AND SETTLEMENT	SUMMARY	11001 del 1001. 13 002	From 01/01/2018 F To 12/31/2018 E	Parts I-III Date/Time Prepared: 5/28/2019 7:03 pm
PART I - COST	REPORT STATUS			
Provi der use only	1. [ X ] Electronically filed cost report 2. [ ] Manually submitted cost report		Date: 5/28/2019	7:03 pm
	3. [ 0 ] If this is an amended report enter the number 4. [ F ] Medicare Utilization. Enter "F" for full or "L		r resubmitted this cos	t report
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for (3) Settled with Audit 9. [ N ] Final Report for (4) Reopened (5) Amended	or this Provider CCN 1		

## PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOSHEN HOSPITAL (15-0026) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	27, 314	79, 330	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	27, 314	79, 330	0	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.

Health Financial Systems GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0026 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 7:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 200 HIGH PARK AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: GOSHEN Zip Code: 46526 County: ELKHART 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 GOSHEN HOSPITAL 150026 21140 1 07/11/1966 N 3.00 Hospi tal Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 CARE AT HOME SERVICES 157174 21140 04/17/1986 N Ρ Ν 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce CARE AT HOME HOSPICE 151527 21140 04/17/1986 14.00 SERVI CES 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this Ν Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22. 02 22.02 N Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3

		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medicaid HMO days	Other Medicaid	
		paid days	eligible unpaid days	Medicaid paid days	Medicaid eligible unpaid		days	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	594	. 0	0	3, 850	128	24. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ГА	Provi der C	CN: 15-0026	Peri od: From 01/01/2018	Worksheet S-2 Part I	
				To 12/31/2018	Date/Time Pre 5/28/2019 7:0	
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5.00	
<ul> <li>1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports</li> </ul>	N			0.00	0.00	61. (
ending and submitted before March 23, 2010. (see instructions)  1.02 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. (
ACA). (see instructions)  1.03 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 instructions)						61.
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).  1.05 Enter the difference between the baseline primary						61.
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)  1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. (
care or general surgery. (see instructions)	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count		
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00		61
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  1. 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		
					ME Unweighted Direct GME FTE Count 4.00 00 0.00  1.00  1.00  N  Ratio (col. 1/(col. 1 + col.	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	tions) Teachi ram. (s	ng Health Cen ee instructio	iter (THC) int			
Teaching Hospitals that Claim Residents in Nonprovider se 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63.
i ioi yes or ni ioi no in corunni i. Ii yes, compre	te iiile	3 04 till Ough	67. (see inst Unweighted FTEs Nonprovider Site	Unweighted FTEs in		
		l C-+	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 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 resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	e June y train -primar all non non-pr column	30, 2010.  ed residents y care provider imary care 3 the ratio	0.			64.

	beginning on or after July 1, 20	)10					
66.00	Enter in column 1 the number of	unweighted non-primar	ry care resident	0.00	0. 00	0. 000000	66. 00
	FTEs attributable to rotations of	occurring in all nonpr	rovider settings.				
	Enter in column 2 the number of	unweighted non-primar	y care resident				
	FTEs that trained in your hospit	al. Enter in column 3	S the ratio of				
	(column 1 divided by (column 1 +	column 2)). (see ins	structi ons)				
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		_		FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
		1. 00	2.00	3. 00	4.00	5. 00	
67. 00	Enter in column 1, the program			0.00	0. 00	0. 000000	67. 00
	name associated with each of						
	your primary care programs in						
	which you trained residents.						
	Enter in column 2, the program						
	code. Enter in column 3, the						
	number of unweighted primary						
	care FTE residents attributable						
	to rotations occurring in all						
	non-provider settings. Enter in						
	column 4, the number of						
	unweighted primary care						
	resident FTEs that trained in						
	your hospital. Enter in column						
	5, the ratio of (column 3						
	divided by (column 3 + column						
		1	l .	1		1	

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods

Unwei ghted

FTEs

Nonprovi der

Si te 1.00 Unwei ghted

FTEs in

Hospi tal

2.00

Ratio (col. 1/

(col. 1 + col.

