36	2 1, 897, 597	578, 867	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 063437	0. 167162	44, 233. 62000	0 0. 005824	2.054935	203.00
204.00	Cost to be allocated (per Wkst. B,	233, 328	197, 898	108, 00	3 51, 686	4, 042	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 309703	0. 017172	1, 080. 03000	0 0. 000159	0. 014349	205.00
206.00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems	SCHNECK MEDICAL			of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-0065	Period: From 01/01/2017	Worksheet B-1
				To 12/31/2017	Date/Time Prepared: 5/18/2018 10:30 am
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED			
		TI ME) 19.00			
	GENERAL SERVICE COST CENTERS				1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE				7.00
8.00 9.00	00900 HOUSEKEEPING				9.00
	01000 DI ETARY				10.00
	01100 CAFETERIA				11.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY				13.00 14.00
	01500 PHARMACY				15.00
	01600 MEDI CAL RECORDS & LI BRARY				16.00
	01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	100			18.00 19.00
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	100			19.00
	03000 ADULTS & PEDIATRICS	0			30.00
	03100 I NTENSI VE CARE UNI T	0			31.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0			43.00
50.00	05000 OPERATI NG ROOM	0			50.00
	05100 RECOVERY ROOM	0			51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 100			52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	0			54.00
	03630 ULTRA SOUND	0			54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0			54.02
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			57.00 58.00
	06000 LABORATORY	0			60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0			63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0			64.00 65.00
	06600 PHYSI CAL THERAPY	0			66.00
	06700 OCCUPATI ONAL THERAPY	0			67.00
		0			68.00 69.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00 76.00
	03952 WOUND CARE (DIABETES CENTER) 03951 CASE MANAGEMENT	0			76.00
76.03	03950 PALN MANAGEMENT	0			76.03
76.97	07697 CARDI AC REHABI LI TATI ON	0			76. 97
90, 00	OUTPATIENT SERVICE COST CENTERS	0			90.00
	09001 PALLI ATI VE HEALTH	0			90.01
	09002 VEIN CENTER	0			90.02
	09003 OBGYN 09100 EMERGENCY	0			90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	04952 BEHAVI ORAL HEALTH	0			93.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0			101.00
101.00	SPECIAL PURPOSE COST CENTERS	0			101.00
	11300 INTEREST EXPENSE				113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	100			116.00 118.00
10.00	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 WELLNESS	0			192.00 194.00
	07950 WELLNESS 07951 JACKSON MOB	0			194.00
194.02	07952 EXTERNAL SVCS MARKETING	0			194.02
	07953 WASHINGTON CLINIC	0			194.03
	07954 PHYSICIAN OFFICES 07955 INTEGRATED MEDICINE	0			194. 04 194. 05
194.06	07956 SURGI CAL PROFESSI ONAL	ŏ			194.06
	07957 PRI MARY CARE	o o			194.07
194.08	07958 EMPLOYER CLINIC	0			194.08

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0065 Period: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared: Cost Center Description NONPHYSICIAN ANESTHETISTS
To 12/31/2017 Date/Time Prepared: 5/18/2018 Cost Center Description NONPHYSICIAN ANESTHETISTS
ANESTHETI STS
(ASSI GNED
TIME)
19.00
194. 09 07959 UROLOGY PROF 0 194. 09
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 201.00
202.00 Cost to be allocated (per Wkst. B, 123, 431 202.00
Part I)
203.00 Unit cost multiplier (Wkst. B, Part I) 1,234.31000 203.00
204.00 Cost to be allocated (per Wkst. B, 951 204.00
Part II)
205.00 Unit cost multiplier (Wkst. B, Part 9.51000) 205.00 205.00
206.00 NAHE adjustment amount to be allocated 206.00
(per Wkst. B-2)
207.00 NAHE unit cost multiplier (Wkst. D, 207.00
Parts III and IV)

COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
					To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared:
			Title	XVIII	Hospi tal	PPS	<u>50 alli</u>
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	10.011.101					
	3000 ADULTS & PEDIATRICS	12, 911, 401		12, 911, 40		12, 911, 401	
	3100 I NTENSI VE CARE UNI T	2, 383, 080		2, 383, 08		2, 383, 080	
	4300 NURSERY	998, 011		998, 01	1 0	998, 011	43.00
	NCI LLARY SERVICE COST CENTERS	0.000.000		0.000.00		0.000.000	1 50 00
	5000 OPERATING ROOM	8, 888, 299		8, 888, 29		8, 888, 299	
	5100 RECOVERY ROOM	997, 791		997, 79		997, 791	
	5200 DELIVERY ROOM & LABOR ROOM	2, 082, 685		2, 082, 68		2, 082, 685	
	5300 ANESTHESI OLOGY	628, 803		628, 80		628, 803	
	5400 RADI OLOGY-DI AGNOSTI C	6, 575, 844		6, 575, 84		6, 685, 691	
	3630 ULTRA SOUND	545, 681		545, 68		545, 681	
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	212, 140		212, 14		212, 140	
	5700 CT SCAN	1, 081, 027		1, 081, 02		1, 081, 027	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	555, 914		555, 91		555, 914	
	6000 LABORATORY	5, 294, 221		5, 294, 22		5, 316, 482	
	6300 BLOOD STORING, PROCESSING, & TRANS.	358, 472		358, 47		358, 472	
	6400 I NTRAVENOUS THERAPY	604, 278		604, 27		604, 278	
	6500 RESPI RATORY THERAPY	2, 076, 705				2, 076, 705	
	6600 PHYSI CAL THERAPY	2, 530, 364				2, 530, 364	
	6700 OCCUPATI ONAL THERAPY	608, 118	0	608, 11	8 0	608, 118	
68.00 06	6800 SPEECH PATHOLOGY	378, 544	0	378, 54	4 0	378, 544	68.00
	6900 ELECTROCARDI OLOGY	490, 260		490, 26	0 1, 679	491, 939	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 032, 796		11, 032, 79	6 0	11, 032, 796	71.0
	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	3, 218, 397		3, 218, 39		3, 218, 397	
	7300 DRUGS CHARGED TO PATIENTS	12, 420, 515		12, 420, 51		12, 420, 515	
	3952 WOUND CARE (DIABETES CENTER)	446, 559		446, 55		446, 559	
	3951 CASE MANAGEMENT	310, 686		310, 68		310, 686	
	3950 PALN MANAGEMENT	1, 431, 023		1, 431, 02		1, 431, 023	
	7697 CARDIAC REHABILITATION	746, 061		746, 06	1 0	746, 061	76. 9
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0			0 0	0	
	9001 PALLI ATI VE HEALTH	186, 015		186, 01		186, 015	
	9002 VEIN CENTER	346, 970		346, 97	0 0	346, 970	90.02
	9003 0BGYN	1, 572, 557		1, 572, 55		1, 572, 557	
	9100 EMERGENCY	6, 539, 989		6, 539, 98		6, 539, 989	
2.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 686, 492		2, 686, 49	2	2, 686, 492	92.00
	4952 BEHAVI ORAL HEALTH	544, 667		544, 66	7 0	544, 667	93.00
	THER REIMBURSABLE COST CENTERS						
	0100 HOME HEALTH AGENCY	2, 495, 892		2, 495, 89	2	2, 495, 892	101.00
SF	PECIAL PURPOSE COST CENTERS	1			1		
	1300 INTEREST EXPENSE						113.00
	1600 HOSPI CE	1, 286, 540		1, 286, 54		1, 286, 540	
200.00	Subtotal (see instructions)	95, 466, 797	0			95, 600, 584	
201.00	Less Observation Beds	2, 686, 492		2, 686, 49	2	2, 686, 492	201.00
202.00	Total (see instructions)	92, 780, 305	0	92, 780, 30	5 133, 787	92, 914, 092	1202 0

COMPUTATI O	ancial Systems N OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od:	Worksheet C	2552-1
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared
				XVIII	Hospi tal	5/18/2018 10: PPS	30 am
			Charges	AVIII		PP3	
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
				+ COL. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	00 ADULTS & PEDI ATRI CS	6, 352, 346		6, 352, 34	-6		30. C
31.00 0310	DO INTENSIVE CARE UNIT	1, 427, 645		1, 427, 64	5		31.0
	00 NURSERY	1,021,329		1, 021, 32	.9		43. C
	I LLARY SERVICE COST CENTERS				_		
	OO OPERATING ROOM	15, 321, 200	70, 091, 625	85, 412, 82		0.000000	
	DO RECOVERY ROOM	996, 091	7, 728, 658	8, 724, 74	9 0. 114363	0.000000	51.0
	00 DELIVERY ROOM & LABOR ROOM	6, 604, 991	337, 182	6, 942, 17		0.00000	
	00 ANESTHESI OLOGY	1, 090, 303	4, 924, 723	6, 015, 02		0.000000	
	00 RADI OLOGY-DI AGNOSTI C	823, 116	17, 170, 949	17, 994, 06	0. 365445	0.00000	54. C
54.01 0363	30 ULTRA SOUND	356, 780	4, 051, 176	4, 407, 95	6 0. 123795	0.00000	54. C
54.02 0345	50 NUCLEAR MEDICINE - DIAGNOSTIC	33, 347	1, 791, 550	1, 824, 89	0. 116248	0.000000	54. C
57.00 0570	DO CT SCAN	2, 704, 966	33, 490, 863	36, 195, 82	0. 029866	0.00000	57.0
8. 00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	557, 011	8, 863, 246	9, 420, 25	0. 059013	0.000000	58.0
0. 00 0600	00 LABORATORY	7, 317, 806	40, 265, 263	47, 583, 06	0. 111263	0.000000	60.0
3.00 0630	00 BLOOD STORING, PROCESSING, & TRANS.	328, 766	385, 564	714, 33	0. 501830	0.000000	63. (
	DO INTRAVENOUS THERAPY	229, 755	1, 106, 924	1, 336, 67		0.000000	64. (
	00 RESPI RATORY THERAPY	3, 469, 723	2, 603, 346	6, 073, 06		0.000000	
	00 PHYSI CAL THERAPY	552, 286	4,063,134	4, 615, 42	0. 548241	0.000000	66.0
	DO OCCUPATI ONAL THERAPY	447, 519	1, 821, 645	2, 269, 16		0.000000	
	DO SPEECH PATHOLOGY	184, 072	605, 615	789, 68		0.000000	
	00 ELECTROCARDI OLOGY	831, 768	6, 221, 899	7,053,66		0.000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 172, 182	6, 138, 791	8, 310, 97		0.000000	
	00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1, 583, 324	3, 413, 329	4, 996, 65		0. 000000	
73.00 0730	DO DRUGS CHARGED TO PATIENTS	3, 883, 239	17, 055, 559	20, 938, 79	0. 593182	0.000000	73.0
	52 WOUND CARE (DI ABETES CENTER)	36, 032	980, 128	1, 016, 16		0. 000000	
	51 CASE MANAGEMENT	33, 462	158, 306	191, 76		0.000000	
	50 PALN MANAGEMENT	750	2, 926, 578	2, 927, 32		0. 000000	
	97 CARDI AC REHABI LI TATI ON	1,806	261, 471	263, 27		0.000000	
	PATIENT SERVICE COST CENTERS	1,000	201, 171	200,21	2.000717	0.00000	, 0.
		0	0		0 0.000000	0. 000000	90.0
	01 PALLI ATI VE HEALTH	2,660	53, 113	55, 77		0. 000000	
0.02 0900	D2 VEIN CENTER	2,000	1, 777, 642	1, 777, 64		0.000000	
	03 OBGYN	0	1, 463, 723	1, 463, 72		0. 000000	
	DO EMERGENCY	1, 343, 353	19, 321, 677	20, 665, 03		0.000000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	231, 418	1, 731, 768	1, 963, 18		0. 000000	
	52 BEHAVI ORAL HEALTH	4,070	519, 675	523, 74		0.000000	
	ER REIMBURSABLE COST CENTERS	4,070	517,075	525,74	1.037747	0.000000	73.0
	00 HOME HEALTH AGENCY	0	2, 419, 071	2, 419, 07	'1		101.0
	CIAL PURPOSE COST CENTERS						1
	DO INTEREST EXPENSE						113. (
	DO HOSPI CE	0	2, 141, 131	2, 141, 13	1		116. (
200.00	Subtotal (see instructions)	59, 943, 116	265, 885, 324	325, 828, 44			200. 0
	Less Observation Beds	2., , , , , , , , , , , , , , , , , , ,	, 500, 021				201.0
201.00							

alth Financial Systems MPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prep	pared
		T: +1 - \//////		5/18/2018 10:	<u>30 am</u>
Cost Center Description	PPS Inpatient Ratio	Title XVIII	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
D. 00 03000 ADULTS & PEDIATRICS					30.0
1. 00 03100 I NTENSI VE CARE UNI T					31.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVICE COST CENTERS					
D. 00 05000 0PERATING ROOM	0. 104063				1 50.0
1.00 05100 RECOVERY ROOM	0. 114363				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 300005				52.0
3. 00 05300 ANESTHESI OLOGY	0. 104539				53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 371550				54.
4. 01 03630 ULTRA SOUND	0. 123795				54.
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 116248				54.
7. 00 05700 CT SCAN	0. 029866				57.
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.059013				58.
D. 00 06000 LABORATORY	0. 111731				60.
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 501830				63.
. 00 06400 I NTRAVENOUS THERAPY	0. 452074				64.
5. 00 06500 RESPI RATORY THERAPY	0. 341953				65.
5. 00 06600 PHYSI CAL THERAPY	0. 548241				66.
7. 00 06700 OCCUPATI ONAL THERAPY	0. 267992				67.
3. 00 06800 SPEECH PATHOLOGY	0. 479360				68.
9. 00 06900 ELECTROCARDI OLOGY	0.069742				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 327498				71.
2. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 644111				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 593182				73.
5.00 03952 WOUND CARE (DIABETES CENTER)	0. 439457				76.
5. 02 03951 CASE MANAGEMENT	1. 620114				76.
5. 03 03950 PALN MANAGEMENT	0. 488850				76.
5. 97 07697 CARDI AC REHABI LI TATI ON	2.833749				76.
OUTPATIENT SERVICE COST CENTERS	1				
D. 00 09000 CLINIC	0. 000000				90.
D. 01 09001 PALLI ATI VE HEALTH	3. 335216				90.
D. 02 09002 VEIN CENTER	0. 195186				90.
D. 03 09003 OBGYN	1. 074354				90.
1. 00 09100 EMERGENCY	0. 316476				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 368435				92.
3. 00 04952 BEHAVI ORAL HEALTH	1. 039947				93.
OTHER REIMBURSABLE COST CENTERS					4
D1. 00 10100 HOME HEALTH AGENCY					101.
SPECIAL PURPOSE COST CENTERS					4
13. 00 11300 INTEREST EXPENSE					113.
16. 00 11600 HOSPI CE					116.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared:
				e XIX	Hospi tal	5/18/2018 10: Cost	30 am
			1111		Costs	COST	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		<u>26)</u> 1.00	2.00	2.00	4.00	F 00	
LN	IPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	3000 ADULTS & PEDIATRICS	12, 911, 401		12, 911, 40	1 0	12, 911, 401	30.00
	3100 I NTENSI VE CARE UNI T	2, 383, 080		2, 383, 08			
	1300 NURSERY	998, 011		998, 01			
	ICI LLARY SERVI CE COST CENTERS	770,011		770, 01	<u> </u>	770, 011	45.00
	5000 OPERATING ROOM	8, 888, 299		8, 888, 29	9 0	8, 888, 299	50.00
	5100 RECOVERY ROOM	997, 791		997, 79		-,,	
	5200 DELIVERY ROOM & LABOR ROOM	2, 082, 685		2, 082, 68			
	5300 ANESTHESI OLOGY	628, 803		628, 80		628, 803	
	5400 RADI OLOGY-DI AGNOSTI C	6, 575, 844		6, 575, 84		6, 685, 691	
	3630 ULTRA SOUND	545, 681		545, 68		545, 681	
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	212, 140		212, 14			
	5700 CT SCAN	1, 081, 027		1, 081, 02			
	5800 MAGNETIC RESONANCE IMAGING (MRI)	555, 914		555, 91		555, 914	
	5000 LABORATORY	5, 294, 221		5, 294, 22		5, 316, 482	
	5300 BLOOD STORING, PROCESSING, & TRANS.	358, 472		358, 47		358, 472	
	5400 INTRAVENOUS THERAPY	604, 278		604, 27			
	5500 RESPIRATORY THERAPY						
	5600 PHYSI CAL THERAPY	2,076,705	0			2,076,705	
	5700 OCCUPATIONAL THERAPY	2, 530, 364				2, 530, 364	
		608, 118	0			608, 118	
	5800 SPEECH PATHOLOGY	378, 544	0	378, 54		378, 544	
	5900 ELECTROCARDI OLOGY	490, 260		490, 26			
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	11, 032, 796		11, 032, 79			
	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	3, 218, 397		3, 218, 39	7 0	-, -, -, -	
73.00 07	7300 DRUGS CHARGED TO PATIENTS	12, 420, 515		12, 420, 51	5 0	12, 420, 515	73.0
6.00 03	3952 WOUND CARE (DIABETES CENTER)	446, 559		446, 55	9 0	446, 559	76.0
	3951 CASE MANAGEMENT	310, 686		310, 68	6 0	310, 686	76.0
6. 03 03	3950 PALN MANAGEMENT	1, 431, 023		1, 431, 02	3 0	1, 431, 023	76.0
6. 97 07	7697 CARDIAC REHABILITATION	746, 061		746, 06	1 0	746, 061	76.9
OU	JTPATIENT SERVICE COST CENTERS			_			
	2000 CLINIC	0			0 0	0	90.00
	2001 PALLIATIVE HEALTH	186, 015		186, 01	5 0	186, 015	90.0
	2002 VEIN CENTER	346, 970		346, 97	0 0	346, 970	90.0
	POO3 OBGYN	1, 572, 557		1, 572, 55	7 0	1, 572, 557	90.03
91.00 09	P100 EMERGENCY	6, 539, 989		6, 539, 98	9 0	6, 539, 989	91.00
2.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 686, 492		2, 686, 49	2	2, 686, 492	92.00
3. 00 04	1952 BEHAVI ORAL HEALTH	544, 667		544, 66	7 0	544, 667	93.00
ОТ	HER REIMBURSABLE COST CENTERS						
	D100 HOME HEALTH AGENCY	2, 495, 892		2, 495, 89	2	2, 495, 892	101.00
SP	PECIAL PURPOSE COST CENTERS	1		I			
	1300 INTEREST EXPENSE						113.00
	1600 HOSPI CE	1, 286, 540		1, 286, 54		1, 286, 540	
200.00	Subtotal (see instructions)	95, 466, 797	0				
201.00	Less Observation Beds	2, 686, 492		2, 686, 49	2	2, 686, 492	201.00
201.00		_,				-,,	

COMPUTATIO	ancial Systems N OF RATIO OF COSTS TO CHARGES	SCHNECK MEDI				u of Form CMS-	2552-10
COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider CO	IN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	pared:
				e XIX	Hospi tal	5/18/2018 10: Cost	30 am
			Charges			0031	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9,00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	00 ADULTS & PEDIATRICS	6, 352, 346		6, 352, 34	6		30.00
	DO INTENSIVE CARE UNIT	1, 427, 645		1, 427, 64			31.00
	00 NURSERY	1,021,329		1, 021, 32			43.00
	LLARY SERVICE COST CENTERS				-		1
50.00 0500	00 OPERATING ROOM	15, 321, 200	70, 091, 625	85, 412, 82	0. 104063	0.00000	50.00
51.00 0510	DO RECOVERY ROOM	996, 091	7, 728, 658	8, 724, 74	9 0. 114363	0.000000	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	6, 604, 991	337, 182	6, 942, 17	3 0. 300005	0.000000	52.00
	00 ANESTHESI OLOGY	1,090,303	4, 924, 723	6, 015, 02		0.000000	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	823, 116	17, 170, 949	17, 994, 06	0. 365445	0.000000	54.00
	BO ULTRA SOUND	356, 780	4, 051, 176	4, 407, 95		0.000000	
	50 NUCLEAR MEDICINE - DIAGNOSTIC	33, 347	1, 791, 550	1, 824, 89		0.000000	
	DO CT SCAN	2, 704, 966	33, 490, 863	36, 195, 82		0.000000	
	DO MAGNETIC RESONANCE IMAGING (MRI)	557,011	8, 863, 246	9, 420, 25		0. 000000	
	DO LABORATORY	7, 317, 806	40, 265, 263	47, 583, 06		0. 000000	
	00 BLOOD STORING, PROCESSING, & TRANS.	328, 766	385, 564	714, 33		0. 000000	
	DO INTRAVENOUS THERAPY	229, 755	1, 106, 924	1, 336, 67		0. 000000	
	O RESPIRATORY THERAPY	3, 469, 723	2, 603, 346	6, 073, 06		0. 000000	
	O PHYSI CAL THERAPY	552, 286	4, 063, 134	4, 615, 42		0.000000	
	00 OCCUPATI ONAL THERAPY	447, 519	1, 821, 645	2, 269, 16		0. 000000	
	O SPEECH PATHOLOGY	184,072	605, 615	789, 68		0.000000	
	DO ELECTROCARDI OLOGY	831, 768	6, 221, 899	7, 053, 66		0. 000000	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 172, 182	6, 138, 791	8, 310, 97		0.000000	
	00 IMPLANTABLE DEVICES CHARGED TO PATTENTS					0.000000	
	PATIENTS	1, 583, 324	3, 413, 329	4, 996, 65			
	00 DRUGS CHARGED TO PATIENTS	3, 883, 239	17,055,559	20, 938, 79		0.000000	
	22 WOUND CARE (DIABETES CENTER)	36, 032	980, 128	1, 016, 16		0.000000	
	1 CASE MANAGEMENT	33, 462	158, 306	191, 76		0.000000	
		750	2, 926, 578	2, 927, 32		0.000000	
	27 CARDIAC REHABILITATION	1, 806	261, 471	263, 27	2. 833749	0. 000000	76.97
	DO CLINIC	0	0		0 0.000000	0. 000000	90.00
		-	-	EF 7-			
	01 PALLI ATI VE HEALTH	2,660	53, 113	55, 77		0.000000	
	2 VEIN CENTER	0	1,777,642	1, 777, 64		0.000000	
	03 OBGYN	0	1, 463, 723	1, 463, 72		0.000000	
	00 EMERGENCY	1, 343, 353	19, 321, 677	20, 665, 03		0.000000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	231, 418	1, 731, 768	1, 963, 18		0.000000	
	52 BEHAVI ORAL HEALTH	4,070	519, 675	523, 74	5 1.039947	0. 000000	93.00
	R REIMBURSABLE COST CENTERS		0 440 074	0 440 0			101 00
	00 HOME HEALTH AGENCY	0	2, 419, 071	2, 419, 07	1		101.00
	AL PURPOSE COST CENTERS						110 0-
	00 INTEREST EXPENSE						113.00
116.001160		0	2, 141, 131	2, 141, 13			116.00
200.00	Subtotal (see instructions)	59, 943, 116	265, 885, 324	325, 828, 44	0		200.00
201.00 202.00	Less Observation Beds						201.00
	Total (see instructions)	59, 943, 116	265, 885, 324	325, 828, 44			202.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepa 5/18/2018 10:30
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00		· · · · · · · · · · · · · · · · · · ·	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDIATRICS				
. 00 03100 I NTENSI VE CARE UNI T				
3. 00 04300 NURSERY				
ANCI LLARY SERVICE COST CENTERS				
0. 00 05000 OPERATI NG ROOM	0. 000000			Į
. 00 05100 RECOVERY ROOM	0. 000000			
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			
3. 00 05300 ANESTHESI OLOGY	0. 000000			
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			
I. 01 03400 RADIOLOGI-DIAGNOSTIC	0.000000			
I. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			Į
7.00 05700 CT SCAN	0.00000			Į
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			Į
0.00 06000 LABORATORY	0. 000000			
8. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0. 000000			
I. 00 06400 I NTRAVENOUS THERAPY	0. 000000			
5. 00 06500 RESPIRATORY THERAPY	0. 000000			0
5. 00 06600 PHYSI CAL THERAPY	0. 000000			
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000			
3. 00 06800 SPEECH PATHOLOGY	0. 000000			
P. 00 06900 ELECTROCARDI OLOGY	0. 000000			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			
2. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 000000			
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			
5.00 03952 WOUND CARE (DIABETES CENTER)	0. 000000			
5. 02 03951 CASE MANAGEMENT	0. 000000			
5. 03 03950 PALN MANAGEMENT	0. 000000			
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			-
OUTPATIENT SERVICE COST CENTERS				
). 00 09000 CLINIC	0. 000000			
0. 01 09001 PALLI ATI VE HEALTH	0. 000000			
D. 02 09002 VEIN CENTER	0. 000000			
). 03 09003 OBGYN	0. 000000			
. 00 09100 EMERGENCY	0. 000000			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			
3. 00 04952 BEHAVI ORAL HEALTH	0. 000000			0
OTHER REIMBURSABLE COST CENTERS				
01.00 10100 HOME HEALTH AGENCY				1(
SPECIAL PURPOSE COST CENTERS				
3.00 11300 INTEREST EXPENSE				1'
6. 00 11600 HOSPI CE				1 ⁻
00.00 Subtotal (see instructions)				20
01.00 Less Observation Beds				20
02.00 Total (see instructions)				20

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E CAPITAL COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared:
		Title	e XVIII	Hospi tal	PPS	SU alli
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	Aujustillerit	Related Cost		37 601. 4)	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENT						
30. 00 ADULTS & PEDIATRICS	1, 614, 017	6, 548	1, 607, 46	9 10, 516	152.86	30.00
31.00 INTENSIVE CARE UNIT	227, 817		227, 81			•
43.00 NURSERY	26, 335		26, 33			•
200.00 Total (lines 30 through 199)	1, 868, 169		1, 861, 62	1 13, 236		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 CENT						
30. 00 ADULTS & PEDIATRICS	3, 074	469, 892				30.00
31.00 INTENSIVE CARE UNIT	439	91, 922				31.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	3, 513	561, 814				200.00

Health Financial Systems	SCHNECK MEDI				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SER	VICE CAPITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod
				10 12/31/2017	5/18/2018 10:	30 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
· · · ·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS					•	
50. 00 05000 OPERATI NG ROOM	1, 186, 407		0. 01389	6, 613, 487	91, 861	50.00
51.00 05100 RECOVERY ROOM	99, 700	8, 724, 749	0. 01142	357, 334	4, 083	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	129, 573	6, 942, 173	0. 01866	99, 521	1, 858	52.00
53.00 05300 ANESTHESI OLOGY	47,080	6, 015, 026	0. 00782	443, 323	3, 470	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	931, 292	17, 994, 065	0. 05175	6 461, 515	23, 886	54.00
54. 01 03630 ULTRA SOUND	39, 927	4, 407, 956	0.00905	162, 684	1, 474	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTI	C 9,857			27, 154	147	54.02
57. 00 05700 CT SCAN	65, 648		1			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (
60. 00 06000 LABORATORY	353, 347					
63.00 06300 BLOOD STORING, PROCESSING, 8						
64. 00 06400 I NTRAVENOUS THERAPY	112, 122				10, 361	
65. 00 06500 RESPIRATORY THERAPY	131, 301					
66. 00 06600 PHYSI CAL THERAPY	266, 132		1			
67. 00 06700 OCCUPATI ONAL THERAPY	13, 542					
68. 00 06800 SPEECH PATHOLOGY	10, 495					
69. 00 06900 ELECTROCARDI OLOGY	49, 449					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO	-					
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO						
PATIENTS	10 00, 201	4, 990, 003	0.01200	0/0,955	0, 104	/2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	164, 224	20, 938, 798	0. 00784	3 1, 744, 505	13, 682	73.00
76. 00 03952 WOUND CARE (DIABETES CENTER)						
76. 02 03951 CASE MANAGEMENT	40, 683					
76. 03 03950 PALN MANAGEMENT	109, 428				0	
76. 97 07697 CARDI AC REHABI LI TATI ON	50, 102					
OUTPATIENT SERVICE COST CENTERS	50, 102	203, 277	0. 19030	1, 170	223	/0.9/
90. 00 09000 CLINIC	C		0.00000	0 0	0	90.00
		-				
	7,004					
90. 02 09002 VEI N CENTER	11, 485					
90. 03 09003 OBGYN	217,603				0	
91.00 09100 EMERGENCY	366, 591					
92.00 09200 OBSERVATION BEDS (NON-DISTIN						
93.00 04952 BEHAVI ORAL HEALTH	32, 803				, o	
200.00 Total (lines 50 through 199)	5, 137, 741	312, 466, 918		20, 747, 894	293, 741	1200.00

Health Financial Systems	SCHNECK MEDICA	AL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS	Provider C		Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Nu	ursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
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	0	31.00
43. 00 04300 NURSERY	0	0	(0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
		sum of cols.	Days	5 ÷ col. 6)	Program Days	
		1 through 3,				
		inus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	10, 51	6 0.00	3, 074	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 08	0.00		
43. 00 04300 NURSERY		0	1, 63		0	43.00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent			- 1		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDI ATRI CS	0					1 30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
						1200.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am
			XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			50.00
50. 00 05000 OPERATING ROOM	0			0 0	0	
51.00 05100 RECOVERY ROOM	0			0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	02.00
53. 00 05300 ANESTHESI OLOGY	0	C)	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	000
54. 01 03630 ULTRA SOUND	0	C)	0 0	0	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	C)	0 0	0	
57.00 05700 CT SCAN	0	C)	0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C)	0 0	0	
60.00 06000 LABORATORY	0	C)	0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	C)	0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	C)	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	00.00
66.00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	C		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	C		0 0	0	76.00
76.02 03951 CASE MANAGEMENT	0	C		0 C	0	76.02
76. 03 03950 PALN MANAGEMENT	0	C		0 C	0	
76. 97 07697 CARDIAC REHABILITATION	0	C)	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		0 0	0	
90. 01 09001 PALLI ATI VE HEALTH	0	C		0 0	0	
90. 02 09002 VEIN CENTER	0	C		0 0	0	
90. 03 09003 0BGYN	0	C		0 0	0	
91. 00 09100 EMERGENCY	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			C	0	
93. 00 04952 BEHAVI ORAL HEALTH	0	C		0 0	0	,
200.00 Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR	Y SERVICE OTHER PASS	S Provider C	CN: 15-0065	Period: From 01/01/2017	Worksheet D	
THROUGH COSTS				To 12/31/2017	Date/Time Pre	epared:
					5/18/2018 10:	30 am
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical	(sum of col 1				
	Education Cost		Cost (sum o		(col. 5 ÷ col.	
		4)	col. 2, 3 an 4)	id 8)	7)	
	4,00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	4.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 85, 412, 825	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0)	0 8, 724, 749		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 6, 942, 173		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 6, 015, 026		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 17, 994, 065	0.000000	54.00
54.01 03630 ULTRA SOUND	0	0		0 4, 407, 956	0.000000	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 1, 824, 897	0.000000	54.02
57.00 05700 CT SCAN	0	0		0 36, 195, 829		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 9, 420, 257		58.00
60. 00 06000 LABORATORY	0	0		0 47, 583, 069		
63.00 06300 BLOOD STORING, PROCESSING, & TRANS	. O	0		0 714, 330		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1, 336, 679		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 073, 069		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 615, 420		
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 2, 269, 164		
68.00 06800 SPEECH PATHOLOGY	0	0		0 789, 687		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 7, 053, 667		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		-		0 8, 310, 973		
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 4, 996, 653	0.000000	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 20, 938, 798	0. 000000	73.00
76. 00 03952 WOUND CARE (DIABETES CENTER)	0			0 1, 016, 160		1
76. 02 03951 CASE MANAGEMENT	0	0		0 191, 768		1
76. 03 03950 PALN MANAGEMENT	0	-		0 2, 927, 328		
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 263, 277		
OUTPATIENT SERVICE COST CENTERS	0		1	0 203,277	0.00000	/0. //
90. 00 09000 CLINIC	0	0		0 0	0.00000	90.00
90. 01 09001 PALLI ATI VE HEALTH	0			0 55, 773		1
90. 02 09002 VEIN CENTER	0	-		0 1, 777, 642		
90. 03 09003 0BGYN	0	0		0 1, 463, 723		
91.00 09100 EMERGENCY	0	0		0 20, 665, 030		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T) 0	0		0 1, 963, 186		
93. 00 04952 BEHAVI ORAL HEALTH	0	0)	0 523, 745	0.00000	93.00
200.00 Total (lines 50 through 199)	0	l o	1	0 312, 466, 918	1	200.00

	Financial Systems	SCHNECK MEDIC			In Li	eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0065	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/201 To 12/31/201		narod
					10 12/31/201	5/18/2018 10:	30 am
-			Title	× XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
		(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	6, 613, 487		0 13, 551, 54		50.00
51.00	05100 RECOVERY ROOM	0.000000	357, 334		0 1, 611, 53	7 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	99, 521		0 1, 05	1 0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	443, 323		0 866, 20	1 0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	461, 515		0 4, 242, 48	2 0	54.00
54.01	03630 ULTRA SOUND	0. 000000	162, 684		0 898, 88	6 0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	27, 154		0 664, 98	в о	54.02
57.00	05700 CT SCAN	0. 000000	1, 734, 130		0 7, 480, 14	5 0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	349, 702		0 2, 290, 09	9 0	58.00
60.00	06000 LABORATORY	0.000000	3, 241, 220		0 4, 529, 68	4 0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	181, 386		0 100, 40		63.00
64.00	06400 INTRAVENOUS THERAPY	0,000000	123, 521		0 294, 28		
65.00	06500 RESPI RATORY THERAPY	0.000000	1, 643, 834		0 410, 68		65.00
66.00	06600 PHYSI CAL THERAPY	0.000000	297, 096		0 20, 54		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0.000000	244, 978		0 108, 44		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	32, 489		0 1,47		
69.00	06900 ELECTROCARDI OLOGY	0, 000000	500, 554		0 1, 553, 45		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1, 102, 324		0 1, 164, 63		
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0.000000	676, 955		0 585, 44		
72.00	PATIENTS	0.000000	070, 700		0 000, 11	о 	12.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 744, 505		0 4, 427, 31	4 0	73.00
	03952 WOUND CARE (DI ABETES CENTER)	0.000000	8, 603		0 330, 28		
	03951 CASE MANAGEMENT	0.000000	0,000		0 23		
76.03	03950 PALN MANAGEMENT	0.000000	0		0 696, 48		
	07697 CARDI AC REHABI LI TATI ON	0.000000	1, 170		0 105, 69		
	OUTPATIENT SERVICE COST CENTERS	0.000000	1, 170		103, 07	0 0	/0. //
90.00	09000 CLINIC	0.000000	0		0	0 0	90.00
	09001 PALLI ATI VE HEALTH	0. 000000	438		0 15, 73		
90.01 90.02	09002 VEIN CENTER	0.000000	430		0 12, 81		90.01
90.02 90.03	09003 0BGYN	0.000000	0		0 113, 95		
90.03 91.00	09100 EMERGENCY	0.000000	668, 717		0 2, 923, 55		
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	31, 254		0 2, 923, 55		
92.00 93.00	04952 BEHAVIORAL HEALTH	0.000000	31, 234		0 448, 49		
93.00 200.00		0.000000	20, 747, 894		0 49, 549, 24		200.00
∠00.00	I'U'di (I'I'I'ES SU L'II'UUGII 199)	I I	20, 747, 894	1	0 49, 549, 24	oj U	l∠00. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0065	Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	nared.
				10 12/01/2011	5/18/2018 10:	
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
	Part I, COL. 9		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 104063	13, 551, 544		0 0	1, 410, 214	50.00
51.00 05100 RECOVERY ROOM	0. 114363	1, 611, 537		0 0	184, 300	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 300005	1, 051		0 0	315	52.00
53. 00 05300 ANESTHESI OLOGY	0. 104539			0 0	90, 552	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 365445	4, 242, 482		0 0	1, 550, 394	54.00
54.01 03630 ULTRA SOUND	0. 123795			0 0	111, 278	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 116248			0 0	77, 304	
57.00 05700 CT SCAN	0. 029866			0 0	223, 402	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 059013			0 0	135, 146	
60. 00 06000 LABORATORY	0. 111263			0 0	503, 986	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 501830			0 0	50, 388	
64. 00 06400 I NTRAVENOUS THERAPY	0. 452074			0 0	133, 037	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 341953 0. 548241			0 0 0 0	140, 435 11, 263	
67. 00 06700 OCCUPATIONAL THERAPY	0. 267992			0 0	29, 061	
68. 00 06800 SPEECH PATHOLOGY	0. 207992			0 0	707	
69. 00 06900 ELECTROCARDI OLOGY	0. 069504			0 0	107, 972	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 327498			0 0	1, 546, 045	1
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0. 644111			0 0	377, 088	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 593182	4, 427, 314	11, 85	0	2, 626, 203	73.00
76. 00 03952 WOUND CARE (DI ABETES CENTER)	0. 439457			0 0	145, 146	
76. 02 03951 CASE MANAGEMENT	1. 620114			0 0	379	
76. 03 03950 PALN MANAGEMENT	0. 488850	696, 484		0 0	340, 476	
76. 97 07697 CARDI AC REHABILI TATI ON	2.833749	105, 690		0 0	299, 499	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 PALLI ATI VE HEALTH	3. 335216			0 0	52, 463	
90. 02 09002 VEIN CENTER	0. 195186			0 0	2, 501	1
90. 03 09003 0BGYN	1.074354			0 0	122, 428	
91.00 09100 EMERGENCY	0. 316476			0 0	925, 236	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	1. 368435			0 0	610, 997	
93.00 04952 BEHAVI ORAL HEALTH	1. 039947			0 0	104, 740	
200.00 Subtotal (see instructions)		49, 549, 248	11, 85	52 0 0 0	11, 912, 955	
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		49, 549, 248	11, 85	52 0	11, 912, 955	

	nancial Systems	SCHNECK MEDI				u of Form CMS-	2552-10
APPORTI ON	NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/18/2018 10:	epared: 30 am
			Title	XVIII	Hospi tal	PPS	00 4
		Cos					
	Cost Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	CILLARY SERVICE COST CENTERS		0				50.00
	0000 OPERATING ROOM	0					50.00
	100 RECOVERY ROOM	0	0				51.00
	200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESIOLOGY	0					52.00
	400 RADI OLOGY-DI AGNOSTI C	0					54.00
	630 ULTRA SOUND	0					54.00
	450 NUCLEAR MEDICINE - DIAGNOSTIC	0					54.01
	1700 CT SCAN	0	0				57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	000 LABORATORY	0	0				60.00
	300 BLOOD STORING, PROCESSING, & TRANS.	0					63.00
	400 I NTRAVENOUS THERAPY	0	0				64.00
	500 RESPI RATORY THERAPY	0	0				65.00
	600 PHYSI CAL THERAPY	0	0				66.00
	700 OCCUPATIONAL THERAPY	0	0				67.00
	800 SPEECH PATHOLOGY	0	0				68.00
	900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07	100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07	2000 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	0				72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	7,030	0				73.00
76.00 03	952 WOUND CARE (DIABETES CENTER)	0	0				76.00
76.02 03	951 CASE MANAGEMENT	0	0				76.02
76.03 03	950 PALN MANAGEMENT	0	0				76.03
76.97 07	697 CARDI AC REHABI LI TATI ON	0	0				76.97
	TPATIENT SERVICE COST CENTERS	F					
	2000 CLINIC	0					90.00
	2001 PALLI ATI VE HEALTH	0					90.01
	002 VEIN CENTER	0	0	•			90.02
	0003 OBGYN	0	0				90.03
	100 EMERGENCY	0	0				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	952 BEHAVI ORAL HEALTH	0	0				93.00
200.00	Subtotal (see instructions)	7,030	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
202.00	Only Charges Net Charges (line 200 - line 201)	7,030	0				202.00
202.00	liver charges (The 200 - The 201)	7,030	0	I			1202. UU

APPORTIO	NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/18/2018 10:	
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00		(see inst.)	(see inst.)		
0.01		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS	0.404040			0 00(011		1 50 00
	0000 OPERATI NG ROOM	0. 104063			0 906, 211	0	
	100 RECOVERY ROOM	0. 114363			0 99,670	0	
	200 DELIVERY ROOM & LABOR ROOM	0. 300005			0 15, 526	0	
	300 ANESTHESI OLOGY	0. 104539			0 107, 420	0	
	400 RADI OLOGY-DI AGNOSTI C	0. 365445			0 225, 823	0	
	630 ULTRA SOUND	0. 123795			0 60, 633	0	
	450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 116248			0 13, 667	0	
	700 CT SCAN	0. 029866			0 543, 081	0	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059013			0 98, 252	0	
	0000 LABORATORY	0. 111263			0 586, 592	0	
	300 BLOOD STORING, PROCESSING, & TRANS.	0. 501830			0 7,066	0	
	400 I NTRAVENOUS THERAPY	0. 452074			0 16, 288	0	
	500 RESPI RATORY THERAPY	0. 341953			0 51, 820	0	
	600 PHYSI CAL THERAPY	0. 548241	0		0 45, 849	0	
	0700 OCCUPATIONAL THERAPY	0. 267992			0 19, 442	0	
	800 SPEECH PATHOLOGY	0. 479360			0 22, 351	0	
	900 ELECTROCARDI OLOGY	0.069504			0 88, 188	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 327498			0 127, 372	0	
	200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 644111	0		0 0	0	
	300 DRUGS CHARGED TO PATIENTS	0. 593182			0 143, 130	0	
	952 WOUND CARE (DIABETES CENTER)	0. 439457			0 11, 193	0	
	951 CASE MANAGEMENT	1. 620114			0 0	0	
	950 PALN MANAGEMENT	0. 488850			0 91, 925	0	
	697 CARDI AC REHABI LI TATI ON	2. 833749	0		0 1, 556	0	76.97
	TPATIENT SERVICE COST CENTERS	0.000000					
		0. 000000			0 0	0	
	001 PALLI ATI VE HEALTH	3. 335216			0 3, 372	0	
	2002 VEIN CENTER	0. 195186			0 32, 835	0	
	003 OBGYN	1.074354			0 0	0	
	100 EMERGENCY	0. 316476			0 455, 850	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 368435			0 95, 682	0	
	952 BEHAVI ORAL HEALTH	1. 039947	0		0 16, 458	0	
200.00	Subtotal (see instructions)		0		0 3, 887, 252	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00

APPORT	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	SCHNECK MEDI VACCINE COST	Provider CC	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet D Part V Date/Time Pre 5/18/2018 10:	epared:
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
F0 00	ANCI LLARY SERVICE COST CENTERS		04.202				
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0					50.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0					51.00
52.00 53.00	05300 ANESTHESI OLOGY		4, 658 11, 230				52.00
54.00	05400 RADI OLOGY – DI AGNOSTI C		82, 526				54.00
54. 01 54. 02	03630 ULTRA SOUND		7, 506				54.01 54.02
54.02 57.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	0	1, 589				54.02
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		16, 220 5, 798				58.00
60.00	06000 LABORATORY						60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		65, 266 3, 546				63.00
64.00	06400 I NTRAVENOUS THERAPY		7, 363				64.00
65.00	06500 RESPIRATORY THERAPY	0					65.00
66.00	06600 PHYSI CAL THERAPY		25, 136				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0					67.00
68.00	06800 SPEECH PATHOLOGY	0	10, 714				68.00
69.00	06900 ELECTROCARDI OLOGY	0	6, 129				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169, 086				71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0					72.00
	PATIENTS						
	07300 DRUGS CHARGED TO PATIENTS	0					73.00
	03952 WOUND CARE (DI ABETES CENTER)	0	4, 919				76.00
	03951 CASE MANAGEMENT	0	0				76.02
	03950 PALN MANAGEMENT	0					76.03
76.97	07697 CARDI AC REHABI LI TATI ON	0	4, 409				76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS	-					
90.00		0					90.00
90.01	09001 PALLI ATI VE HEALTH	0					90. 01 90. 02
90. 02 90. 03	09002 VEIN CENTER 09003 OBGYN	0	6, 409 0				90.02
90.03 91.00	09100 EMERGENCY		144, 266				90.03
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						91.00
	04952 BEHAVIORAL HEALTH		130, 935	1			92.00
200.00				•			200.00
200.00			774, 038				200.00
201.00	Only Charges						201.00
202.00		0	994, 538				202.00