2))

3.00

		1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70. 00
	Enter "Y" for yes or "N" for no.				
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71. 00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
	(see instructions)				
	Inpatient Rehabilitation Facility PPS				
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75. 00
	subprovider? Enter "Y" for yes and "N" for no.				
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	76. 00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for				
	no. Column 2: Did this facility train residents in a new teaching program in accordance with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y,				
	indicate which program year began during this cost reporting period. (see instructions)				

4)). (see instructions)

ealth Financial Systems GOSHEN HOS OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0026	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S- Part I Date/Time Pi 5/28/2019 7:	repared:
				1.00	+
Long Term Care Hospital PPS					
<ul> <li>D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes</li> <li>1. 00 Is this a LTCH co-located within another hospital for part or</li> <li>"Y" for yes and "N" for no.</li> </ul>			ng period? Enter	N N	80. 0 81. 0
TEFRA Providers  5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  6.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	cl assi fi ed	under sectio	ı	N	87. 0
Tooo(u)(T)(B)(VE)? EITER T TOE YES OF N TOE HO.			V 1. 00	XI X 2. 00	
Title V and XIX Services			1.00	2.00	
Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? E	nter "Y" for	N	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the			N	N	91.0
full or in part? Enter "Y" for yes or "N" for no in the appli 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dua				N	92.0
instructions) Enter "Y" for yes or "N" for no in the applicate 3.00 Does this facility operate an ICF/IID facility for purposes of		NIX2 Enter	N	N	93. 0
"Y" for yes or "N" for no in the applicable column.					
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for n	oin the	N	N	94.0
5.00   If line 94 is "Y", enter the reduction percentage in the appl 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 0 96. 0
7.00   If line 96 is "Y", enter the reduction percentage in the appl 3.00   Does title V or XIX follow Medicare (title XVIII) for the interest stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	terns and res	dents post	0. 00 Y	0. 00 Y	97. 98.
column 1 for title V, and in column 2 for title XIX.  3.01   Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98.
B.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Y	Y	98.
3.03 Does title V or XIX follow Medicare (title XVIII) for a criti- reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98.
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N t	N	98.
3.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.				Y	98.
B. 06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.
Rural Providers  05.00 Does this hospital qualify as a CAH?			N		105. (
06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	nod of payme			106. (
07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see inst	ructions) If			107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the (	·	· ·			108.
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				D : :	
	Physi cal 1.00	0ccupationa 2.00	Speech 3.00	Respiratory 4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. (
				1 00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "\				1. 00 N	110. 0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-002		eriod: rom 01/01/2 o 12/31/2		Workshe Part I Date/Ti 5/28/20	me Pr	epared:
			1. 00		2.0	00	
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting period? E lumn 1 is Y, enter the ticipating in column 2		N				111.00
				1. 00	2.00	3. 00	1
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y"	If column 2 is "E", e t for long term care ( s) based on the defini	nter i includ	n column es	N N		0	115. 00
17.00 s this facility legally-required to carry malpractice insurno.		s or "	N" for	Υ			117. 00
18.00 is the mal practice insurance a claims-made or occurrence policial im-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the po	licy i	s	1			118. 00
	Premi	ums	Losses	5	Insura	ance	
18.01 List amounts of malpractice premiums and paid losses:	1.0	0 11, 493	2.00	5, 000	3. 0		0118.0
10.01,2.01 discusse of marphases of promise and para 100000.	, ., .	, . , .	1. 00	,, 000	2. 0		-
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.		rs	N		2.0		118. 02
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes alifies for the Outpat	or i ent	N		N		119. 0 120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable devices charged	to	Υ				121. 0
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N				122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N" for no.	lf	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, en		date					126. 0
in column 1 and termination date, if applicable, in column 2 27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certification c	ate					127. 0
28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certification o	ate					128. C
29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		te in					129. C
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		n					130.0
31.00 of this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	, enter the certificat	i on					131. 0
32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2							132. 0
33.00   f this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2							133. 0
34.00 If this is an organ procurement organization (OPO), enter th and termination date, if applicable, in column 2.	e OPO number in columr	1					134. 0
All Providers							

Health Financial Systems GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0026 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: Zip Code: 143. 00 State: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01 exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	9. 99	169. 00
transition factor. (see instructions)		<u> </u>	
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171. 00