	Financial Systems SCHNECK MEDICAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0065	Period: From 01/01/2017	u of Form CMS-2 Worksheet D-1	
			To 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	I NPATI ENT DAYS	o ovoluding nowhorm)		10, 779	
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			10, 779	
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		8, 319	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	182	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.		-	
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	r 31 of the cost	81	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			0.074	
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	y swing-bed and	3, 074	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	115	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	, , , , , , , , , , , , , , , , , , ,		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI. through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	am (exer daring swring bed	uuys)	0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost	218.85	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	218.85	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	155.02	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	-		155.02	
. 00	reporting period			133.02	20
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	12, 911, 401 39, 831	
. 00	5 x line 17)	er 31 of the cost repor	ting period (inne	39, 831	22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportion	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	12, 557	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			52, 388	24
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 859, 013	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abaamiation had a		0	
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed ci	larges)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li		/	0.00	
	Private room cost differential adjustment (line 3 x line 35)	-		0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	12, 859, 013	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
0.0	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 000]
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 222. 80 3, 758, 887	
	Medically necessary private room cost applicable to the Progra	-		3,730,007	
. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		3, 758, 887	1 11

MPUTATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 01/01/2017	Worksheet D-1	
			Te		Date/Time Pre 5/18/2018 10:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only)	0	C	0.00	0	0	42.
Intensive Care Type Inpatient Hospital Unit		1 000	2 100 22	420		1 42
. 00 INTENSIVE CARE UNIT . 00 CORONARY CARE UNIT	2, 383, 080	1, 088	2, 190. 33	439	961, 555	43. 44.
. 00 BURN INTENSIVE CARE UNIT						44.
. 00 SURGICAL INTENSIVE CARE UNIT						46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description						<u> </u>
.00 Program inpatient ancillary service cost (1	West D 2 col 2	Lino 200)			1.00 5,619,764	48.
.00 Total Program inpatient costs (sum of lines			ons)		10, 340, 206	
PASS THROUGH COST ADJUSTMENTS					10,010,200	
.00 Pass through costs applicable to Program in	npatient routine s	ervices (from	n Wkst. D, sum o	of Parts I and	561, 814	50.
					000 744	
.00 Pass through costs applicable to Program in and IV)	npatient anciiiary	services (Tr	OM WKST. D, SUR	n of Parts II	293, 741	51.
.00 Total Program excludable cost (sum of lines	s 50 and 51)				855, 555	52.
.00 Total Program inpatient operating cost excl		ated, non-phy	sician anesthe [.]	tist, and	9, 484, 651	
medical education costs (line 49 minus line	e 52)					
TARGET AMOUNT AND LIMIT COMPUTATION .00 Program di scharges					0	54.
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient opera	ating cost and tar	get amount (I	ine 56 minus li	ne 53)	0	57.
.00 Bonus payment (see instructions)	0					
.00 Lesser of lines 53/54 or 55 from the cost market basket	bounded by the	0.00	59.			
.00 Lesser of lines 53/54 or 55 from prior year	r cost report. upd	ated by the m	arket basket		0.00	60.
.00 If line 53/54 is less than the lower of lin				ne amount by	0	
which operating costs (line 53) are less the		(lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (see .00 Relief payment (see instructions)	e instructions)				0	62.
.00 Relief payment (see instructions) .00 Allowable Inpatient cost plus incentive pay	vment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	,					
.00 Medicare swing-bed SNF inpatient routine co	osts through Decem	ber 31 of the	e cost reportino	g period (See	25, 168	64.
instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient routine co	acto aftar Dacamba	r 21 of the c	act reporting	ariad (Saa	0	65.
instructions) (title XVIII only)	USIS aller Decembe		ust reporting p	beillou (See	0	05.
.00 Total Medicare swing-bed SNF inpatient rou	tine costs (line 6	4 plus line 6	5)(title XVIII	only). For	25, 168	66.
CAH (see instructions)					_	
.00 Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ine costs through	December 31 c	of the cost repo	orting period	0	67.
.00 Title V or XIX swing-bed NF inpatient routi	ine costs after De	cember 31 of	the cost report	tina period	0	68.
(line 13 x line 20)					_	
.00 Total title V or XIX swing-bed NF inpatien	````		/		0	69.
PART III - SKILLED NURSING FACILITY, OTHER .00 Skilled nursing facility/other nursing faci					I	70.
.00 Skilled nursing facility/other nursing faci .00 Adjusted general inpatient routine service						71.
.00 Program routine service cost (line 9 x line			_)			72.
.00 Medically necessary private room cost appli						73.
.00 Total Program general inpatient routine ser	•					74.
.00 Capital-related cost allocated to inpatien 26. line 45)	t routine service	COSTS (From W	iorksneet B, Pai	τιι, column		75.
.00 Per diem capital-related costs (line 75 ÷ l	line 2)					76.
.00 Program capital-related costs (line 9 x lin						77.
.00 Inpatient routine service cost (line 74 min	,					78.
.00 Aggregate charges to beneficiaries for exce			· · · · · · · · · · · · · · · · · · ·	Line 70		79.
.00 Total Program routine service costs for cor .00 Inpatient routine service cost per diem lin	•	st iimitation	i (iine /8 minus	5 ITTIE 79)		80
.00 Inpatient routine service cost per drem in						82
.00 Reasonable inpatient routine service costs	•					83
.00 Program inpatient ancillary services (see i						84.
.00 Utilization review - physician compensation						85.
.00 Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		ougn 85)				86.
.00 Total observation bed days (see instruction					2, 197	87.
. 00 Adjusted general inpatient routine cost per		line 2)			1, 222. 80	
					2, 686, 492	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1		
				To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	1, 614, 017	12, 911, 401	0. 12500	7 2, 686, 492	335, 830	90.00	
91.00 Nursing School cost	0	12, 911, 401	0.00000	0 2, 686, 492	0	91.00	
92.00 Allied health cost	0	12, 911, 401	0.00000	0 2, 686, 492	0	92.00	
93.00 All other Medical Education	0	12, 911, 401	0. 00000	0 2, 686, 492	0	93.00	

^{5/18/2018 10:30} am

	Financial Systems SCHNECK MEDICAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0065	Period: From 01/01/2017	u of Form CMS-2 Worksheet D-1	
		Title XIX	To 12/31/2017 Hospi tal	Date/Time Prep 5/18/2018 10:3 Cost	
	Cost Center Description		nospital	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		10, 779	1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		ivate room days,	10, 516 0	23
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be			8, 319	4
00	Total swing-bed SNF type inpatient days (including private roor reporting period			182	
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	5		0	e
00	Total swing-bed NF type inpatient days (including private roor reporting period			81	
00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	1, 708	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period		e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0 1, 632	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			822	
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	218.85	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	218.85	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	155.02	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	155.02	20
	reporting period Total general inpatient routine service cost (see instructions			12, 911, 401	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)		31 (39, 831	
. 00	Swing-bed cost applicable to SNF type services after December x line 18) $$			0	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)			12, 557	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		52, 388 12, 859, 013	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ·	Line 28)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)	· · · · · · · · · 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min		tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minutine line 20	and private room cost di	fferential (line	0 12, 859, 013	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 222 00	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 222. 80 2, 088, 542	
	Medically necessary private room cost applicable to the Progra			2,000,042	
	Total Program general inpatient routine service cost (line 39	, , ,		2, 088, 542	

MPUTATION OF INPATIENT OPERATING COST		Provider CC	l: 15-0065 Pe	eriod:	Worksheet D-1	1	
			Fi To	rom 01/01/2017 o 12/31/2017	Date/Time Pre		
		Title	XIX	Hospi tal	5/18/2018 10: Cost	30 a	
Cost Center Description	Total Inpatient CostI	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
00 NURSERY (title V & XIX only)	998, 011	1, 632	611.53	822	502, 678	3 42	
Intensive Care Type Inpatient Hospital Ur		1 000	2 100 22	(0)	101.400	1 42	
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT	2, 383, 080	1, 088	2, 190. 33	60	131, 420	43	
00 BURN INTENSIVE CARE UNIT						45	
00 SURGI CAL I NTENSI VE CARE UNI T						46	
00 OTHER SPECIAL CARE (SPECIFY)						47	
Cost Center Description					1.00		
00 Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)			1.00	2 48	
00 Total Program inpatient costs (sum of lin			s)		3, 272, 632		
PASS THROUGH COST ADJUSTMENTS							
00 Pass through costs applicable to Program	inpatient routine s	services (from	Wkst. D, sum d	of Parts I and	0	50	
<pre>111) 00 Pass through costs applicable to Program</pre>	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II						
and IV)							
00 Total Program excludable cost (sum of lin					0		
00 Total Program inpatient operating cost ex		ated, non-phys	ician anesthe	tist, and	0	53	
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					-	
00 Program discharges					0	54	
00 Target amount per discharge					0.00		
00 Target amount (line 54 x line 55)							
3 1 1	, , , , , , , , , , , , , , , , , , ,						
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cos	t roporting poriod o	nding 1006 up	dated and com	ocurded by the	0.00		
market basket	r reporting period e	inding 1990, up		Jounded by the	0.00		
00 Lesser of lines 53/54 or 55 from prior ye					0.00		
00 If line 53/54 is less than the lower of					0	61	
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		6 (IT nes 54 x 6	U), OF 1% OF 1	the target			
00 Relief payment (see instructions)					0	62	
00 Allowable Inpatient cost plus incentive	payment (see instruc	ctions)			0	63	
PROGRAM INPATIENT ROUTINE SWING BED COST							
00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through becen		cost reporting	j period (see	0	64	
00 Medicare swing-bed SNF inpatient routine	costs after Decembe	er 31 of the co	st reporting p	period (See	0	65	
instructions)(title XVIII only)							
00 Total Medicare swing-bed SNF inpatient re	outine costs (line 6	54 plus line 65)(title XVIII	only). For	0) 66	
CAH (see instructions) 00 Title V or XIX swing-bed NF inpatient rou	utine costs through	December 31 of	the cost rep	orting period	0	67	
(line 12 x line 19)				si ting period			
00 Title V or XIX swing-bed NF inpatient room	utine costs after De	ecember 31 of t	he cost report	ting period	0	68	
(line 13 x line 20)	ant nouting goats (1	ing (7 . ling	(0)				
00 Total title V or XIX swing-bed NF inpatio PART III - SKILLED NURSING FACILITY, OTHE			,		0) 69	
00 Skilled nursing facility/other nursing facility/						70	
00 Adjusted general inpatient routine service		ne 70 ÷ line 2)			71	
00 Program routine service cost (line 9 x li	,	(Lipo 14	- 2E)			72	
00 Medically necessary private room cost app 00 Total Program general inpatient routine			e 35)			73	
00 Capital -related cost allocated to inpatie	•		rksheet B, Pa	ct II, column		75	
26, line 45)							
00 Per diem capital -related costs (line 75 -	,					76	
00 Program capital-related costs (line 9 x 1 00 Inpatient routine service cost (line 74 r						77	
00 Aggregate charges to beneficiaries for ex	· ·	ovider records	.)			79	
00 Total Program routine service costs for a			*	s line 79)		80	
00 Inpatient routine service cost per diem						81	
00 Inpatient routine service cost limitation	• • • • •					82	
00 Reasonable inpatient routine service cost 00 Program inpatient ancillary services (see	•	<i>>)</i>				83	
00 Utilization review - physician compensati		ıs)				85	
00 Total Program inpatient operating costs	(sum of lines 83 thr					86	
PART IV - COMPUTATION OF OBSERVATION BED							
00 Total observation bed days (see instruct)	ons)				2, 197		
00 Adjusted general inpatient routine cost		line 2)			1, 222. 80	88 (

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1		
				To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am	
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	1, 614, 017	12, 911, 401	0. 12500	7 2, 686, 492	335, 830	90.00	
91.00 Nursing School cost	0	12, 911, 401	0.00000	0 2, 686, 492	0	91.00	
92.00 Allied health cost	0	12, 911, 401	0.00000	0 2, 686, 492	0	92.00	
93.00 All other Medical Education	0	12, 911, 401	0. 00000	0 2, 686, 492	0	93.00	

^{5/18/2018 10:30} am

Health Financial Systems SCHNECK MEDI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0065	Peri od:	u of Form CMS-2 Worksheet D-3	
INPATTENT ANGILLART SERVICE COST APPORTIONWIENT	Provider C	CN. 15-0065	From 01/01/2017	WOLKSHEEL D-3	
			To 12/31/2017	Date/Time Pre	pared:
				5/18/2018 10:	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	0.000.450		
30. 00 03000 ADULTS & PEDIATRICS			2, 093, 152		30.00
31.00 03100 I NTENSI VE CARE UNI T			574, 645		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.4040	(0) ((40,407	(00.010	50.00
50. 00 05000 OPERATING ROOM		0.1040		688, 219	
51.00 O5100 RECOVERY ROOM		0. 1143		40, 866	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3000		29, 857	
53. 00 05300 ANESTHESI OLOGY		0. 1045		46, 345	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3715		171, 476	
54.01 03630 ULTRA SOUND		0. 1237		20, 139	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1162		3, 157	54.02
57.00 05700 CT SCAN		0. 0298		51, 792	
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI)		0.0590		20, 637	58.00
60. 00 06000 LABORATORY		0. 11173		362, 145	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5018		91, 025	
64.00 06400 I NTRAVENOUS THERAPY		0. 4520		55, 841	
65. 00 06500 RESPIRATORY THERAPY		0.3419		562, 114	
66.00 06600 PHYSI CAL THERAPY		0. 5482		162, 880	
67.00 06700 OCCUPATI ONAL THERAPY		0. 2679			
68.00 06800 SPEECH PATHOLOGY		0. 4793		15, 574	
69. 00 06900 ELECTROCARDI OLOGY		0.0697		34, 910	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3274		1, 463, 333	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 6441		436, 034	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5931		1, 034, 809	
76.00 03952 WOUND CARE (DI ABETES CENTER)		0. 4394		3, 781	
76. 02 03951 CASE MANAGEMENT		1. 6201		0	76.02
76. 03 03950 PAIN MANAGEMENT		0. 4888		0	76.03
76. 97 07697 CARDI AC REHABI LI TATI ON		2. 8337	49 1, 170	3, 315	76.97
OUTPATIENT SERVICE COST CENTERS		1	[-	-	
90. 00 09000 CLINIC		0.0000		0	
90. 01 09001 PALLI ATI VE HEALTH		3. 3352		1, 461	90.01
90. 02 09002 VEIN CENTER		0. 1951		0	
90. 03 09003 0BGYN		1.0743		0	
91.00 09100 EMERGENCY		0. 3164		211, 633	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 36843		42, 769	
93. 00 04952 BEHAVI ORAL HEALTH		1.0399		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			20, 747, 894	5, 619, 764	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			20, 747, 894		202.00

ealth Financial Systems SCHNECK MEDICAL				u of Form CMS-2	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0065	Peri od:	Worksheet D-3	
	Component	CCN: 15-U065	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Title	XVIII	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
0. 00 03000 ADULTS & PEDIATRICS			0		30. C
1. 00 03100 INTENSIVE CARE UNIT			0		31.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS			- I		1
0. 00 05000 OPERATI NG ROOM		0. 1040	63 0	0	50. C
1.00 05100 RECOVERY ROOM		0. 1143	63 0	0	51. C
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3000		0	52.0
3. 00 05300 ANESTHESI OLOGY		0. 1045		0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3654		449	54. C
4. 01 03630 ULTRA SOUND		0. 1237		17	54. C
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1162		0	54.0
7. 00 05700 CT SCAN		0. 0298		0	57.0
8. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0590		0	58.0
0. 00 06000 LABORATORY		0. 1112		1, 897	60.0
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5018		0	63.0
4. 00 06400 I NTRAVENOUS THERAPY		0. 4520		0	64.0
5. 00 06500 RESPI RATORY THERAPY		0.3419		7, 117	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 5482		15, 906	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2679		0	67.0
8.00 06800 SPEECH PATHOLOGY		0. 4793		0	68.0
9. 00 06900 ELECTROCARDI OLOGY		0.0695		13	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3274		15, 066	71. (
2. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 6441		0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5931		19, 822	73.0
6.00 03952 WOUND CARE (DIABETES CENTER)		0. 4394		0	76.0
6. 02 03951 CASE MANAGEMENT		1. 6201		0	76.0
6. 03 03950 PALN MANAGEMENT		0. 4888		0	76.0
6. 97 07697 CARDI AC REHABI LI TATI ON		2.8337		0	76. 9
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC		0.0000	0 00	0	90. (
0. 01 09001 PALLI ATI VE HEALTH		3. 3352	16 0	0	90.0
0. 02 09002 VEIN CENTER		0. 1951	86 0	0	90. (
0. 03 09003 OBGYN		1. 0743	54 0	0	90. (
1.00 09100 EMERGENCY		0. 3164	76 0	0	91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 3684	35 0	0	92.
3. 00 04952 BEHAVI ORAL HEALTH		1. 0399	47 0	0	93. (
00.00 Total (sum of lines 50 through 94 and 96 through 98)			113, 188	60, 287	200. 0
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			113, 188		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CN: 15-0065	Peri od:	Worksheet D-3	2552-1
NFATIENT ANGLEART SERVICE COST AFFORTIONMENT	FIOVIDEI C	CN. 15-0005	From 01/01/2017	WOLKSHEEL D-3	
			To 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS			228, 330		30.00
1. 00 03100 I NTENSI VE CARE UNI T			57, 981		31.00
3. 00 04300 NURSERY			140, 376		43.00
ANCI LLARY SERVI CE COST CENTERS				00.444	1
0. 00 05000 OPERATING ROOM		0. 1040			
1.00 05100 RECOVERY ROOM		0. 1143		2, 441	51.00
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.3000		183, 857	52.00
3. 00 05300 ANESTHESI OLOGY		0. 1045		11, 201	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3654		7, 501	
4. 01 03630 ULTRA SOUND		0. 1237		1, 496	
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1162		25	54.0
7. 00 05700 CT SCAN		0.0298		2, 166	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0590		1, 231	58.00
0. 00 06000 LABORATORY		0. 1112		37,067	60.00
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5018		5, 241	
4. 00 06400 I NTRAVENOUS THERAPY		0. 4520		2, 988	
5. 00 06500 RESPI RATORY THERAPY		0. 3419		33, 924	
6. 00 06600 PHYSI CAL THERAPY		0.5482			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2679		1, 685	
8. 00 06800 SPEECH PATHOLOGY		0. 4793		174	68.00
9. 00 06900 ELECTROCARDI OLOGY		0.06950		2, 068	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3274		89, 982	
2. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 6441		0	72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5931		84, 903	1
6.00 03952 WOUND CARE (DI ABETES CENTER)		0. 4394			
6. 02 03951 CASE MANAGEMENT		1. 6201		0	
6. 03 03950 PALN MANAGEMENT		0. 4888		268	
6. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		2.8337	49 0	0	76.9
0. 00 09000 CLINIC		0.0000	0 00	0	90.00
0. 01 09001 PALLI ATI VE HEALTH		3. 3352		6, 457	90.0
0. 02 09002 VEIN CENTER		0. 1951		0	90.0
0. 03 09003 OBGYN		1. 0743		0	90.0
1. 00 09100 EMERGENCY		0. 3164		28, 367	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		1. 36843		1, 036	
3. 00 04952 BEHAVI ORAL HEALTH		1. 0399		3, 823	
00.00 Total (sum of lines 50 through 94 and 96 through 98)		1.00//	2, 037, 283	549, 992	
01.00 Less PBP Clinic Laboratory Services-Program only charge	nes (line 61)		2,037,203	017,772	201.00
	,	1	0		1-01.00

5/18/2018 10:30 am

Health Financial Systems SCHNECK MEDICA	L_CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0065	Peri od:	Worksheet D-3	
	Component	CCN: 15-U065	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	
	Ti tl	e XIX	Swing Beds - NF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
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
ANCI LLARY SERVI CE COST CENTERS					l
50. 00 05000 OPERATI NG ROOM		0. 1040	63 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 1143	63 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3000	05 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 1045	39 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3654	45 0	0	54.00
54.01 03630 ULTRA SOUND		0. 1237	95 0	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1162	48 0	0	54.02
57. 00 05700 CT SCAN		0. 0298	66 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0590	13 0	0	58.00
60. 00 06000 LABORATORY		0. 1112	63 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5018	30 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 4520	74 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0.3419	53 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 5482	41 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2679	92 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 4793	60 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0695	04 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.3274	98 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 6441		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5931		0	73.00
76. 00 03952 WOUND CARE (DI ABETES CENTER)		0. 4394		0	76.00
76. 02 03951 CASE MANAGEMENT		1. 6201		0	76. 02
76. 03 03950 PALN MANAGEMENT		0. 4888		0	76.03
76. 97 07697 CARDI AC REHABI LI TATI ON		2.8337	49 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0.0000		0	90.00
90. 01 09001 PALLI ATI VE HEALTH		3. 3352		0	90.01
90. 02 09002 VEI N CENTER		0. 1951		0	90.02
90. 03 09003 0BGYN		1.0743		0	90.03
91.00 09100 EMERGENCY		0. 3164		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.3684		0	92.00
93. 00 04952 BEHAVI ORAL HEALTH		1.0399		0	93.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (iine 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	0		202.00

CUL.	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/18/2018 10:	pared
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00	DRG Amounts Other than Outlier Payments			0	1.0
)1	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see	4, 955, 462	1.0
)2	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (SPP	1, 651, 821	1.0
~ _	instructions)	ing on of arter betober	1 (300	1,001,021	
)3	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1.0
)4	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1.0
-	October 1 (see instructions)			0	1. (
0	Outlier payments for discharges. (see instructions)			303, 074	2. (
)1	Outlier reconciliation amount			0	
)2)0	Outlier payment for discharges for Model 4 BPCI (see instructi Managed Care Simulated Payments	ons)		0 1, 320, 172	
0	Bed days available divided by number of days in the cost report	rting period (see instru	uctions)	85.26	
	Indirect Medical Education Adjustment			00120	1
0	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.
~	or before 12/31/1996. (see instructions)		+- +	0.00	
0	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0.00	6.0
00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7.
)1	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7.
	cost report straddles July 1, 2011 then see instructions.				
0	Adjustment (increase or decrease) to the FTE count for alloparaffiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.
	1998), and 67 FR 50069 (August 1, 2002).	79(C)(Z)(TV), 04 TK 2034	iu (way iz,		
)1	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8.
	report straddles July 1, 2011, see instructions.				
)2	The amount of increase if the hospital was awarded FTE cap slo under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8.
0	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (see	0.00	9.
	instructions)				
	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	rds	0.00	
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00	
00	Total allowable FTE count for the prior year.			0.00	
00	Total allowable FTE count for the penultimate year if that yea	ar ended on or after Sep	otember 30, 1997,	0.00	
	otherwise enter zero.				
	Sum of lines 12 through 14 divided by 3.			0.00	
	Adjustment for residents in initial years of the program	SUFO		0.00 0.00	
	Adjustment for residents displaced by program or hospital clos Adjusted rolling average FTE count	sure		0.00	
00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22.
00	Number of additional allopathic and osteopathic IME FTE reside		CFR 412.105	0.00	23.
	(f)(1)(iv)(C).				
	IME FTE Resident Count Over Cap (see instructions)		0 4 (0.00	
00	If the amount on line 24 is greater than -O-, then enter the linstructions)	ower of line 23 or line	e 24 (see	0.00	25.
00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions))		0	
00 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		0	
υī	Disproportionate Share Adjustment	1)		0	29.
00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	ctions)	2.99	30.
	Percentage of Medicaid patient days (see instructions)	, , , , , , , , , , , , , , , , , , ,		28.03	
	Sum of lines 30 and 31			31.02	
00	Allowable disproportionate share percentage (see instructions))		12.00	1 33.

CALCUL	Financial Systems SCHNECK MEDI (ATI ON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0065	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2017 To 12/31/2017		
			lloopital	5/18/2018 10:	30 am
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		5, 977, 483, 147		
35.01	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	tor zoro on this line) (or	0. 000093254	0. 000079442	
35. 02	instructions)	ter zero on this fine) (se	e 557, 424	537, 560	35. C
35.03	Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	416, 922	135, 495	35.0
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35		552, 417		36. C
	Additional payment for high percentage of ESRD beneficiary of				
10.00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGs	0		40.0
1.00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41. (
11.00	instructions)		0		
1.01	Total ESRD Medicare covered and paid discharges excluding M	S-DRGs 652, 682, 683, 684	ŧ О		41.0
	an 685. (see instructions)				
12.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.0
13.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	682, 683, 684 all 685. (See	0		43.0
14.00	Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0.00000		44.
	days)	5			
5.00	Average weekly cost for dialysis treatments (see instruction	-	0.00		45.
6.00	Total additional payment (line 45 times line 44 times line -	41.01)	0		46.
7.00 8.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural bosnitals	7, 660, 993		47. 48.
+0. 00	only. (see instructions)		0		40.
				Amount	
				1.00	10
19.00 50.00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. 1)			7, 660, 993 577, 410	
51.00	Exception payment for inpatient program capital (Irom WKSt. L, Pt. I)			0	51.
52.00	Direct graduate medical education payment (from Wkst. E-4,			0	52.
53.00	Nursing and Allied Health Managed Care payment			0	53.
64.00	Special add-on payments for new technologies			0	54.
64.01	Islet isolation add-on payment			0	54.
5.00 6.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in	-		0	55. 56.
57.00	Routi ne service other pass through costs (from Wkst. D, Pt.	III. column 9. lines 30 1	hrough 35).	0	57.
8. 00	Ancillary service other pass through costs from Wkst. D, Pt		5 ,	0	58.
9.00	Total (sum of amounts on lines 49 through 58)			8, 238, 403	
0.00	Primary payer payments			4, 235	
1.00	Total amount payable for program beneficiaries (line 59 min	us line 60)		8, 234, 168	
3.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			920, 724 4, 606	
4.00	Allowable bad debts (see instructions)			79, 341	
5.00	Adjusted reimbursable bad debts (see instructions)			51, 572	
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		27, 283	66.
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7, 360, 410	
8.00	Credits received from manufacturers for replaced devices fo			0	68.
9.00 0.00	Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)). (FOR SCH SEE FISTRUCTION	15)	0	69. 70.
0.50	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	70.
0.87	Demonstration payment adjustment amount before sequestration	· · ·		0	70.
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
0.89	Pioneer ACO demonstration payment adjustment amount (see in	structions)			70.
0.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0.91	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0 60, 759	70.
70.92	HV/RP navment adjustment amount (see instructions)				
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-4, 731	70.

CULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/18/2018 10:	
	Title	XVIII	Hospi tal	PPS	
		FF	Ү (уууу)	Amount	
			0	1.00	
96 Low volume adjustment for federal fiscal year (yyyy) (Ent			2017	8, 833	70
 the corresponding federal year for the period prior to 10 27 Low volume adjustment for federal fiscal year (yyyy) (Ent the corresponding federal year for the period ending on o 	er in column O		2018	155, 743	70
98 Low Volume Payment-3				0	70
99 HAC adjustment amount (see instructions)				0	70
00 Amount due provider (line 67 minus lines 68 plus/minus li	nes 69 & 70)			7, 581, 014	
01 Sequestration adjustment (see instructions)				151, 620	
02 Demonstration payment adjustment amount after sequestrati	on			0	71
00 Interim payments				7, 089, 692	
00 Tentative settlement (for contractor use only)				0	73
00 Balance due provider/program (line 71 minus lines 71.01, 73)	71.02, 72, and			339, 702	
00 Protested amounts (nonallowable cost report items) in acc CMS Pub. 15-2, chapter 1, §115.2	cordance with			94, 158	75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			Т		
00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see	e instructions)			0	90
00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Operating outlier reconciliation adjustment amount (see i				0	92
00 Capital outlier reconciliation adjustment amount (see ins				0	93
00 The rate used to calculate the time value of money (see i				0.00	
00 Time value of money for operating expenses (see instructi	,			0	95
00 Time value of money for capital related expenses (see ins	structions)			0	96
			Prior to 10/1		
HSP Bonus Payment Amount			1.00	2.00	
			0	0	1100
D.00 HSP bonus amount (see instructions)			0	0	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	tions)		0. 000000000	0.000000000	101
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) 	tions)			0.000000000	101
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 	ctions)		0.0000000000000000000000000000000000000	0.0000000000000000000000000000000000000	101 102
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 			0. 000000000	0. 000000000 0 0. 0000	101 102 103
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct 	i ons)	stment	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000	10 ⁻ 102 103
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 	ions) monstration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 102 103
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration 	ions) monstration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 102 103
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 	ions) monstration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 102 103
 0.0 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.0 HVBP adjustment factor (see instructions) 0.0 HVBP adjustment factor (see instructions) 0.0 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 0.0 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstratio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.0 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 	ions) wonstration) Adju on period under t		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 102 102 200
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 	ions) wonstration) Adju on period under t		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 	ions) wonstration) Adju on period under t		0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 0.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/ 	ions) monstration) Adju on period under t line 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 	ions) monstration) Adju on period under t line 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstratio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 	tions) nonstration) Adju on period under t line 49) A in first year	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstratio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 	tions) Nonstration) Adju On period under t line 49) A in first year	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 204 205
 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 00 HVBP adjustment factor (see instructions) 00 HVBP adjustment factor (see instructions) 00 HRR Adjustment for HSP Bonus Payment 00 HRR adjustment factor (see instructions) 00 HRR adjustment factor (see instructions) 00 HRR adjustment for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, period) 00 Medicare target amount (line 203 times line 204) 00 Medicare inpatient routine cost cap (line 202 times line 	tions) Nonstration) Adju On period under t line 49) A in first year	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 204
 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 00 HVBP adjustment factor (see instructions) 00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 00 HRR adjustment factor (see instructions) 00 HRR adjustment factor (see instructions) 00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 	ions) ionstration) Adju on period under t line 49) A in first year	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	102 103 104 200 201 202 203 204 205 206
 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 00 HVBP adjustment factor (see instructions) 00 HVBP adjustment for HSP Bonus Payment 00 HRR adjustment for HSP Bonus Payment 00 HRR adjustment factor (see instructions) 00 HRR adjustment factor (see instructions) 00 HRR adjustment factor (see instructions) 00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare target amount 00 Medicare to patient routine cost cap (line 203 times line 204) 00 Medicare to Medicare Part A Inpatient Reimbursement 00 Program reimbursement under the §410A Demonstration (see 	ions) ponstration) Adju on period under t line 49) A in first year 205) instructions)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 ration	101 102 103 104 200 201 202 203 204 205 206
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 0.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204) 4.00 Medicare inpatient routine cost cap (line 202 times line Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see 3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt 	ions) ponstration) Adju on period under t line 49) A in first year 205) instructions)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 ration	101 102 103 104 200 201 202 203 204 205 206 207 208
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem O Is this the first year of the current 5-year demonstratio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Computation of Demonstration Target Amount Limitation (N/ period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare part A Inpatient Reimbursement 6.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. 00 Program reimbursement under the §410A Demonstration (see B.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 00 Program reimbursement under the S410A Demonstration (see B.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 00 Program reimbursement under the S410A Demonstration (see B.00 Medicare IPPS payments (see instructions) 	ions) ponstration) Adju on period under t line 49) A in first year 205) instructions)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 ration	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstratio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt 9.00 Adjustment to Medicare IPPS payments (see instructions) 9.00 Reserved for future use 	ions) nonstration) Adju on period under t line 49) (A in first year 205) instructions) . A, line 59)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Program reimbursement under the §410A Demonstration (see Adjustment to Medicare IPPS payments (see instructions) 5.00 Reserved for future use 5.00 Total adjustment to Medicare IPPS payments (see instructions) 	ions) nonstration) Adju on period under t line 49) (A in first year 205) instructions) . A, line 59)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Computation of Demonstration Target Amount Limitation (N/ period) 3.00 Case-mix adjustment factor (see instructions) 3.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Medicare Part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Case-mix adjustment Instruction Structions) 5.00 Medicare Part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Medicare Part A inpatient Service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Cost adjustment to Medicare IPPS payments (see instructions) 5.00 Cost adjustment to Medicare IPPS payments (see instructions) 	ions) ionstration) Adju ion period under t line 49) (A in first year 205) instructions) c. A, line 59) ons)	he 21st	0. 000000000 0 0. 0000 0	0.000000000000000000000000000000000000	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see adjustment to Medicare IPPS payments (see instructions) 5.00 Medicare Part A inpatient service costs (from Wkst. E, Pt 0.01 Adjustment to Medicare IPPS payments (see instructions) 5.00 Comparts of future use 6.00 Medicare Part A Medicare IPPS payments (see instructions) 	ions) ionstration) Adju ion period under t line 49) (A in first year 205) instructions) c. A, line 59) ons)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 ration	101 102 103 200 201 202 203 204 205 206 207 208 209 210 211 212
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instruct HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruct Rural Community Hospital Demonstration Project (§410A Dem 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Computation of Demonstration Target Amount Limitation (N/ period) 3.00 Case-mix adjustment factor (see instructions) 3.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Medicare Part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Case-mix adjustment Instruction Structions) 5.00 Medicare Part A inpatient service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Medicare Part A inpatient Service costs (from Wkst. E, Pt Adjustment to Medicare IPPS payments (see instructions) 5.00 Cost adjustment to Medicare IPPS payments (see instructions) 5.00 Cost adjustment to Medicare IPPS payments (see instructions) 	ions) nonstration) Adju on period under t line 49) (A in first year 205) instructions) c. A, line 59) ons) ine 211)	he 21st	0. 000000000 0 0. 0000 0	0.000000000 0 0.0000 0 ration	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210

OW VC	Financial Systems DLUME CALCULATION EXHIBIT 4		SCHNECK MEDI	Provider C		Peri od:	u of Form CMS-2 Worksheet E	
						From 01/01/2017 To 12/31/2017	Part A Exhibi	pare
				Title	XVIII	Hospi tal	5/18/2018 10: PPS	30 8
		W/S E. Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4, 955, 462	0	4, 955, 46	2	4, 955, 462	1
02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 651, 821	0		1, 651, 821	1, 651, 821	1
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0		0	0	1
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1
00	Outlier payments for	2.00	303, 074	0	227, 30	5 75, 769	303, 074	2
01	discharges (see instructions) Outlier payments for	2. 02	0	0		o o	0	2
00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0		o o	0	3
00	reconciliation Managed care simulated payments	3. 00	1, 320, 172	0	990, 12	9 330, 043	1, 320, 172	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		o o	0	6
01	instructions) IME payment adjustment for managed care (see	22. 01	0	0		0 0	0	6
	instructions)							
	Indirect Medical Education Adju							
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0.00000	0 0. 000000		7
00	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	9
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	ç
	Disproportionate Share Adjustme	ent	· · · · · ·		1	<u> </u>		
. 00	Allowable disproportionate share percentage (see	33.00	0. 1200	0. 1200	0. 120	0 0. 1200		10
. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	198, 219	0	148, 66	4 49, 555	198, 219	11
. 01	Uncompensated care payments	36.00	552, 417	0	416, 92	2 135, 495	552, 417	11
. 00	Additional payment for high per Total ESRD additional payment	46.00		di scharges 0		0 0	0	12
. 00 . 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	7, 660, 993 0	0		3 1, 912, 640 0 0		13 14
. 00	(see instructions) Total payment for inpatient	49.00	7, 660, 993	0	5, 748, 35	3 1, 912, 640	7, 660, 993	1
	operating costs (see instructions)							
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	577, 410	0				
. 00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17
7.01 7.02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		o o	0	17 17

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	-	Period: From 01/01/2017 Fo 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/18/2018 10:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		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, 181, 41	2, 056, 993	8, 238, 403	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	527, 848	0	395, 88	5 131, 962	527, 848	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	49, 562	0	37, 17	1 12, 391	49, 562	21.00
21.01	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	577, 410	0	433, 05	7 144, 353	577, 410	26.00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00142 8, 83		8, 833	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				155, 743	155, 743	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4, 955, 462		0	0	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 651, 821		6, 607, 282	6, 607, 282	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	303, 074		0 303, 074	303, 074	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	1, 320, 172		0 0	0	4.00
	Indirect Medical Education Adjustment					1	
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		o o	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t		- 1		
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0 0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment					1	
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 120	0 0. 1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	198, 219		0 198, 219	198, 219	11.00
11.01	Uncompensated care payments	36.00	552, 417	416, 92	2 135, 495	552, 417	11.01
	Additional payment for high percentage of ESR	RD beneficiary	di scharges				
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	7, 660, 993	416, 92	2 7, 244, 071	7, 660, 993	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see		0		0 0		
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 660, 993	416, 92	2 7, 244, 071	7, 660, 993	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	577, 410		0 577, 410	577, 410	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 00 17. 01
17.01	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
18.00		93.00	0		0 0	0	18.00
19.00	SUBTOTAL			416, 92	2 7, 821, 481	8, 238, 403	19.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider C		Period: From 01/01/2017 To 12/31/2017		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	527, 848		0 527, 848	527, 848	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	49, 562		0 49, 562	49, 562	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.00	0. 0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 C	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	577, 410		0 577, 410	577, 410	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00	0	1.00	2.00	3.00	4.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	8, 833	8, 8	33	8, 833	
29.00 Low volume adjustment on or after October 1	70.97	155, 743		155, 743		
30.00 HVBP payment adjustment (see instructions)	70.93	60, 759		0 60, 759		
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0		
31.00 HRR adjustment (see instructions)	70.94	-4, 731		0 -4, 731	-4, 731	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 C	0	•
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Wkst. E, Pt. A.

	Financial Systems SCHNECK MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0065	Peri od:	u of Form CMS-: Worksheet E	_002
			From 01/01/2017 To 12/31/2017	Part B Date/Time Pre	pare
		Title XVIII	Hospi tal	5/18/2018 10: PPS	
			nospital		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			7, 030	1.
00	Medical and other services reimbursed under OPPS (see instruct	ctions)		11, 912, 955	
00	OPPS payments			10, 033, 743	
00 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			255, 803 0	
00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
. 00 . 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			7, 030	10
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			7,030	1''
	Reasonable charges				1
	Ancillary service charges			11, 852	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	13
. 00	Total reasonable charges (sum of lines 12 and 13)			11, 852	14
. 00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15
	Amounts that would have been realized from patients liable for			0	16
	had such payment been made in accordance with 42 CFR §413.13(1 5	<u> </u>		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			11, 852	
. 00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ine 11) (see	4, 822	19
. 00	Excess of reasonable cost over customary charges (complete or	nlvifline 11 exceeds l	ine 18) (see	0	20
	instructions)			-	
	Lesser of cost or charges (see instructions)			7, 030	
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0 10 200 E4(23
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			10, 289, 546	24
. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25
. 00	Deductibles and Coinsurance relating to amount on line 24 (for	or CAH, see instructions)	2, 026, 513	26
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	8, 270, 063	27
. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	Lino 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)	,		8, 270, 063	
. 00	Primary payer payments			9, 961	31
. 00	Subtotal (line 30 minus line 31)			8, 260, 102	32
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	(CES)		0	1
	Allowable bad debts (see instructions)			0 274, 544	
	Adjusted reimbursable bad debts (see instructions)			178, 454	
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		206, 874	
	Subtotal (see instructions)			8, 438, 556	37
	MSP-LCC reconciliation amount from PS&R			111	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nc)		0	
	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	•		0	39
. 97	Partial or full credits received from manufacturers for repla		ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39
. 00	Subtotal (see instructions)			8, 438, 445	40
	Sequestration adjustment (see instructions)			168, 769	
	Demonstration payment adjustment amount after sequestration			0 8 003 E04	
	Interim payments Tentative settlement (for contractors use only)			8, 093, 504	41
. 00	Balance due provider/program (see instructions)			176, 172	
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	168, 157	
	§115. 2		-		1
00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)			0.00	
				0	1

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017		pared
		Title	XVIII	Hospi tal	PPS	-
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		7, 089, 6	92	8, 093, 504	1.
. 00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
. 00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
05	Dravidar to Dragram			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM		[0	0	3.
50	ADJUSTMENTS TO FROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 089, 69	92	8, 093, 504	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
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	1				
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
03	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
01	the cost report. (1)		220 7	12	17/ 170	,
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		339, 70		176, 172 0	6
02	Total Medicare program liability (see instructions)		7, 429, 39	0	8, 269, 676	
00			1,427,3	Contractor	NPR Date	/
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
00	Name of Contractor					8

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Fr	riod: om 01/01/2017		
		Component (CCN: 15-U065	То	12/31/2017	Date/Time Pre 5/18/2018 10:	
		Title	XVIII	Swi	ing Beds - SNF		
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		19, 5	47		0	1.
00	Interim payments payable on individual bills, either			0		0	2.
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero						
00	List separately each retroactive lump sum adjustment						3.
00	amount based on subsequent revision of the interim rate						J 3.
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
01	ADJUSTMENTS TO PROVIDER			0		0	
02				0 0		0	
03 04				0		0	
04 05				0		0	
	Provider to Program						
50	ADJUSTMENTS TO PROGRAM			0		0	3
51				0		0	
52				0		0	
53				0		0	
54	Subtatal (ave af lines 2.01.2.40 pinus ave af lines			0		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		19, 5	47		0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					-	
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after						5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider					<u> </u>	
01	TENTATI VE TO PROVI DER			0		0	5
02				0		0	
03				0		0	5
50	Provider to Program TENTATIVE TO PROGRAM			0		0	5
50 51	TENTATIVE TO PROGRAM			0		0	
52				0		0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	
	5. 50-5. 98)						
00	Determined net settlement amount (balance due) based on						6
11	the cost report. (1)					_	
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0		0	-
02	Total Medicare program liability (see instructions)		19, 5	-		0	
55			17, 5	/	Contractor	NPR Date	<u> </u>
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

Heal th	Financial Systems SCHNECK MEDICA	L CENTER	In Lie	u of Form CMS-	-2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	epared:	
		Title XVIII	Hospi tal	5/18/2018 10: PPS	<u>30 ann</u>	
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	e 14		1.00		
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00	
					•	

LCUL	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0065	Period: From 01/01/2017	Worksheet E-2	
		Component CCN: 15-U065	To 12/31/2017	Date/Time Pre 5/18/2018 10:	pare 30 a
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
1	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		20, 111	0	
00	Inpatient routine services - swing bed-NF (see instructions)				2
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				3
00	Per diem cost for interns and residents not in approved teachi			0.00	4
	instructions)	ng program (see		0.00	4
00	Program days		115	0	5
00	Interns and residents not in approved teaching program (see in	structions)		0	
	Utilization review - physician compensation - SNF optional met		0	-	7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5	20, 111	0	8
00	Primary payer payments (see instructions)		0	0	9
00	Subtotal (line 8 minus line 9)		20, 111	0	10
00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11
	professional services)				
	Subtotal (line 10 minus line 11)		20, 111	0	
00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	165	0	13
00	for physician professional services)			0	
	80% of Part B costs (line 12 x 80%) Subtatel (onten the lesson of line 12 minus line 12, on line 1	4)	10.044	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	19, 946	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	`	0	0	16 16
	Rural community hospital demonstration project (§410A Demonstr		0		16
55	adjustment (see instructions)	atton) payment	0		
99	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	
00	Total (see instructions)		19, 946	0	19
01	Sequestration adjustment (see instructions)		399	0	19
02	Demonstration payment adjustment amount after sequestration)		0	0	19
	Interim payments		19, 547	0	
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, a	-	0	0	
00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2 Dural Community Haspital Demonstration Draiget (\$4104 Demonstra	ation) Adjustment			-
	Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration per				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				200
	Cost Reimbursement				1
. 00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
2. 00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	ne		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in [.] period)	first year of the curre	ent 5-year demonst	ration	
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 til	mes line 204)			206
•	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	· · ·			
	Program reimbursement under the §410A Demonstration (see instr				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				
00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215

LCUL	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0065	Peri od:	Worksheet E-2
		Component CCN: 15-U065	From 01/01/2017 To 12/31/2017	Date/Time Prepa 5/18/2018 10:30
		Title XIX	Swing Beds - NF	
			Part A	Part B
			1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
00	Inpatient routine services - swing bed-SNF (see instructions)		0	
	Inpatient routine services - swing bed-NF (see instructions)		0	
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins			
	Per diem cost for interns and residents not in approved teachi	ng program (see	0.00	
	instructions)			
	Program days		0	
	Interns and residents not in approved teaching program (see in		0	
	Utilization review – physician compensation – SNF optional met Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	.nou oni y	0	
	Primary payer payments (see instructions)		0	
	Subtotal (line 8 minus line 9)	0		
	Deductibles billed to program patients (exclude amounts applic	sable to physician	0	
	professional services)		0	
	Subtotal (line 10 minus line 11)		0	
	Coinsurance billed to program patients (from provider records)	(exclude_coinsurance	0	
	for physician professional services)		Ŭ	
. 00	80% of Part B costs (line 12 x 80%)		0	
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		
55	Rural community hospital demonstration project (§410A Demonstr	ation) payment		
	adjustment (see instructions)			
. 99	Demonstration payment adjustment amount before sequestration		0	
	Allowable bad debts (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions)		0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	
	Total (see instructions)		0	
	Sequestration adjustment (see instructions)		0	
	Demonstration payment adjustment amount after sequestration)		0	
	Interim payments		0	
	Tentative settlement (for contractor use only)		0	
	Balance due provider/program (line 19 minus lines 19.01, 20, a	-	0	
	Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	ice with CMS Pub. 15-2,	0	
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment		
	Is this the first year of the current 5-year demonstration per			2
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
1.00	Medicare swing-bed SNF inpatient routine service costs (from W	Kst. D-1, Pt. II, line		2
	66 (title XVIII hospital))			
	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	ne	2
	200 (title XVIII swing-bed SNF))			
	Total (sum of lines 201 and 202)			2
	Medicare swing-bed SNF discharges (see instructions)	<u> </u>		2
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demonst	ration
	period) Madiaara awing had SNE targat amount			
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mos Lino 204)		2
•	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs			2
	Program reimbursement under the §410A Demonstration (see instr			2
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1	2
2. 00	and 3)		·	
9, 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)		2
	Reserved for future use			2
	Comparision of PPS versus Cost Reimbursement			
		209 plus line 210) (see		2

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet G Date/Time Pre 5/18/2018 10:	
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	48, 031, 241		0 0	0	1.
00	Temporary investments	8,000,000		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	67, 884, 145		0 0	0	4.
00	Other receivable	14, 701, 804		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-51, 566, 986		0 0	0	
00	Inventory	3, 719, 021		0 0	0	
00 00	Prepaid expenses Other current assets	2, 379, 467 22, 721, 432		0 0	0	
	Due from other funds	193, 000		0 0	0	
	Total current assets (sum of lines 1-10)	116, 063, 124		0 0	0	
	FIXED ASSETS	110,000,121			0	1
	Land	8, 505, 131		0 0	0	12.
00	Land improvements	4, 516, 131		0 0	0	13.
	Accumul ated depreciation	-2, 696, 955		0 0	0	14.
	Bui I di ngs	89, 419, 028		0 0	0	
	Accumulated depreciation	-43, 146, 184		0 0	0	
	Leasehold improvements	3, 999, 418		0 0	0	
	Accumulated depreciation	-94, 659		0 0	0	
	Fixed equipment Accumulated depreciation	5, 291, 444 -4, 261, 796		0 0	0	
	Automobiles and trucks	-4,201,790		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	48, 671, 036		0 0	0	
	Accumulated depreciation	-35, 989, 012		0 0	0	24
00	Minor equipment depreciable	3, 728, 772		0 0	0	25
	Accumulated depreciation	-3, 331, 226		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0 74, 611, 128		0 0 0 0	0	
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	/4, 011, 128	<u> </u>	0 0	0	30
	Investments	10, 411, 719		0 0	0	31
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
00	Other assets	164, 453, 335		0 0	0	34
00	Total other assets (sum of lines 31-34)	174, 865, 054		0 0	0	35
	Total assets (sum of lines 11, 30, and 35)	365, 539, 306		0 0	0	36
	CURRENT_LIABILITIES					
	Accounts payable	3, 666, 488		0 0	0	
	Salaries, wages, and fees payable Payroll taxes payable	10, 831, 092 16, 094		0 0 0 0	0	
	Notes and Loans payable (short term)	26, 351			0	
	Deferred income	20, 331		0 0	0	
	Accelerated payments	0		-	-	42
	Due to other funds	0		0 0	0	43
00	Other current liabilities	1, 082		0 0	0	44
00	Total current liabilities (sum of lines 37 thru 44)	14, 541, 107		0 0	0	45
	LONG TERM LIABILITIES		L			
	Mortgage payable	0		0 0	0	
	Notes payable Unsecured Loans	29, 331, 961		0 0	0	
	Other long term liabilities	9, 652, 250		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	38, 984, 211		0 0	0	
	Total liabilities (sum of lines 45 and 50)	53, 525, 318		0 0	0	
	CAPI TAL ACCOUNTS					
00	General fund balance	312, 013, 988				52
00	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	312, 013, 988		0 0	o	59
				VI U		1 39

Health Financial Systems	SCHNECK MEDIC	AL CENTER		In Li	eu of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0065	Period: From 01/01/2017 To 12/31/2017		
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00.006.00.007.008.009.0010.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.0018.0018.00Total deductions (sum of lines 12-17)19.00Fund balance at end of period per balance	29) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	292, 649, 823 19, 364, 165 312, 013, 988 312, 013, 988 312, 013, 988 0 312, 013, 988				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
sheet (line 11 minus line 18)	Endowment Fund	PI ant			,	19.00
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00	29) 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 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 18.00 Total deductions (sum of lines 12-17)	000	0 0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19.00 Fund balance at end of period per balanc sheet (line 11 minus line 18)	e 0			0		19. 00

	Financial Systems SCHNECK MEDICA				eu of Form CMS-	
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0065	Period: From 01/01/201 To 12/31/201		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		6, 268, 7	05	6, 268, 705	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 268, 7	05	6, 268, 705	10.00
	Intensive Care Type Inpatient Hospital Services			T	- 1	
11.00	INTENSIVE CARE UNIT		1, 543, 9	61	1, 543, 961	
12.00	CORONARY CARE UNIT					12.00
	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 543, 9	61	1, 543, 961	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 10)	7, 812, 6		7, 812, 666	1
18.00	Ancillary services		60, 000, 3			
19.00	Outpatient services			-	0 0	
	RURAL HEALTH CLINIC				0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			-	0 0	
	HOME HEALTH AGENCY			2, 419, 07	1 2, 419, 071	
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE			0 2, 141, 13		1
27.00	OTHER OUTPATI ENT		87, 5			
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	67, 900, 4	87 295, 064, 52	2 362, 965, 009	28.00
	G-3, line 1)					-
00.00	PART II - OPERATING EXPENSES			407 445 44	al	00.00
29.00	Operating expenses (per Wkst. A, column 3, line 200)			137, 445, 11		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00	Tatal additions (our of lines 20 25)			-	o	35.00
36.00	Total additions (sum of lines 30-35)			0	0	
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Total deductions (sum of lines 27 41)			-	0	41.00
42.00	Total deductions (sum of lines 37-41)	(1) (transfer			-	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)			137, 445, 11	1	43.00
	1.0 WK31, 0-3, 1110 4/			1	1	1

Health Financial Systems	SCHNECK MEDI CA	L CENTER	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSI	ËS	Provider CCN: 15-0065	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prep 5/18/2018 10:3	
	and What C 2 Dart L and what 2 Lin	- 20)		1.00	1 00
	rom Wkst. G-2, Part I, column 3, lin			362, 965, 009	1.00
	es and discounts on patients' accoun	ts		222, 181, 554	2.00
3.00 Net patient revenues (line		42)		140, 783, 455	3.00
	nses (from Wkst. G-2, Part II, line	43)		137, 445, 111	4.00
	patients (line 3 minus line 4)			3, 338, 344	5.00
OTHER I NCOME	hammada ata			385, 858	(00
6.00 Contributions, donations,	bequests, etc				6.00
7.00 Income from investments				11, 560, 490	7.00
	nd other miscellaneous communication	SELVICES		7, 146	8.00
9.00 Revenue from tel evision ar	id radio service			0	9.00
10.00 Purchase di scounts				60, 657	10.00
11.00 Rebates and refunds of exp	Jenses			0	11.00
12.00 Parking lot receipts	1			0	12.00
13.00 Revenue from Laundry and L 14.00 Revenue from meals sold to				0	13.00 14.00
				418, 056	
		han nationta		620, 491 0	15.00 16.00
	cal and surgical supplies to other t	nan patrents		165, 933	
5					17.00
18.00 Revenue from sale of medic 19.00 Tuition (fees, sale of tex				20, 553 5, 280	18.00 19.00
	rs, coffee shops, and canteen			6, 704 0	20. 00 21. 00
)			74, 671	21.00
23.00 Governmental appropriation 24.00 CONTRACT REVENUE	IS			0	23.00 24.00
				1, 562, 256	
24.01 GRANT REVENUE 24.02 MI SCELLANEOUS I NCOME				90, 310	
				1,053,998	
24. 03 UNREALI ZED GAI NS/LOSSES				-36, 137	24. 03 24. 04
24.04 EHR INCENTIVE 25.00 Total other income (sum of	flipor ()()			29, 555 16, 025, 821	24.04 25.00
26.00 Total (line 5 plus line 25))			19, 364, 165	26.00
27.00 OTHER EXPENSES (SPECIFY)	of line 27 and subserints)			0	27.00 28.00
28.00 Total other expenses (sum	the period (line 26 minus line 28)			19, 364, 165	
27.00 INEL TICOINE (OF TOSS) TOP I	The period (TTHE 20 millios TTHE 28)		I	17, 304, 105	∠ 9. UU

	Financial Systems		SCHNECK MEDI				u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS		Provider C	F	Period: From 01/01/2017	Worksheet H	
				HHA CCN:	15-7155 1	o 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee	Transportati on	Contracted/Pur		Total (sum of	
			Benefits	(see instructions)	chased Servi ces		cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0		0	0	1.00
	Fixtures			0		Ŭ		
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	C	0 0	0	3.00
4.00 5.00	Transportation Administrative and General	0 471, 674	0	0 4, 289	25, 979	0 0 104, 226	0 606, 168	
5.00	HHA REI MBURSABLE SERVI CES	4/1,0/4	0	4, 207	23, 77	104, 220	000, 100	5.00
6.00	Skilled Nursing Care	434, 625	0	0			434, 625	1
7.00 8.00	Physical Therapy Occupational Therapy	174, 385 174, 246	0	0			174, 385 174, 246	
9.00	Speech Pathology	17, 404	0	0	(C	0 0	17, 404	9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0 49,011	0	0			0 49, 011	
12.00	Supplies (see instructions)	49,011	0	0		5, 769	5, 769	
13.00	Drugs	0	0	0			0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0			0	
17.00	Clinic	0	0	0			0	
19.00	Health Promotion Activities	0	0	0	C	0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	
22.00	Homemaker Service	0	0	0		0	0	
23.00	All Others (specify)	0	0	0	0	0	0	
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	1, 321, 345	0	4, 289	25, 979	109, 995	1, 461, 608	23.50 24.00
	· · · · ·	Recl assi fi cati		Adjustments	Net Expenses			
		on	Trial Balance (col. 6 +		for Allocatior (col. 8 + col.	1		
			col.7)		9)			-
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0	0)		1.00
2.00	Fixtures Capital Related - Movable	0	0	0				2.00
2.00	Equipment	0	0	0				
3.00	Plant Operation & Maintenance							2.00
	The second second set is a second sec	0	0	0	(3.00
4.00 5.00	Transportation Administrative and General	000000000000000000000000000000000000000		0 0 773	C)		
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	606, 168	773	606, 941			3.00 4.00 5.00
5.00 6.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	000	606, 168 434, 625	773	606, 941 434, 625	5		3. 00 4. 00 5. 00 6. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	606, 168	773	606, 941 434, 625	5		3.00 4.00 5.00
5.00 6.00 7.00 8.00 9.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	000000000000000000000000000000000000000	606, 168 434, 625 174, 385	773	606, 941 434, 625 174, 385 174, 246) ; ;		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5.00 6.00 7.00 8.00 9.00 10.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services		606, 168 434, 625 174, 385 174, 246 17, 404 0	773 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
5.00 6.00 7.00 8.00 9.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology		606, 168 434, 625 174, 385 174, 246	773 0 0 0 0	606, 941 434, 625 174, 385 174, 246			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 01 6 49, 011 5, 769			$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ \end{array}\\ \begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		606, 168 434, 625 174, 385 174, 246 17, 40 0 49, 011	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 01 6 49, 011 5, 769			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 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	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			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
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	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 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
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 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
$\begin{array}{c} 5.\ 00\\ \hline 0.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 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
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0		606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 765 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 765 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			$\begin{array}{c} 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ \end{array}\\ \begin{array}{c} 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ \end{array}$
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 23.50	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		606, 168 434, 625 174, 385 174, 246 17, 404 0 49, 011 5, 769 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	606, 941 434, 625 174, 385 174, 246 17, 404 (0 49, 011 5, 769 (0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

Heal th	Financial Systems		SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provider C	CN: 15-0065	Period: From 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7155	To 12/31/2017		pared:
						Home Health	PPS	<u>50 alli</u>
			Capital Rela	ated Costs		Agency I		
		Net Expenses	BIdgs &	Movabl e	Plant	Transportation	Subtotal	-
		for Cost	Fixtures	Equi pment	Operation &		(col s. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col. 10)	1.00		2.00	4.00	14.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.00
2.00	Capital Related - Movable	0		C			C	2.00
3.00	Equipment Plant Operation & Maintenance	0	o	C		0	C	3.00
4.00	Transportation	0	0	Q		0 0		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	606, 941	0	C		0 0	606, 941	5.00
6.00	Skilled Nursing Care	434, 625	0	C		0 0	434, 625	1
7.00 8.00	Physical Therapy Occupational Therapy	174, 385 174, 246	0	0		0 0 0 0	174, 385 174, 246	1
9.00 10.00	Speech Pathology Medical Social Services	17, 404	0	0		0 0	17, 404 C	
11.00	Home Heal th Ai de	49, 011	0	0		0 0	49, 011	
12.00 13.00	Supplies (see instructions) Drugs	5, 769	0	0		0 0	5, 769 C	1
14.00	DME	0	0	0		0 0	C	
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	1	0 0	C	15.00
16.00	Respiratory Therapy	0	ō	0		0 0	C	16.00
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0		
19.00	Health Promotion Activities	0	0	C		0 0	C	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	C		0 0	C	
22.00	Homemaker Service	0	0	0		0 0	C	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0		0 0	C	
24.00	Total (sum of lines 1-23)	1, 462, 381 Admi ni strati ve	0 Total (cols	C		0 0	1, 462, 381	24.00
		& General	4A + 5)					-
	GENERAL SERVICE COST CENTERS	5.00	6.00					
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	101 011						4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	606, 941						5.00
6.00 7.00	Skilled Nursing Care Physical Therapy	308, 370 123, 727	742, 995 298, 112					6.00 7.00
8.00	Occupational Therapy	123, 629	297, 875					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	12, 348	29, 752					9.00 10.00
11.00	Home Health Aide	34, 774	83, 785					11.00
12.00 13.00	Supplies (see instructions) Drugs	4, 093 0	9, 862 0					12.00 13.00
14.00	DME	0	0					14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
	Clinic	0	0					18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.50	Tel emedi ci ne	0	0					23.50
24.00	Total (sum of lines 1-23)	1	1, 462, 381					24.00

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0065 15-7155	Period: From 01/01/2017 To 12/31/2017		pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		· · · · · ·	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	-
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS					-		
1.00	Capital Related - Bldg. & Fixtures	1, 690				0		1.00
2.00	Capital Related – Movable Equipment		1, 840			0		2.00
3.00	Plant Operation & Maintenance	0	0	1, 690		0		3.00
4.00	Transportation (see instructions)	0	0	C		0		4.00
5.00	Administrative and General	1, 690	1, 840	1, 690		0 -606, 941	855, 440	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C		0 0	434, 625	6.00
7.00	Physical Therapy	0	0	C		0 0	174, 385	7.00
8.00	Occupational Therapy	0	0	C		0 0	174, 246	8.00
9.00	Speech Pathology	0	0	C		0 0	17, 404	9.00
10.00	Medical Social Services	0	0	C		0 0	0	10.00
11.00	Home Health Aide	0	0	C		0 0	49, 011	11.00
12.00	Supplies (see instructions)	0	0	C		0 0	5, 769	12.00
13.00	Drugs	0	0	C		0	0	13.00
14.00	DME	0	0	C		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0	C		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	C		0 0	0	17.00
18.00	Clinic	0	0	C		0 0	0	18.00
19.00	Health Promotion Activities	0	0	C		0 0	0	19.00
20.00	Day Care Program	0	0	C		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	C		0 0	0	21.00
22.00	Homemaker Service	0	0	C		0 0	0	22.00
23.00	All Others (specify)	0	0	C		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	C		0 0	0	1
24.00	Total (sum of lines 1-23)	1, 690	1, 840	1, 690		-606, 941	855, 440	
25.00	Cost To Be Allocated (per	0	0	., 0,0		0	606, 941	
	Worksheet H-1, Part I)							
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.0000	00	0. 709507	26.00

LOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CC		Period:	Worksheet H-2	
				HHA CCN:		From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/18/2018 10:	pare 30 a
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency		
	Cost Center Description	HHA Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	{
		Bal ance (1)	bebo a rimi		BENEFITS DEPARTMENT	oub to tai	& GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
0	Administrative and General	0 742, 995	19, 904	881	133, 99			
0 0	Skilled Nursing Care Physical Therapy	742, 995 298, 112	0	0	123, 27 49, 46			
0	Occupational Therapy	290, 112	0	0	49,40			
0	Speech Pathol ogy	29, 752	0	0	4, 93			
0	Medical Social Services	0	0	0		0 0	0	e
0	Home Health Aide	83, 785	0	0	13, 90			
0	Supplies (see instructions)	9, 862	0	0		0 9, 862		
0	Drugs	0	0	0		0 0		
00 00	DME Home Dialysis Aide Services	0	0	0		0 0	0	
00	Respiratory Therapy		0	0		0 0	0	
00	Private Duty Nursing	0	0	0		0 0	0	
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	0		0 0	0	
00	Day Care Program	0	0	0		0 0	0	1
00	Home Delivered Meals Program	0	0	0		0 0	0	
00 00	Homemaker Service All Others (specify)	0	0	0		0 0 0 0	0	
50	Telemedicine	0	0	0		0 0	0	
00	Total (sum of lines 1-19) (2)	1, 462, 381	19, 904	881	374, 98		-	
00	Unit Cost Multiplier: column	, ,				0.000000		21
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT	LINEN SERVICE				ADMI NI STRATI ON	<u> </u>
0	Administrative and General	7.00 37,709	8.00	9.00	10.00	11.00 0 7,471	13.00 67,735	1
0	Skilled Nursing Care	0	0	0,201		0 9, 506		
0	Physical Therapy	0	0	0		0 2,648		
0	Occupational Therapy	0	0	0		0 2,686	24, 351	
0	Speech Pathology	0	0	0		0 221	2,007	
0	Medical Social Services Home Health Aide	0	0	0		0 0	0	
0 0	Supplies (see instructions)		0	0		0 1,610 0 0	14, 595 0	
0	Drugs		0	0		0 0	-	
	DME	0	0	0		0 0	0	
00	Home Dialysis Aide Services	0	0	0		0 0	0	1
00	Respiratory Therapy	0	0	0		0 0	0	12
00	Private Duty Nursing	0	0	0		0 0	0	
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	0		0 0 0 0	0	
00 00	Day Care Program Home Delivered Meals Program		0	0		0 0	0	
00	Homemaker Service	0	0	0		0 0	0	
00	All Others (specify)	0	0	0		0 0	0	
	Tel emedi ci ne	0	0	0		0 0	0	19
	Total (sum of lines 1-19) (2)	37, 709	0	10, 234		0 24, 142	218, 872	
50 00		1						21
50 00 00	Unit Cost Multiplier: column							1
50 00	26, line 1 divided by the sum							
50 00								

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101. 5/18/2018 10:30 am

ALLOCA	ATION OF GENERAL SERVICE COSTS 1	TO HHA COST CENT	TERS	Provider CO	CN: 15-0065 15-7155	Period: From 01/01/2017 To 12/31/2017		pared:
						Home Health	PPS	
					OTHER GENERA	Agency I		
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	
		14.00	15.00	16.00	18.00	19.00	24.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 21. \ 00\\ \end{array}$	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 Homeaker 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 1, rounded to	14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		14,089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			319, 602 1, 116, 304 436, 165 436, 218 43, 097 0 131, 298 131, 298 13, 208 0 <td>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 14.00 15.00 14.00 17.00 18.00 19.00 19.50</td>	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 14.00 15.00 14.00 17.00 18.00 19.00 19.50
	6 decimal places. Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
$\begin{array}{c} 1. 00\\ 2. 00\\ 3. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 13. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 18. 00\\ 19. 00\\ 19. 50\\ 20. 00\\ 21. 00\\ \end{array}$	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 1, rounded to 6 decimal places.	20.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	319, 602 1, 116, 304 436, 165 436, 218 43, 097 0 131, 298 13, 208 0 0 0 0 0 0 0 0 0 0 0 0 0	163, 937 64, 053 64, 061 6, 329 0 19, 282 1, 940 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 280, 2 500, 2 500, 2 49, 4 150, 5 15, 1 2, 495, 8	18 79 26 0 80 48 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101. 5/18/2018 10:30 am

	Financial Systems		SCHNECK MEDIC				u of Form CMS-2	
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS 1	TO HHA COST CEN	TERS STATISTICA	L Provider C HHA CCN:	CN: 15-0065 15-7155	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Pre 5/18/2018 10:	pared
						Home Health	PPS	<u>50 am</u>
		CAPI TAL REL	ATED COSTS			Agency I		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	DNADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATI ON OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\end{array}$	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)	1, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 840 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	472, 448 434, 625 174, 385 174, 246 17, 404 0 49, 011 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{smallmatrix} 0 & 154, 783 \\ 0 & 866, 266 \\ 0 & 347, 572 \\ 0 & 347, 296 \\ 0 & 34, 688 \\ 0 & 0 \\ 0 & 97, 686 \\ 0 & 9, 862 \\ 0 & 0 \\ 0 & $		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 19.50 20.00
21.00	Total cost to be allocated	19, 904	881	374, 987	,	331, 104	37, 709	21.00
22.00	Unit cost multiplier Cost Center Description	11. 777515 LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	0. 478804 HOUSEKEEPI NG (SQUARE FEET)	0. 283626 DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	0. 178190 NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	22.00
1.00	Administrative and General	8.00	9.00	10.00 0	11.00 11,1	13.00	14.00 0	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\end{array}$	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) Total cost to be allocated Unit cost multiplier		1, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		14, 2 3, 9, 4, 0 3 2, 4 2, 4 3 3 6 3 6 3 6 3 6 9 3 6, 0 2 4, 1	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	0 0 0 0 9, 508 0 0 0 0 0 0 0 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 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 19.00 19.00 20.00 21.00

ALLCOATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS Provider CON: 15-0065 HHA CCN: Period: 15-0065 HHA CCN: Period: To m 01/01/2017 To m 01/01/2017 Period: To m 01/2017 Period	Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
HHA CCN: HHA CCN: 15-7155 To 12/31/2017 Date/Time Prepared: 518/2018 10:30 am Cost Center Description PHARMACY (COSTED REOULS.) MEDICAL RECORDS & LIBRARY (GROSS OTHER CENERAL SERVICE PHYSICIAN PRIVATE NONPHYSICIAN ANESTHETISTS (ASSI GRUED NONPHYSICIAN ANESTHETISTS (ASSI GRUED NONPHYSICIAN ANESTHETISTS 1.00 Administrative and General 0 2.419,071 0 0 0 2.00 3.00 Physical Therapy 0 0 0 0 0 2.00 3.00 Occupational Therapy 0 0 0 0 0 0 0 2.00 3.00 Dypical Therapy 0		TO HHA COST CEN	TERS STATISTICA	AL Provider C	CN: 15-0065			
Cost Center Description PHARMACY (COSTED REOUIS.) MEDICAL RECORDS & LIBRARY (GROSS CHARGES) OTHER GENERAL SERVICE PHYSICIAN PRVATE PRACTICE NONPHYSICIAN PRVATE PRACTICE NONPHYSICIAN PRACTICE 1.00 Administrative and General 0.00 0 0 15.00 16.00 19.00 1 0 2.00 Skilled Nursing Care 0.00 0 0 0 0 0 0 2.00 3.00 Physical Therapy 0.00 0 0 0 0 0 0 2.00 0.00 Speech Pathology 0.00 0	BASIS			HHA CCN:	15-7155			pared:
Cost Center Description PHARMACY (COSTED REQUIS.) MEDICAL RECORDS & LI BRARY (GROSS OTHER GENERAL SERVICE NONPHYSICIAN PRIVATE NONPHYSICIAN AMESTHETISTS (ASSIGNED NONPHYSICIAN AMESTHETISTS (ASSIGNED 1.00 Administrative and General 0.00 0 0 19.00 10.00 1.00 Administrative and General 0.00 0 0 19.00 10.00 1.00 Administrative and General 0.00 0 0 10.00 18.00 19.00 1.00 Administrative and General 0.00 0 0 0 10.00 2.00 2.00 Skilled Nursing Care 0.00 0 0 0 0 10.00 3.00 Hysical Therapy 0.00 0 0 0 0 2.00 4.00 Occupational Therapy 0.00 0 0 0 0 0 0 0 0.00 Drugs 0 0 0 0 0 0 0 0 0.00 Drugs 0 0 0 0 0 0 <								<u>30 am</u>
Cost Center Description PHARMACY (COSTED, REOU MEDICAL RECORDS & LIBRAR (GROSS) OTHER GENERAL PHYSICIAN PRATICE (CROSTS) NONPHYSICIAN ARESTHETISTS (SSIGNED TIME) 1.00 Administrative and General 0 2,419,071 0 0 1.00 2.00 Skilled Nursing Care 0 2,419,071 0 0 2.00 3.00 Physical Therapy 0 0 0 0 3.00 0.00 Skilled Nursing Care 0 0 0 0 2.00 3.00 Physical Therapy 0 0 0 0 0 3.00 0.00 Speech Pathology 0 0 0 0 3.00 0.00 Supplies (see instructions) 0							PPS	
Cost Center Description PHARMACY (COSTED REDUIS.) MEDICAL RECORDS & EQUIS.) MEDICAL RECORDS & LIBRARY (GROSS SERVICE PHYSICIAN PRIVATE (CASSIGNED TIME) NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME) 1.00 Administrative and General 2.00 0 15.00 16.00 18.00 19.00 1.00 Skilled Nursing Care 0.00 0 0 0 0 0 0 0.00 Physical Therapy 0.00 0 0 0 0 0 0 0 0.00 Speech Pathology 0.00 0				OTHER GENERAL		Agency I		
Image: Constraint of the								
REQUIS.) LIBRARY (GROSS PRACTICE (TIME (ASSIGNED TIME) 1.00 Administrative and General 0 2,419,071 0 0 10.00 2.00 Skilled Nursing Care 0 0 0 0 2.00 3.00 3.00 Physical Therapy 0 0 0 0 3.00 4.00 Occupational Therapy 0 0 0 0 3.00 5.00 Speech Pathology 0 0 0 0 3.00 6.00 Medical Social Services 0 0 0 0 6.00 6.00 Brugs 0 0 0 0 0 0 0.00 Drugs 0	Cost Center Description	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSICIA	N		1
Image: Construction of the second system of the s						S		
Image: Charges bit is spend of the second		REQUIS.)						
Image: 15.00 16.00 18.00 19.00 1.00 Admin is strative and General 0 2,419,071 0 0 2.00 Skilled Nursing Care 0 0 0 0 0 3.00 Physical Therapy 0 0 0 0 3.00 4.00 Occupational Therapy 0 0 0 0 3.00 5.00 Speech Pathology 0 0 0 0 4.00 5.00 Speech Pathology 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 0 10.00 11.00 Home Dial ysis Aide Services 0 0 0 10.00 11.00 12.00 Respiratory Therapy 0 0 0 0					IIME)			
1.00 Administrative and General 0 2,419,071 0 0 1.00 2.00 Skilled Nursing Care 0 0 0 0 0 0 3.00 Physical Therapy 0		15.00			19.00			-
2.00 Skilled Nursing Care 0 0 0 0 3.00 3.00 Physical Therapy 0 0 0 0 3.00 4.00 Occupational Therapy 0 0 0 0 4.00 5.00 Speech Pathology 0 0 0 0 5.00 6.00 Medical Social Services 0 0 0 0 6.00 7.00 Home Health Aide 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 Drugs 0 0 0 9.00 11.00 Home Dialysis Aide Services 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 11.00 13.00 Private Duty Nursing 0 0 0 13.00 14.00 Clinic 0 0 0 14.00 15.00 Health Promotion Activities 0 0 0 15.00 16.00 Da	1.00 Administrative and General			0	17.00	0		1.00
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 Ai de 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 Drugs 0 0 0 0 8.00 9.00 DME 0 0 0 0 9.00 11.00 Home Dialysis Aide Services 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 11.00 13.00 Private Duty Nursing 0 0 0 13.00 14.00 Clinic 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 0 17.00 18.00 Homemaker Serv		0	0	0		0		2.00
5.00 Speech Pathology 0 0 0 0 5.00 6.00 Medical Social Services 0 0 0 0 6.00 6.00 7.00 Home Heal th Aide 0 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 7.00 8.00 9.00	3.00 Physical Therapy	0	0	0		0		3.00
6.00 Medical Social Services 0 0 0 0 0 7.00 Home Heal th Aide 0 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 9.00 10.00 DME 0 0 0 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 10.00 12.00 Respiratory Therapy 0 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 14.00 15.00 15.00 Heal th Promotion Activities 0 0 0 0 16.00 17.00 18.00 Homemaker Service 0 0 0 0 17.00 <t< td=""><td></td><td>0</td><td>0</td><td>0</td><td></td><td>0</td><td></td><td></td></t<>		0	0	0		0		
7.00 Home Heal th Ai de 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 0 9.00 Drugs 0 0 0 0 9.00 10.00 DME 0 0 0 0 10.00 11.00 Home Dial ysis Aide Services 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 18.00 17.00 18.00 19.00		0	0	0		0		
8.00 Supplies (see instructions) 0 0 0 0 0 0 9.00 9.00 Drugs 0 0 0 0 0 9.00 10.00 DME 0 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 Private Duty Nursing 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 Day Care Program 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 19.50 Telemedicine 0 0 0 19.50 20.00 Total (sum of Lines 1-19) 2,419,071 0		0	0	0		0		
9.00 Drugs 0 0 0 0 0 0 10.00 DME 10.00 10.00 11.00 10.00 11.00 11.00 11.00 11.00 12.00 12.00 13.00 12.00 13.00 14.00 0 0 0 0 13.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00 16.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 10.00 17.00 10.00 17.00 10.00 17.00 10.00 10.00 17.00 10.00 10.00 17.00 10.00 17.00 10.00 17.00 10.00 17.00 10.00 17.00 10.00 17.00 10.00 19.00		0	0	0		0		
10.00 DME 0 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 12.00 Respiratory Therapy 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 15.00 15.00 Health Promotion Activities 0 0 0 0 16.00 16.00 Day Care Program 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 19.00 19.00 19.50 Telemedicine 0 0 0 0 19.00 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 21.00		0	0	0		0		
11.00 Home Dialysis Aide Services 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 13.00 14.00 Clinic 0 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 Day Care Program 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 emedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 21.00		0	0	0		0		
12.00 Respiratory Therapy 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 14.00 15.00 Heal th 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 emedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 21.00 Total cost to be allocated 0 14,089 0 0 21.00		0	0	0		0		
14.00 Clinic 0 0 0 14.00 15.00 Heal th Promotion Activities 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 0 17.00 18.00 Homemaker Service 0 0 0 0 18.00 19.00 Al I Others (specify) 0 0 0 19.00 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 21.00		0	0	0		0		
15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 Day Care Program 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 Telemedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 21.00		0	0	0		0		13.00
16.00 Day Care Program 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 Telemedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 24,419,071 0 0 20.00 21.00 Total cost to be allocated 0 14,089 0 0 21.00		0	0	0		0		
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 emedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2, 419, 071 0 0 20.00 21.00 Total cost to be allocated 0 14, 089 0 0 21.00		0	0	0		0		
18.00 Homemaker Service 0 0 0 18.00 19.00 All Others (specify) 0 0 0 19.00 19.50 Tel emedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2, 419, 071 0 0 20.00 21.00 Total cost to be allocated 0 14, 089 0 0 21.00		0	0	0		0		
19.00 All Others (specify) 0 0 0 19.00 19.50 Telemedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 21.00 Total cost to be allocated 0 14,089 0 0 21.00		0	0	0		0		
19.50 Telemedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 21.00 Total cost to be allocated 0 14,089 0 0 21.00		0	0	0		0		
20.00 Total (sum of lines 1-19) 0 2,419,071 0 0 20.00 20.00 21.00 21.00 0 0 0 0 10.00 21.			0	0		0		
21.00 Total cost to be allocated 0 14,089 0 0 0		0	2 419 071	0		0		
		0		0		0		
		0. 000000			0.0000	00		22.00

	Financial Systems		SCHNECK MEDI			In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-0065	Period: From 01/01/2017	Worksheet H-3 Part I	
				HHA CCN:	15-7155	To 12/31/2017		
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (col s. + 2)	1	Per Visit (col. 3 ÷ col.	
		20, 11110	11-2, Tart 1)	Part II)	+ 2)		4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	ITATION COST, OF	R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1, 280, 241		1, 280, 24	1 3, 575	358. 11	1.00
2.00	Physical Therapy	3.00		C				2.00
3.00	Occupational Therapy	4.00		C				
4.00	Speech Pathol ogy	5.00		C	49, 42			
5.00 6.00	Medical Social Services Home Health Aide	6. 00 7. 00			150, 58	0 23 0 1, 168		
7.00	Total (sum of lines 1-6)	7.00	2, 480, 744	C				7.00
			2/100//11		Program Visit			7100
						nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
					Deductibles Coinsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	C				8.00
8.01	Skilled Nursing Care		31140 18020			3		8. 01 8. 02
8.02 9.00	Skilled Nursing Care Physical Therapy		99915					9.02
9.00	Physical Therapy		31140	0		8		9.01
9.02	Physical Therapy		18020	C		9		9. 02
10.00	Occupational Therapy		99915	C	, , , , , , , , , , , , , , , , , , , ,			10.00
10.01	Occupational Therapy		31140	0		9		10.01
10. 02 11. 00	Occupational Therapy Speech Pathology		18020 99915			8		10.02 11.00
11.00	Speech Pathology		31140	0		0		11.00
11.02	Speech Pathol ogy		18020	C		6		11.02
12.00	Medical Social Services		99915	C	D	9		12.00
12.01	Medical Social Services		31140	C		0		12.01
12.02 13.00	Medical Social Services Home Health Aide		18020 99915		39	1		12.02 13.00
13.00	Home Health Aide		31140))	9		13.00
13.02	Home Heal th Aide		18020	C	5	9		13.02
14.00	Total (sum of lines 8-13)			C		4		14.00
	Cost Center Description		Facility Costs		Total HHA	Total Charges		
		Part I, col. 28. line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (col s. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 1110	11 2, 101(1)	Part II)	1 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa							
15.00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00				8 45, 578 0 0		
16.00			Program Visits	(Cost of	0 0	0.000000	16.00
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Deductibles & Coinsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
				corrisul anec				
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		7.00					
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	7.00 PROGRAM COST, A			ITATION COST, OF	R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	OF AGGREGATE F	7.00 PROGRAM COST, A 1,879			0 672, 889	R	
1.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE F	7.00 PROGRAM COST, A 1,879 1,195			0 672, 889 0 257, 212	R	2.00
2.00 3.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE F	7.00 PROGRAM COST, A 1,879 1,195 769			0 672, 889 0 257, 212 0 256, 646	R	2.00 3.00
2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE F	7.00 PROGRAM COST, A 1,879 1,195 769 40			0 672, 889 0 257, 212	R	2.00 3.00 4.00
2.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE F	7.00 PROGRAM COST, A 1,879 1,195 769 40 10 10	GGREGATE OF TH		I TATI ON COST, OI 0 672, 889 0 257, 212 0 256, 646 0 14, 223	R	1.00 2.00 3.00 4.00 5.00 6.00 7.00

	Financial Systems IONMENT OF PATIENT SERVICE COST	S	SCHNECK MEDI	Provider CC	15-7155	Period: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet H-3 Part I Date/Time Pre 5/18/2018 10:	epared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation						- -	
$\begin{array}{c} 8.\ 00\\ 8.\ 01\\ 8.\ 02\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 11.\ 00\\ 11.\ 01\\ 11.\ 02\\ 12.\ 00\\ 12.\ 01\\ 12.\ 02\\ 13.\ 00\\ 13.\ 01\\ 13.\ 02\\ 14.\ 00\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide Total (sum of lines 8-13)							$\begin{array}{c} 8. \ 00\\ 8. \ 01\\ 8. \ 02\\ 9. \ 00\\ 9. \ 01\\ 9. \ 02\\ 10. \ 00\\ 10. \ 01\\ 10. \ 02\\ 11. \ 00\\ 11. \ 01\\ 11. \ 02\\ 12. \ 00\\ 12. \ 01\\ 12. \ 02\\ 13. \ 00\\ 13. \ 01\\ 13. \ 02\\ 14. \ 00\\ \end{array}$
		Progi	ram Covered Cha	arges	Cost of			
	Cost Center Description		Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Services Part A	Part B Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	
	Supplies and Drugs Cost Computa	6.00 ations	7.00	8.00	9.00	10.00	11.00	
15.00	Cost of Medical Supplies	0	15, 602			0 5, 185		
16.00	Cost of Drugs Cost Center Description	Total Program	0	0		0	C	16.00
		Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER		ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	۱ ۲	
	BENEFICIARY COST LIMITATION							_
1.00	Cost Per Visit Computation Skilled Nursing Care	672, 889						1.00
2.00	Physical Therapy	257, 212						2.00
3.00	Occupational Therapy	256, 646						3.00
4.00	Speech Pathology	14, 223						4.00
5.00	Medical Social Services	0						5.00
6.00 7.00	Home Health Aide Total (sum of lines 1–6)	63, 300 1, 264, 270						6.00 7.00
7.00	Cost Center Description	1,201,270			-			7.00
	· · ·	12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care							8. 01 8. 02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9. 02
10.00	Occupational Therapy							10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy							10. 01 10. 02
11.00	Speech Pathol ogy							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12. 01 12. 02	Medical Social Services Medical Social Services							12.01 12.02
12.02 13.00	Home Health Aide							12.02
13.00	Home Heal th Ai de							13.00
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C		Period: From 01/01/2017	Worksheet H-3 Part II	
			HHA CCN:	15-7155	To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Rati o	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 SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66.00	0. 548241	0)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 267992	0		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 479360	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	1. 327498	0		0 col. 2, line 1	5. 00	4.00
5.00 Cost of Drugs	73.00	0. 593182	0		0 col. 2, line 1	6. 00	5.00

^{5/18/2018 10:30} am

LCULAT	i nanci al Systems SCHNECK MEDI CAL FI ON OF HHA REI MBURSEMENT SETTLEMENT	Provider CC	N: 15-0065	Peri od:	Worksheet H-4	
		HHA CCN:	15-7155	From 01/01/2017 To 12/31/2017	Part I-II Date/Time Pre 5/18/2018 10:	
		Title	XVIII	Home Health	PPS	
				Agency I Par	t B	
			Part A	Not Subject to Deductibles &		
				Coi nsurance	Coi nsurance	
	ART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO		1.00	2.00	3.00	
	easonable Cost of Part A & Part B Services	WART CHARGES	>			1
	leasonable cost of services (see instructions)			0 0	0	1 ·
	otal charges			0 0	0	1 :
	ustomary Charges mount actually collected from patients liable for payment for			0 0	0	Ι.
	n a charge basis (from your records)	Services		0 0	0	:
	mount that would have been realized from patients liable for	payment		0 0	0	
	for services on a charge basis had such payment been made in a rith 42 CFR §413.13(b)	accordance				
	atio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0. 000000	0. 000000	!
	otal customary charges (see instructions)			0 0	0	
	xcess of total customary charges over total reasonable cost (complete		0 0	0	
	nly if line 6 exceeds line 1) xcess of reasonable cost over customary charges (complete onl	vifline		0 0	0	
	exceeds line 6)	y i i i i i i i		0	0	
) P	rimary payer amounts			0 0	0	
				Part A Services	Part B Services	
				1.00	2.00	\vdash
	ART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	otal reasonable cost (see instructions)			0	0	
	otal PPS Reimbursement - Full Episodes without Outliers otal PPS Reimbursement - Full Episodes with Outliers			0	667, 703 50, 671	
	otal PPS Reimbursement - LUPA Episodes			0	14, 129	
т ос	otal PPS Reimbursement - PEP Episodes			0	2, 358	
	otal PPS Outlier Reimbursement - Full Episodes with Outliers			0	9, 957	
	otal PPS Outlier Reimbursement – PEP Episodes otal Other Payments			0	1, 941 0	
	ME Payments			0	0	
	xygen Payments			0	0	1
	rosthetic and Orthotic Payments	,		0	0	
	eart B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21)	irance)		0	0 746, 759	
	ixcess reasonable cost (from line 8)			0	0	
00 S	ubtotal (line 22 minus line 23)			0	746, 759	
	coinsurance billed to program patients (from your records)				0	
	let cost (line 24 minus line 25) laimbursable bad debts (from your records)			0	746, 759	2
	eimbursable bad debts (from your records) eimbursable bad debts for dual eligible beneficiaries (see ir	nstructions)				2
	fotal costs - current cost reporting period (line 26 plus line			0	746, 759	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	
	ioneer ACO demonstration payment adjustment (see instructions	5)		0	0	
	emonstration payment adjustment amount before sequestration ubtotal (see instructions)			0	746, 759	
	equestration adjustment (see instructions)			0	14, 912	
02 D	emonstration payment adjustment amount after sequestration			0	1, 173	3
00 1	nterim payments (see instructions)			0	730, 674	
	entative settlement (for contractor use only)			0	0	3:
00 T	alance due provider/program (line 31 minus lines 31.01, 32, a	and 33)		0	0	

	Financial Systems SCHNECK MEDICA	Provider CC	CN: 15-0065	Peri od:	Worksheet H-5	
PR(IGRAM BENEFI CI ARI ES	HHA CCN:	15-7155	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/18/2018 10:3	bare
				Home Health Agency I	PPS	<u>50 c</u>
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0	730, 674 0	1 2
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3
	Program to Provider					
D1				0	0	3
)2)3				0 0	0	
)3)4				0	0	
)5				0	0	
	Provider to Program					
0				0	0	;
1				0	0	
52 53				0	0	
54 54				0	0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	;
	3. 50-3. 98)					
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	730, 674	
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					į
)1	Program to Provider			0	0	Ę
)1)2				0	0	ļ
)3				0	0	Ę
	Provider to Program					
50				0	0	Į
51 52				0	0	į
o∠ 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	ļ
	5. 50-5. 98)			-		
0	Determined net settlement amount (balance due) based on the cost report. (1)					(
)1	SETTLEMENT TO PROVIDER			0	1, 173	(
)2	SETTLEMENT TO PROGRAM			0	0	(
00	Total Medicare program liability (see instructions)			0 Contractor	731, 847	-
				Contractor Number	NPR Date (Mo/Day/Yr)	

	Financial Systems S OF HOSPITAL-BASED HOSPICE COSTS	SCHNECK MEDICA		:CN: 15-0065	Peri od:	u of Form CMS- Worksheet O	2552-10
			Hospi ce CC	N: 15-1529	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	pared: 30 am
					Hospi ce I	0,10,2010 101	
		SALARI ES	OTHER	SUBTOTAL (cc 1 plus col.		SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT*		12,000			12,000	
	CAP REL COSTS-MVBLE EQUIP*		11, 808	3 11,8		11, 808	
	EMPLOYEE BENEFITS DEPARTMENT*	0	(0 0	0	
	ADMI NI STRATI VE & GENERAL*	24, 280	45, 323			69, 603	
	PLANT OPERATION & MAINTENANCE* LAUNDRY & LINEN SERVICE*	0	15, 461	1 15, 4	0 0	15, 461	
	HOUSEKEEPING*	0	(0 0	0	
	DI ETARY*	0	(0 0	0	
	NURSI NG ADMI NI STRATI ON*	0	(0 0	0	
	ROUTINE MEDICAL SUPPLIES*	0	5, 864	1 5, 8	0 0 864 0	5, 864	
	MEDICAL RECORDS*	0	5,00-	- - -		0	
	STAFF TRANSPORTATION*	0	(0 0	0	
1	VOLUNTEER SERVICE COORDINATION*	0	(0 2,879	2, 879	
1	PHARMACY*	0	1, 681	1,6		1, 681	1
	PHYSICIAN ADMINISTRATIVE SERVICES*	o	(0 0	0	1
	OTHER GENERAL SERVICE*	0	3, 336	3, 3	36 0	3, 336	
	PATIENT/RESIDENTIAL CARE SERVICES						17.00
C	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		(D	0 0	0	25.00
26.00 I	PHYSI CLAN SERVI CES**	81, 762	566	5 82, 3	28 0	82, 328	26.00
27.00	NURSE PRACTITIONER**	0	(D	0 0	0	27.00
28.00 I	REGI STERED NURSE**	317, 254	(317, 2	254 0	317, 254	28.00
29.00	LPN/LVN**	0	(D	0 0	0	29.00
	PHYSI CAL THERAPY**	0	(D	0 0	0	
	OCCUPATIONAL THERAPY**	0	(D	0 0	0	
	SPEECH/LANGUAGE PATHOLOGY**	0	(0	0 0	0	
	MEDICAL SOCIAL SERVICES**	0	()	0 79, 720		
	SPIRITUAL COUNSELING**	108, 507	(108, 5	-82, 599	25, 908	
	DI ETARY COUNSELI NG**	0	()	0 0	0	
	COUNSELING - OTHER**	0 0 0	(0 0	0	
	HOSPICE AIDE & HOMEMAKER SERVICES**	95, 244	(1 50)	95, 2		95, 244	
	DURABLE MEDI CAL EQUI PMENT/OXYGEN** PATI ENT TRANSPORTATI ON**	0	61, 586 15, 089			61, 586 15, 089	
	IMAGING SERVICES**	0	15,065	15,0	0 0	15,089	
	LABS & DI AGNOSTI CS**	0			0 0	0	1
	MEDICAL SUPPLIES-NON-ROUTINE**	0	4, 664	4,6	64 0	4, 664	
	DRUGS CHARGED TO PATIENTS**	0	1,00	1, 0	0 0	0	
	OUTPATI ENT SERVICES**	0	(0 0	0	
	PALLIATIVE RADIATION THERAPY**	o	(0 0	0	
	PALLIATIVE CHEMOTHERAPY**	0	C		0 0	0	1
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	2, 973	(2,9	73 0	2, 973	46.00
Ν	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	(D	0 0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	(D	0 0	0	61.00
	FUNDRAI SI NG*	0	(D	0 0	0	62.00
63.00 I	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	(D	0 0	0	63.00
	PALLIATIVE CARE PROGRAM*	0	(2	0 0	0	
	OTHER PHYSICIAN SERVICES*	0	(ן ע	0 0	0	
	RESIDENTIAL CARE*	0	(0 0	0	
	ADVERTI SI NG*	0	(2	0 0	0	
	TELEHEALTH/TELEMONI TORI NG*	0	0	2	0 0	0	
	THRIFT STORE*	0	(2	U 0	0	
	NURSING FACILITY ROOM & BOARD*	0	(2	0 0	0	
71.00 (100.00	OTHER NONREIMBURSABLE (SPECIFY)*	630, 020	ر 177, 378	807,3		0 807, 398	
	IUTAL	0.30, 020	1// 3/8	י אט א <u>ו</u>	10701 ()	i 807.398	TTUU, UU

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

IALYSI	S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN:		Period: From 01/01/2017	Worksheet 0	
			Hospice CCN:	15-1529	To 12/31/2017 Hospi ce I	Date/Time Prep 5/18/2018 10:3	
		ADJUSTMENTS	TOTAL (col. 5		Nospi ce i		
		6.00	<u>± col. 6)</u> 7.00				
	SENERAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT*	0	12,000				1.
	CAP REL COSTS-MVBLE EQUIP*	0	11, 808				2.
	EMPLOYEE BENEFITS DEPARTMENT* ADMINISTRATIVE & GENERAL*	0	69, 603				3
	PLANT OPERATION & MAINTENANCE*	0	15, 461				5
	LAUNDRY & LINEN SERVICE*	0	0				6
00 H	HOUSEKEEPI NG*	0	0				7
00 [DI ETARY*	0	0				8
1 OC	NURSING ADMINISTRATION*	0	0				9
	ROUTINE MEDICAL SUPPLIES*	0	5, 864				10
	MEDI CAL RECORDS*	0	0				11
	STAFF TRANSPORTATION*	0	0				12
	VOLUNTEER SERVICE COORDINATION*	0	2, 879				13
		0	1, 681				14
	PHYSI CI AN ADMI NI STRATI VE SERVI CES* OTHER GENERAL SERVI CE*	0	0 3, 336				15 16
	PATIENT/RESIDENTIAL CARE SERVICES	0	3, 330				17
-	DI RECT PATI ENT CARE SERVI CE COST CENTERS		I I				1 ''
	INPATIENT CARE-CONTRACTED**	0	0				25
	PHYSICIAN SERVICES**	0	82, 328				26
00 1	NURSE PRACTITIONER**	0	0				27
	REGI STERED NURSE**	0	317, 254				28
00	LPN/LVN**	0	0				29
	PHYSI CAL THERAPY**	0	0				30
	OCCUPATIONAL THERAPY**	0	0				31
	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
	MEDICAL SOCIAL SERVICES** SPIRITUAL COUNSELING**	0	79, 720 25, 908				33
	DI ETARY COUNSELING**	0	25, 908				35
	COUNSELING - OTHER**	0	0				36
	HOSPICE AIDE & HOMEMAKER SERVICES**	0	95, 244				37
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	61, 586				38
00	PATI ENT TRANSPORTATI ON**	0	15, 089				39
00	IMAGING SERVICES**	0	0				40
	LABS & DI AGNOSTI CS**	0	0				41
	MEDICAL SUPPLIES-NON-ROUTINE**	0	4, 664				42
	DRUGS CHARGED TO PATIENTS**	0	0				42
	DUTPATIENT SERVICES** PALLIATIVE RADIATION THERAPY**	0	0				43
	PALLIATIVE RADIATION THERAPY	0					44
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	2, 973				40
	IONREI MBURSABLE COST CENTERS	0	2,713				
	BEREAVEMENT PROGRAM *	0	0				60
	VOLUNTEER PROGRAM *	0	0				61
00 1	FUNDRAI SI NG*	0	0				62
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSICIAN SERVICES*	0	0				65
	RESIDENTIAL CARE*	0	0				66
	ADVERTI SI NG*	0	0				67
	TELEHEALTH/TELEMONI TORI NG*	0	0				68
	THRIFT STORE* NURSING FACILITY ROOM & BOARD*		0				69 70
	OTHER NONREIMBURSABLE (SPECIFY)*		0				71
	TOTAL	0	807, 398				100

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

Health Financial Systems	SCHNECK MEDICA			In Lie	u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E CONTINUOUS	Provider C	CN: 15-0065	Period:	Worksheet 0-1	
HOME CARE		Hospi ce CC	N: 15-1529	From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
			10 1027	10 12/01/2017	5/18/2018 10:	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (co		SUBTOTAL	
			1 + col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS	,					
25.00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSI CLAN SERVI CES	0	C		0 0	C	
27.00 NURSE PRACTITIONER	0	C		0 0	C	1 27.00
28.00 REGI STERED NURSE	0	C		0 0	C	20.00
29.00 LPN/LVN	0	C		0 0	C	
30. 00 PHYSI CAL THERAPY	0	C		0 0	C	00.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	
32.00 SPEECH/LANGUAGE PATHOLOGY	0	C		0 0	C	
33.00 MEDICAL SOCIAL SERVICES	0	C		0 0	C	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	C		0 0	C	34.00
35. 00 DI ETARY COUNSELI NG	0	C		0 0	C	35.00
36.00 COUNSELING - OTHER	0	C		0 0	C	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	C		0 0	C	
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C		0 0	C	38.00
39.00 PATIENT TRANSPORTATION	0	C		0 0	C	39.00
40.00 I MAGI NG SERVI CES	0	C		0 0	C	40.00
41.00 LABS & DIAGNOSTICS	0	C		0 0	C	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	C		0 0	C	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	C		0 0	C	42.50
43. 00 OUTPATI ENT SERVICES	0	C)	0 0	C	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	C		0 0	C	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	C		0 0	C	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	C		0 0	C	46.00
100.00 TOTAL *	0	0		0 0	0	100.00

 100.00
 TOTAL *
 0

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	0	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	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT 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	0	46.00
100.00	TOTAL *	0	0	100.00
* Trar	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 50.		

Health Financial Systems	SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS F	OR HOSPICE ROUTINE HOME	Provider C		Peri od:	Worksheet 0-2	
CARE		Hospi ce CC		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/18/2018 10:	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATI ONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CE	NTERS					
25.00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSI CI AN SERVI CES	78, 743	545	79, 28	38 0	79, 288	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	305, 538	0	305, 53	38 0	305, 538	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	0	0		0 76, 776	76, 776	33.00
34.00 SPIRITUAL COUNSELING	104, 500	0	104, 50	-79, 549	24, 951	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	91, 727	0	91, 72	27 0	91, 727	37.00
38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	61, 586	61, 58	36 0	61, 586	38.00
39.00 PATIENT TRANSPORTATION	0	14, 531			14, 531	
40.00 I MAGI NG SERVI CES	0	0		0 0	0	
AL OD LARS & DIACNOSTICS		0			0	1 11 00

101.00				, v	•	•	101.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	4, 492	4, 492	0	4, 492	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	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)	2, 863	0	2, 863	0	2, 863	46.00
100.00	TOTAL *	583, 371	81, 154	664, 525	-2, 773	661, 752	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 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			2	25.00
26.00	PHYSI CI AN SERVI CES	0	79, 288	2	26.00
27.00	NURSE PRACTITIONER	0	0	2	27.00
28.00	REGI STERED NURSE	0	305, 538	2	28.00
29.00	LPN/LVN	0	0	2	29.00
30.00	PHYSI CAL THERAPY	0	0	3	30.00
31.00	OCCUPATIONAL THERAPY	0	0	3	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	3	32.00
33.00	MEDICAL SOCIAL SERVICES	0	76, 776	3	33.00
34.00	SPI RI TUAL COUNSELI NG	0	24, 951	3	34.00
35.00	DI ETARY COUNSELI NG	0	0	3	35.00
36.00	COUNSELING - OTHER	0	0	3	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	91, 727	3	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	61, 586	3	38.00
39.00	PATIENT TRANSPORTATION	0	14, 531	3	39.00
40.00	I MAGI NG SERVI CES	0	0	4	40.00
41.00	LABS & DIAGNOSTICS	0	0	4	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	4, 492	4	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	4	42.50
43.00	OUTPATI ENT SERVICES	0	0	4	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	4	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	4	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 863	4	46.00
100.00	TOTAL *	0	661, 752	10	00.00

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

ANALYSI S OF HOSPI TAL-BASED HOSPI CE COSTS FOR HOSPI CE INPATI ENT RESPI TE CARE Provi der CCN: 15-00 Hospi ce CCN: 15-1	529 From To (col. R 1. 2)	m 01/01/2017	Worksheet 0-3 Date/Time Prep 5/18/2018 10:3 SUBTOTAL 5.00	
Hospice CCN: 15-1 SALARIES OTHER SUBTOTAL 1:00 2:00 3:0 DI RECT PATIENT CARE SERVICE COST CENTERS 0 1 + cc 25:00 INPATIENT CARE-CONTRACTED 0 3:0 26:00 PHYSICIAN SERVICES 2,436 17 27:00 NURSE PRACTITIONER 0 0 28:00 REGISTERED NURSE 9,453 0 29:00 LPN/LVN 0 0 30:00 PHYSICAL THERAPY 0 0 31:00 OCCUPATIONAL THERAPY 0 0 32:00 SPEECH/LANGUAGE PATHOLOGY 0 0 33:00 MEDI CAL SOCIAL SERVICES 0 0 34:00 SPIRITUAL COUNSELING 3,233 0 35:00 DI ETARY COUNSELING 0 0 36:00 COUNSELING - OTHER 0 0 37:00 HOSPICE AI DE & HOMEMAKER SERVICES 2,838 0 38:00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0	529 To - (col . R 1. 2) 00 0	12/31/2017 Hospi ce I RECLASSI FI - CATI ONS	5/18/2018 10: 3 SUBTOTAL 5. 00	
DI RECT PATIENT CARE SERVICE COST CENTERS 0 1 + cc 25.00 INPATIENT CARE-CONTRACTED 0 0 26.00 PHYSI CI AN SERVICES 2,436 17 27.00 NURSE PRACTITIONER 0 0 28.00 REGI STERED NURSE 9,453 0 29.00 LPN/LVN 0 0 30.00 PHYSI CAL THERAPY 0 0 31.00 OCCUPATI ONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCI AL SERVICES 0 0 33.00 MEDI CAL SOCI AL SERVICES 0 0 35.00 DI ETARY COUNSELI NG 3,233 0 35.00 DI ETARY COUNSELI NG 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2,838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATIENT TRANSPORTATION 0	(col. R 1.2) 00 0	RECLASSI FI - CATI ONS	SUBTOTAL 5. 00	<u>30 am</u>
DI RECT PATIENT CARE SERVICE COST CENTERS 0 1 + co 25.00 INPATIENT CARE-CONTRACTED 0 0 26.00 PHYSICIAN SERVICES 2,436 17 27.00 NURSE PRACTITIONER 0 0 28.00 REGISTERED NURSE 9,453 0 29.00 LPN/LVN 0 0 30.00 PHYSICAL THERAPY 0 0 31.00 OCCUPATIONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCIAL SERVICES 0 0 34.00 SPIRI TUAL COUNSELING 3,233 0 35.00 DI ETARY COUNSELING 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2,838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATIENT TRANSPORTATION 0 450 40.00 IMAGI NG SERVICES 0 0	(col. R 1.2) 00 0	RECLASSI FI - CATI ONS	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS 0 1 + co 25.00 INPATIENT CARE-CONTRACTED 0 0 26.00 PHYSICIAN SERVICES 2,436 17 27.00 NURSE PRACTITIONER 0 0 28.00 REGISTERED NURSE 9,453 0 29.00 LPN/LVN 0 0 30.00 PHYSICAL THERAPY 0 0 31.00 OCCUPATIONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCIAL SERVICES 0 0 34.00 SPIRI TUAL COUNSELING 3,233 0 35.00 DI ETARY COUNSELING 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2,838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATIENT TRANSPORTATION 0 450 40.00 IMAGI NG SERVICES 0 0	0	CATIONS	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS 25. 00 INPATIENT CARE-CONTRACTED 0 26. 00 PHYSICIAN SERVICES 2, 436 17 7. 00 NURSE PRACTITIONER 0 0 28. 00 REGISTERED NURSE 9, 453 0 29. 00 LPN/LVN 0 0 31. 00 OCCUPATIONAL THERAPY 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDI CAL SOCIAL SERVICES 0 0 34. 00 SPI RI TUAL COUNSELING 3, 233 0 35. 00 DI ETARY COUNSELING 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVICES 2, 838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATIENT TRANSPORTATION 0 450 40. 00 IMAGING SERVICES 0 0	0			
DI RECT PATI ENT CARE SERVI CE COST CENTERS 25. 00 INPATI ENT CARE-CONTRACTED 0 26. 00 PHYSI CI AN SERVI CES 2, 436 17 27. 00 NURSE PRACTI TI ONER 0 0 28. 00 REGI STERED NURSE 9, 453 0 29. 00 LPN/LVN 0 0 20. 00 PHYSI CAL THERAPY 0 0 30. 00 PHYSI CAL THERAPY 0 0 31. 00 OCCUPATI ONAL THERAPY 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 34. 00 SPI RI TUAL COUNSELI NG 3, 233 0 35. 00 DI ETARY COUNSELI NG 0 0 36. 00 COUNSELI NG - OTHER 0 0 37. 00 HOSPI CA L EQUI PMENT/OXYGEN 0 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 450 40. 00	0	4.00		
25. 00 INPATIENT CARE-CONTRACTED 0 26. 00 PHYSI CI AN SERVI CES 2, 436 17 27. 00 NURSE PRACTITIONER 0 0 28. 00 REGISTERED NURSE 9, 453 0 29. 00 LPN/LVN 0 0 30. 00 PHYSI CAL THERAPY 0 0 31. 00 OCCUPATIONAL THERAPY 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 34. 00 SPI RI TUAL COUNSELI NG 3, 233 0 35. 00 DI ETARY COUNSELI NG 0 0 36. 00 COUNSELI NG - OTHER 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATION 0 450 40. 00 IMAGI NG SERVI CES 0 0	0 2, 453	0		
26.00 PHYSI CI AN SERVI CES 2,436 17 27.00 NURSE PRACTI TI ONER 0 0 28.00 REGI STERED NURSE 9,453 0 29.00 LPN/LVN 0 0 30.00 PHYSI CAL THERAPY 0 0 31.00 OCCUPATI ONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 34.00 SPI RI TUAL COUNSELI NG 3, 233 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	2, 453	0		25 00
27. 00 NURSE PRACTITIONER 0 0 28. 00 REGISTERED NURSE 9, 453 0 29. 00 LPN/LVN 0 0 30. 00 PHYSICAL THERAPY 0 0 31. 00 OCCUPATIONAL THERAPY 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDICAL SOCIAL SERVICES 0 0 34. 00 SPIRITUAL COUNSELING 3, 233 0 35. 00 DIETARY COUNSELING 0 0 36. 00 COUNSELING - OTHER 0 0 37. 00 HOSPICE AI DE & HOMEMAKER SERVICES 2, 838 0 38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN 0 0 39. 00 PATIENT TRANSPORTATION 0 450 40. 00 IMAGING SERVICES 0 0	2,453		0	25.00
28.00 REGI STERED NURSE 9, 453 0 29.00 LPN/LVN 0 0 30.00 PHYSI CAL THERAPY 0 0 31.00 OCCUPATI ONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 34.00 SPI RI TUAL COUNSELI NG 3, 233 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	0	0	2, 453	26.00 27.00
29.00 LPN/LVN 0 0 30.00 PHYSI CAL THERAPY 0 0 31.00 OCCUPATI ONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 34.00 SPI RI TUAL COUNSELI NG 3, 233 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CA I DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	9, 453	0	0 9, 453	27.00
30. 00 PHYSI CAL THERAPY 0 0 31. 00 OCCUPATI ONAL THERAPY 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 34. 00 SPI RI TUAL COUNSELI NG 3, 233 0 35. 00 DI ETARY COUNSELI NG 0 0 36. 00 COUNSELI NG - OTHER 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 450 40. 00 IMAGI NG SERVI CES 0 0	9,403	0	9, 453	28.00
31.00 OCCUPATIONAL THERAPY 0 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 34.00 SPI RI TUAL COUNSELI NG 3, 233 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	0	0	0	30.00
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 34. 00 SPI RI TUAL COUNSELI NG 3, 233 0 35. 00 DI ETARY COUNSELI NG 0 0 36. 00 COUNSELI NG - OTHER 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 450 40. 00 IMAGI NG SERVI CES 0 0	0	0	0	30.00
33.00 MEDI CAL SOCI AL SERVICES 0 0 34.00 SPI RI TUAL COUNSELI NG 3, 233 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	0	0	0	32.00
34.00 SPI RI TUAL COUNSELING 3, 233 0 35.00 DI ETARY COUNSELING 0 0 36.00 COUNSELING - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 IMAGI NG SERVI CES 0 0	0	2, 375	2, 375	32.00
35. 00 DI ETARY COUNSELI NG 0 0 36. 00 COUNSELI NG - OTHER 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2, 838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 450 40. 00 IMAGI NG SERVI CES 0 0	3, 233	-2, 461	2, 373	34.00
36.00 COUNSELING - OTHER 0 0 37.00 HOSPICE ALDE & HOMEMAKER SERVICES 2,838 0 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATION 0 450 40.00 IMAGING SERVICES 0 0	3, 233	-2,401	0	34.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 2,838 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 450 40. 00 IMAGI NG SERVI CES 0 0	0	0	0	36.00
38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 I MAGI NG SERVI CES 0 0	2, 838	0	2, 838	37.00
39.00 PATI ENT TRANSPORTATI ON 0 450 40.00 I MAGI NG SERVI CES 0 0	2,030	0	2,030	38.00
40. 00 I MAGI NG SERVI CES 0 0	450	0	450	39.00
	430	0	430	40.00
	0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 139	139	0	139	42.00
42. 50 DRUGS CHARGED TO PATI ENTS 0 0		0	0	42.50
43. 00 OUTPATIENT SERVICES 0 0	139	0	0	43.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0	0	0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY 0 0	0		0	45.00
46. 00 OTHER PATI ENT CARE SERVICES (SPECIFY) 89 0	0	0	89	
100. 00 TOTAL * 18, 049 606	139 0 0 0 89	0		46.00

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

		ADJUSTMENTS	TOTAL (col. 5		
		6,00	<u>± col. 6)</u> 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	INPATIENT CARE-CONTRACTED	0	0	25.	5.00
26.00	PHYSI CI AN SERVI CES	0	2, 453	26.	5.00
27.00	NURSE PRACTITIONER	0	0		7.00
28.00	REGI STERED NURSE	0	9, 453	28.	3. 00
29.00	LPN/LVN	0	0	29.	9.00
30.00	PHYSI CAL THERAPY	0	0	30.	0. 00
31.00	OCCUPATIONAL THERAPY	0	0	31.	1.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.	2.00
33.00	MEDICAL SOCIAL SERVICES	0	2, 375	33.	3.00
34.00	SPI RI TUAL COUNSELI NG	0	772	34.	4.00
35.00	DI ETARY COUNSELI NG	0	0	35.	5.00
36.00	COUNSELING - OTHER	0	0	36.	5.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 838	37.	7.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.	3.00
39.00	PATI ENT TRANSPORTATI ON	0	450	39.	9.00
40.00	I MAGI NG SERVI CES	0	0	40.	0. 00
41.00	LABS & DIAGNOSTICS	0	0	41.	1.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	139	42.	2.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.	2.50
43.00	OUTPATI ENT SERVI CES	0	0		3.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.	4.00
	PALLI ATI VE CHEMOTHERAPY	0	0		5.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	89		5.00
100.00	TOTAL *	0	18, 569	100.	0.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 52.			

Health Financial Systems	SCHNECK MEDICA				u of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE GENERAL	Provi der C		Peri od:	Worksheet 0-4	
I NPATI ENT CARE		Hospi ce CC		From 01/01/2017 To 12/31/2017	Date/Time Pre	pared.
		1.00001 000 000	10 1027	10 12/01/2017	5/18/2018 10:	30 am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			1			
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26. 00 PHYSI CI AN SERVI CES	583	4	58	37 0	587	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	
28.00 REGISTERED NURSE	2, 263	0	2,26	0	2, 263	•
29.00 LPN/LVN	0	0		0 0	0	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	
33.00 MEDICAL SOCIAL SERVICES	0	0		0 569	569	
34. 00 SPI RI TUAL COUNSELI NG	774	0	7.	-589	185	
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	
36.00 COUNSELING - OTHER	0	0		0 0	0	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	679	0	67	0	679	
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0		0 0	0	
39. 00 PATIENT TRANSPORTATION	0	108	10	0 8	108	•
40. 00 I MAGI NG SERVI CES	0	0		0 0	0	
41.00 LABS & DI AGNOSTI CS	0	0		0 0	0	
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	33		33 0	33	•
42. 50 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	
43. 00 OUTPATIENT SERVICES	0	0	1	0	0	
44. 00 PALLIATIVE RADIATION THERAPY	0	0	1	0	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	0	0			0	45.00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)	21	0		21 0	21	46.00
100.00 TOTAL *	4, 320	145	4,46	-20	4, 445	100.00

 100.00
 Total
 4,320

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

		ADJUSTMENTS	TOTAL (col. 5		
		6,00	<u>± col. 6)</u> 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	587		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	2, 263		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	569		33.00
34.00	SPI RI TUAL COUNSELI NG	0	185		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	679		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	108		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	33		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT 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	21		46.00
100.00	TOTAL *	0	4, 445	1	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53.			

Heal th	Financial Systems SCHNECK MEDICAL	CENTER		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0065	Peri od:	Worksheet 0-5	
	ES FOR ALLOCATION			From 01/01/2017		
		Hospi ce CC	N: 15-1529	To 12/31/2017		
				Hospice I	5/18/2018 10:	<u>30 am</u>
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
	bescriptions		EXPENSES (se		(sum of cols.	
			i nstructi on			
				WKST B PART I	1 2)	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		12, 0	00 27, 206	39, 206	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		11, 8	08 C	11, 808	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 178, 690	178, 690	3.00
4.00	ADMI NI STRATI VE & GENERAL		69,6	03 193, 484	263, 087	4.00
5.00	PLANT OPERATION & MAINTENANCE		15, 4	61 51, 544	67,005	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 13, 988	13, 988	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSING ADMINISTRATION			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		5, 8	64 1, 760	7, 624	10.00
11.00	MEDI CAL RECORDS			0 12, 470	12, 470	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION		2,8	79	2, 879	13.00
14.00	PHARMACY		1,6	81 C	1, 681	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE		3, 3	36 C	3, 336	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			C	0	17.00
	LEVEL OF CARE				-	
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		661, 7		661, 752	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		18, 5		18, 569	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		4,4	45	4, 445	53.00
	NONREI MBURSABLE COST CENTERS		1		1	
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 PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESIDENTIAL CARE			0	0	66.00
67.00	ADVERTI SI NG			U	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRIFT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			U	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99.00	NEGATI VE COST CENTER		007.0	0	0	99.00
100.00	TOTAL		807, 3	98 479, 142	1, 286, 540	1100.00

Heal th	Financial Systems	SCHNECK MEDICA	AL CENTER		Inlie	u of Form CMS-:	2552-10
	LLLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE		Provider CC Hospice CCN		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre	pared:
					Hospi ce I	5/18/2018 10:	<u>30 am</u>
	Descriptions	TOTAL EXPENSES	AP REL BLDG &	CAP REL MVBL		SUBTOTAL	
			FIX	EQUI P	BENEFI TS DEPARTMENT		
		0	1.00	2.00	3.00	ЗA	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	39, 206	39, 206				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11, 808		11, 80			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	178, 690	0		0 178, 690		3.00
4.00	ADMI NI STRATI VE & GENERAL	263, 087	7, 349		0 6, 886	277, 322	4.00
5.00	PLANT OPERATION & MAINTENANCE	67,005	0		0 0	67,005	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	13, 988	0		0 0	13, 988	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	2, 427		0 0	2, 427	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	7,624	1, 018	11, 80	0 80	20, 450	10.00
11.00	MEDI CAL RECORDS	12, 470	0		0 0	12, 470	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	2, 879	0		0 0	2, 879	13.00
14.00	PHARMACY	1, 681	0		0 0	1, 681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	10, 608		0 0	10, 608	15.00
16.00	OTHER GENERAL SERVICE	3, 336	4, 854		0 0	8, 190	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		3, 615		0	3, 615	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	661, 752			165, 460	827, 212	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	18, 569	0		0 5, 119	23, 688	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	4, 445	0		0 1, 225	5, 670	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	9, 335		0 0	9, 335	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		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 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0 0		99.00
100.00	TOTAL	1, 286, 540	39, 206	11, 80	08 178, 690	1, 286, 540	100.00
							-

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER			In Lie	u of Form CMS	-25	52-10
COST #	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C Hospice CC				Worksheet O- Part I Date/Time Pr 5/18/2018 10	ера	
						Hospi ce I			
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		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	277, 322							4.00
5.00	PLANT OPERATION & MAINTENANCE	18, 412	85, 417						5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0				6.00
7.00	HOUSEKEEPING	3, 844	C)		17, 832			7.00
8.00	DI ETARY	0	C)		0		0	8.00
9.00	NURSI NG ADMI NI STRATI ON	667	5, 285			1, 104			9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	5, 619	2, 218			463			10.00
11.00	MEDI CAL RECORDS	3, 427	C	1		0			11.00
12.00	STAFF TRANSPORTATION	0	C			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	791	C			o			13.00
14.00	PHARMACY	462	C)		0			14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	2, 915	23, 100)		4, 825			15.00
16.00	OTHER GENERAL SERVICE	2, 251	10, 571			2, 208			16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	993	7, 873			0			17.00
	LEVEL OF CARE	-ii							
50.00	HOSPI CE CONTI NUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	227, 309							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6, 509	C)	0	0			52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 558	C)	0	0			53.00
	NONREIMBURSABLE COST CENTERS					·			
60.00	BEREAVEMENT PROGRAM	2, 565	20, 329)		4, 246			60.00
61.00	VOLUNTEER PROGRAM	0	C			0			61.00
62.00	FUNDRAI SI NG	0	C			0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	C			o			64.00
65.00	OTHER PHYSICIAN SERVICES	0	C			0			65.00
66.00	RESI DENTI AL CARE	0	0		0	0			66.00
67.00	ADVERTI SI NG	0	C		-	0			67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			0			68.00
69.00	THRI FT STORE	0	C			0			69.00
70.00	NURSING FACILITY ROOM & BOARD					-			70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	16, 041		0	4, 986			71.00
99.00	NEGATI VE COST CENTER	0	C		0	0			99.00
	TOTAL	277, 322	85, 417		0	17, 832			00.00
	'								

	Financial Systems	SCHNECK MEDIC				u of Form CMS-	
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CO Hospice CCI		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/18/2018 10:	pared:
					Hospi ce I	0/10/2010 101	<u></u>
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	9, 483					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	28, 750				10.00
11.00	MEDI CAL RECORDS	0		15, 8	97		11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	3, 670	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	3, 670	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2, 845	27, 688		10 0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2, 845	857		74 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2, 845	205	1	13 0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	948			0	0	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	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0			0	0	66.00
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	69.00
70.00	NURSING FACILITY ROOM & BOARD				_	-	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	-		0	0	71.00
99.00	NEGATI VE COST CENTER	0	0	45.0	0 0	0	99.00
100.00	TUTAL	9, 483	28, 750	15, 8	97 0	3, 670	100.00

Heal th	Financial Systems	SCHNECK MEDIC	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/18/2018 10:	pared:
					Hospi ce I		
	Descriptions	PHARMACY A	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERAL SERVI CE	PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						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	2, 143					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	41, 448				15.00
16.00	OTHER GENERAL SERVICE	2, 143		29, 03	3		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				12, 481		17.00
	LEVEL OF CARE	· · ·			- · · · · ·		1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	39, 917	27, 96	1	1, 168, 242	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1, 235	86	5 10, 070	46, 543	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	296	20	7 2, 411	13, 305	53.00
	NONREIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
60.00	BEREAVEMENT PROGRAM	0			0	37, 423	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	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			0	0	68.00
69.00	THRI FT STORE	0			o	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		o o	21, 027	
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00
100.00	TOTAL	2, 143	41, 448	29, 03	3 12, 481	1, 286, 540	100.00
							-

Heal th	Financial Systems	SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider CC		Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S				From 01/01/2017	Part II	
			Hospi ce CCN	l: 15-1529	To 12/31/2017	Date/Time Pre 5/18/2018 10:	
					Hospi ce I	37 107 2010 10.	
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (I	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
			ŕ	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2, 310					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		61, 586				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	630, 02			3.00
4.00	ADMI NI STRATI VE & GENERAL	433	0	24, 28	-277, 322	1, 009, 218	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	67, 005	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	13, 988	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	143	0		0 0	2, 427	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60	61, 586		0 0	20, 450	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	12, 470	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	2, 879	13.00
14.00	PHARMACY	0	0		0 0	1, 681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625	0		0 0	10, 608	15.00
16.00	OTHER GENERAL SERVICE	286	0		0 0	8, 190	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	213	0		0	3, 615	17.00
	LEVEL OF CARE	· · · · ·					
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			583, 37		827, 212	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	18, 04		23, 688	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	4, 32	0 0	5, 670	53.00
	NONREIMBURSABLE COST CENTERS	1 1					
60.00	BEREAVEMENT PROGRAM	550	0		0 0	9, 335	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		0		0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER	0	0		0 0	0	71.00 99.00
99.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	39, 206	11, 808	178, 69		277, 322	
	UNIT COST MULTIPLIER	16. 972294	0. 191732	0. 28362		0. 274789	
101.00		10. 772274	0. 171732	0.20302		0.214/07	101.00

	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0065	Period: From 01/01/2017	Worksheet 0-6 Part II	
STATES	TI CAL BASI S		Hospi ce CCI	N: 15-1529	To 12/31/2017		
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N		NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET	· ·	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DIRECT NURS.	
		5.00	6.00	7.00	8.00	HRS.) 9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	2, 311					5.00
6.00	LAUNDRY & LINEN SERVICE	2,011	0				6.00
7.00	HOUSEKEEPING	0	0	2,3	10		7.00
8.00	DI ETARY	0		2,0	0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON	143		1	43	100	9,00
10.00	ROUTI NE MEDI CAL SUPPLI ES	60			60	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATI ON	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	625		6	25	0	15.00
16.00	OTHER GENERAL SERVICE	286			86	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	213		-	0	, v	17.00
	LEVEL OF CARE			1			1
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
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	30	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	550		5	50	10	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	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL 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			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	434	0	6	46 0	0	
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	85, 417	0				100.00
101.00	UNIT COST MULTIPLIER	36. 961056	0. 000000	7.7194	81 0. 000000	94.830000	101.00

	Financial Systems	SCHNECK MEDIC	AL_CENTER		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2017 To 12/31/2017		epared:
					Hospi ce I	0, 10, 2010 101	00 4
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATIC (MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	101.00	11100	12100	101.00	11100	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFITS DEPARTMENT ADMI NI STRATI VE & GENERAL PLANT OPERATI ON & MAI NTENANCE LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY NURSI NG ADMI NI STRATI ON ROUTI NE MEDI CAL SUPPLI ES MEDI CAL RECORDS STAFF TRANSPORTATI ON VOLUNTEER SERVI CE COORDI NATI ON PHARMACY PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE	8, 692	8, 692		0 0 100 0 0 0 0 0 0 0 100	100 0	15.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
	LEVEL OF CARE			1			
50. 00 51. 00 52. 00 53. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREI MBURSABLE COST CENTERS	0 8, 371 259 62	0 8, 371 259 62		0 0 0 0 0 0 0 0	0	51.00 52.00
	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	28, 750 3. 307639	15, 897 1. 828923		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	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0065	Peri od:	Worksheet 0-	6
STATI S	TICAL BASIS		Hospice CC	N: 15-1529	From 01/01/2017 To 12/31/2017	Part II Date/Time Pr	oparod
			nospi ce co	N. 15-1527	10 12/31/2017	5/18/2018 10	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT)	(
		15.00	14.00	DAYS)	_		
		15.00	16.00	17.00			
1 00	GENERAL SERVICE COST CENTERS						1.00
1.00 2.00	CAP REL COSTS-BLDG & FLXT						2.00
2.00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						3.00
3.00 4.00	ADMINISTRATIVE & GENERAL						4.00
4.00 5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	8, 692					15.00
16.00	OTHER GENERAL SERVICE	0,072	8, 692				16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		-,	32	21		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	8, 371	8, 371				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	259	259	25	59		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	62	62		52		53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRIFT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD		_				70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER	41 440	20,022	10 40	21		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	41, 448	29, 033				100.00
101.00	UNIT COST MULTIPLIER	4. 768523	3. 340198	38. 88162	201		101.00

LEVEL OF CARE From 01/01/2017 Hospice CCN: 15-1529 To 12/31/2017 Date/	neet 0-7 Time Prep 2018 10:3	
Hospice CCN: 15-1529 To 12/31/2017 Date/7	[ime Pre 2018 10:3	
		pared: 30 am
Charges by LOC (from Provider Rec		
	ords)	
Cost Center Descriptions From Wkst. C, Cost to Charge HCHC HRHC HI Part I, Col. 9 Ratio Line	RC	
0 1.00 2.00 3.00 4.	00	
ANCI LLARY SERVICE COST CENTERS		
1.00 PHYSI CAL THERAPY 66.00 0.548241 0 0	502	1.00
2.00 OCCUPATI ONAL THERAPY 67.00 0.267992 0 0	778	2.00
3.00 SPEECH PATHOLOGY 68.00 0.479360 0 0	0	3.00
4.00 DRUGS CHARGED TO PATIENTS 73.00 0.593182 0 0	53, 131	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED 96.00		5.00
6.00 LABORATORY 60.00 0.111263 0 0	3, 112	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1.327498 0 0	16, 968	7.00
8.00 BEHAVI ORAL HEALTH 93.00 1.039947 0 0	455	8.00
9.00 RADI OLOGY-THERAPEUTI C 55.00		9.00
10. 00 WOUND CARE (DI ABETES CENTER) 76. 00 0. 439457 0 0	198, 446	10.00
10. 02 CASE MANAGEMENT 76. 02 1. 620114 0 0	0	10. 02
10. 03 PALN MANAGEMENT 76. 03 0. 488850 0 0	0	10. 03
10. 97 CARDI AC REHABI LI TATI ON 76. 97 2. 833749 0 0	0	10. 97
11.00 Totals (sum of lines 1-11)		11.00
Charges by LOC Shared Service Costs by LOC (from Provider Records)		
Cost Center Descriptions HGIP HCHC (col. 1 xHRHC (col. 1 xHIRC (col. 1 xHIRC (col. 1 xHIRC)		
	. 5)	
	00	
ANCI LLARY SERVICE COST CENTERS		
1.00 PHYSICAL THERAPY 0 0 275	0	1.00
2.00 OCCUPATIONAL THERAPY 0 0 0 208	0	2.00
3.00 SPEECH PATHOLOGY 0 0 0	0	3.00
4.00 DRUGS CHARGED TO PATLENTS 0 0 31, 516	0	4.00
5. 00 DURABLE MEDI CAL EQUI P-RENTED	_	5.00
6.00 LABORATORY 0 0 346	0	6.00
7.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 22, 525	0	7.00
8.00 BEHAVI ORAL HEALTH 0 0 473	0	8.00
9.00 RADIOLOGY-THERAPEUTIC	_	9.00
10.00 WOUND CARE (DI ABETES CENTER) 0 0 87,208	0	10.00
10. 02 CASE MANAGEMENT 0 0 0 0	0	10.02
10. 03 PAIN MANAGEMENT 0 0 0 0	0	10.03
10. 97 CARDI AC REHABI LI TATI ON 0 0 0	0	10.97
11.00 Totals (sum of lines 1-11) 0 0 142,551	0	11.00

Health Financial Systems	SCHNECK MEDICAL				u of Form CMS-2	
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COS	Т	Provider CO	CN: 15-0065	Period: From 01/01/2017	Worksheet 0-8	
		Hospi ce CCN	N: 15-1529	To 12/31/2017	Date/Time Pre	nared
			10 1027	10 12/01/2017	5/18/2018 10:	
				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. O-	7, col. 6,			0	1.00
line 11)					_	
2.00 Total unduplicated days (Wkst. S-9, col. 4,					0	2.00
3.00 Total average cost per diem (line 1 divided					0.00	3.00
4.00 Unduplicated program days (Wkst. S-9 col. as	s appropriate, line	e 10)		0 0		4.00
5.00 Program cost (line 3 times line 4)				0 0		5.00
HOSPICE ROUTINE HOME CARE						
5.00 Total cost (Wkst. 0-6, Part I, col. 18, line	ə 51 plus Wkst. O-	7, col. 7,			1, 168, 242	6.00
line 11)						
7.00 Total unduplicated days (Wkst. S-9, col. 4,	,				8, 371	7.00
8.00 Total average cost per diem (line 6 divided					139.56	8.00
9.00 Unduplicated program days (Wkst. S-9, col. a	as appropriate, li	ne 11)	8, 1 ⁻			9.00
10.00 Program cost (line 8 times line 9)			1, 132, 52	29 32, 238		10.00
HOSPICE INPATIENT RESPITE CARE				-		
11.00 Total cost (Wkst. 0-6, Part I, col. 18, line	∋52 plus Wkst. O-	7, col. 8,			189, 094	11.00
line 11)					050	
12.00 Total unduplicated days (Wkst. S-9, col. 4,						12.00
13.00 Total average cost per diem (line 11 divided					730.09	
14.00 Unduplicated program days (Wkst. S-9, col. a	as appropriate, lii	ne 12)		38 15		14.00
15.00 Program cost (line 13 times line 14)			173, 70	51 10, 951		15.00
HOSPICE GENERAL INPATIENT CARE					10.005	
16.00 Total cost (Wkst. 0-6, Part I, col. 18, line	e 53 plus Wkst. O-	7, col. 9,			13, 305	16.00
line 11)						
17.00 Total unduplicated days (Wkst. S-9, col. 4,					62	17.00
18.00 Total average cost per diem (line 16 divided		4.0.		-	214.60	
19.00 Unduplicated program days (Wkst. S-9, col. a	as appropriate, lii	ne 13)		41 5		19.00
20.00 Program cost (line 18 times line 19)			8, 79	99 1, 073		20.00
TOTAL HOSPICE CARE					1 070	
21.00 Total cost (sum of line 1 + line 6 + line 1'	,				1, 370, 641	•
22.00 Total unduplicated days (Wkst. S-9, col. 4,	,				8, 692	
23.00 Average cost per diem (line 21 divided by li	ne 22)				157.69	23.00

ealth Financial Systems ALCULATION OF CAPITAL PAYMENT	SCHNECK MEDICAL CENTER In Lieu of Form CMS-22 Provider CCN: 15-0065 Period: Worksheet L	
	From 01/01/2017 Parts I-III To 12/31/2017 Date/Time Prep	nare
	5/18/2018 10: 3	
	Title XVIII Hospital PPS	
	1.00	
PART I - FULLY PROSPECTIVE METHOD		
CAPITAL FEDERAL AMOUNT		
Copital DRG other than outlier	527, 848	
Model 4 BPCI Capital DRG other than outlier	0	1.
Capital DRG outlier payments	49, 562	2.
01 Model 4 BPCI Capital DRG outlier payments 00 Total inpatient days divided by number of da	avs in the cost reporting period (see instructions) 26.19	
00 Number of interns & residents (see instructi 00 Indirect medical education percentage (see i		
	ply line 5 by the sum of lines 1 and 1.01, columns 1 and 0	6
1.01) (see instructions)		
00 Percentage of SSI recipient patient days to 30) (see instructions)	Medicare Part A patient days (Worksheet E, part A line 0.00	7
DO Percentage of Medicaid patient days to total	days (see instructions) 0.00	8
00 Sum of lines 7 and 8	0.00	9
00 Allowable disproportionate share percentage	(see instructions) 0.00	10
.00 Disproportionate share adjustment (see instr	ructions) 0	11
.00 Total prospective capital payments (see inst	tructions) 577, 410	12
	1.00	
PART II - PAYMENT UNDER REASONABLE COST	1.00	
00 Program inpatient routine capital cost (see	instructions) 0	1 1
00 Program inpatient ancillary capital cost (see		2
00 Total inpatient program capital cost (line 1		3
00 Capital cost payment factor (see instruction		4
00 Total inpatient program capital cost (line 3		
PART III - COMPUTATION OF EXCEPTION PAYMENTS	1.00	
00 Program inpatient capital costs (see instruct		1
DO Program inpatient capital costs for extraord		2
00 Net program inpatient capital costs (line 1		3
00 Applicable exception percentage (see instruc		4
00 Capital cost for comparison to payments (lin		5
00 Percentage adjustment for extraordinary circ	cumstances (see instructions) 0.00	6
	for extraordinary circumstances (line 2 x line 6) 0	7
00 Capital minimum payment level (line 5 plus l		8
00 Current year capital payments (from Part I,	line 12, as applicable) 0	9
00 Current year comparison of capital minimum p	payment level to capital payments (line 8 less line 9) 0	10
00 Carryover of accumulated capital minimum pay Worksheet L, Part III, line 14)	yment level over capital payment (from prior year 0	11.
	evel to capital payments (line 10 plus line 11) 0	12
.00 Current year exception payment (if line 12 i	vment level over capital payment for the following period 0	
.00 Current year exception payment (if line 12 i .00 Carryover of accumulated capital minimum pay		
 Current year exception payment (if line 12 i Carryover of accumulated capital minimum pay (if line 12 is negative, enter the amount on 	h this line)	15
.00 Current year exception payment (if line 12 i .00 Carryover of accumulated capital minimum pay (if line 12 is negative, enter the amount on	h this line) 0	