SPI T	Financial Systems GOSHEN H AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Period: From 01/01/2018	u of Form CMS- Worksheet S-2 Part II	2
				To 12/31/2018	Date/Time Pre 5/28/2019 7:0	
				Y/N	Date	
	0 11 1 1 5 1 1 1 1 1 5 1 1 1 1 1 1 1 1 1	1 C 11 NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	I for all NO re	sponses. Ente	r all dates in t	he	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions)			
			Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F		N			2.0
	yes, enter in column 2 the date of termination and in column land under the column and in column and the column are the column and the column are the column	nn 3, "V" Tor				
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na managomont	N			3.0
00	contracts, with individuals or entities (e.g., chain home of		IN IN			] 3. 0
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert	Life: Dodeli -	Y	Δ.		١.,
00	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1		Y	А		4.0
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	3114616 111				
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.0
	those on the filed financial statements? If yes, submit red					
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities			T		
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6.0
00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	etructions		Υ		7.0
00	Were nursing school and/or allied health programs approved		l during the	N		8.0
00	cost reporting period? If yes, see instructions.	and/or renewed	a durring the	IN		0.0
00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9.0
	program in the current cost report? If yes, see instruction					
0. 00	Was an approved Intern and Resident GME program initiated of	or renewed in t	he current	N		10.0
	cost reporting period? If yes, see instructions.					
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				V//NI	
					Y/N 1. 00	
	Bad Debts				1.00	
2 00	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Υ	12. (
3. 00	If line 12 is yes, did the provider's bad debt collection p			st reporting	N	13. 0
, 00	period? If yes, submit copy.	or roy onango c	idi ing tino oo	or roportring		
1. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructi ons.	N	14. 0
	Bed Complement					
- 00	Did total beds available change from the prior cost reporti		-		N	15.0
5. 00			t A		t B	
5. 00		Y/N	Date	Y/N	Date	
5. 00			2.00	3. 00	4. 00	
5. 00	DCOD Data	1.00	1			
	PS&R Data			V	OF /20 /2010	14 (
	Was the cost report prepared using the PS&R Report only?	Y	05/29/2019	Y	05/29/2019	16. 0
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through			Y	05/29/2019	16. (
	Was the cost report prepared using the PS&R Report only?			Y	05/29/2019	16.0
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	05/29/2019	
o. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y			05/29/2019	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y			05/29/2019	
5. 00 7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y N		N	05/29/2019	17. (
o. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y			05/29/2019	17. (
5. 00 7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y N		N	05/29/2019	17. (
5. 00 7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y N		N	05/29/2019	17. (
6. 00 7. 00 3. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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.	Y N N		N N	05/29/2019	16. C
5. 00 7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y N		N	05/29/2019	17. (

	al Systems GOSHEN HO HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0026	Period: From 01/01/2018 To 12/31/2018		5-2 Prepared:
		Descr	i pti on	Y/N	Y/N	
			0	1. 00	3. 00	
	16 or 17 is yes, were adjustments made to PS&R data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
- Face -		1. 00	2.00	3. 00	4. 00	
	cost report prepared only using the provider's ? If yes, see instructions.	N		N		21. 00
					1.00	
	ED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS F	HOSPI TALS)			
	Related Cost				l N	
	sets been relifed for Medicare purposes? If yes, see				N N	22. 00
	anges occurred in the Medicare depreciation expense ng period? If yes, see instructions.	due to apprais	sais made dur	ing the cost	N	23. 00
24.00 Were n	w leases and/or amendments to existing leases entere see instructions	ed into during	this cost re	porting period?	N	24. 00
25.00 Have t	ere been new capitalized leases entered into during	the cost repor	rting period?	'If yes, see	N	25. 00
instru 26.00 Were a	τιons. sets subject to Sec.2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
instru 27.00 Has th	tions. provider's capitalization policy changed during the	. cost roporti	a noriod2 lf	ivos submit	l N	27. 00
copy.		- cost reportir	ig perrou: II	yes, subili t	IN IN	27.00
28.00 Were n	t Expense w Loans, mortgage agreements or Letters of credit en	ntered into dum	ing the cost	reporti ng	N	28. 00
	If yes, see instructions.  provider have a funded depreciation account and/or	bond funds (De	ebt Service R	eserve Fund)	N N	29. 00
	as a funded depreciation account? If yes, see instr sting debt been replaced prior to its scheduled matu		doht2 Lf vos	. 500	N	30.00
instru	ti ons.	•	-			
instru		ssuance of new	debt? If yes	, see	N	31.00
	ed Services anges or new agreements occurred in patient care ser	ovi cos furni sh	od through co	ntractual	N	32.00
arrang	ments with suppliers of services? If yes, see instru	uctions.	•			
no, se	32 is yes, were the requirements of Sec. 2135.2 app instructions.	olied pertainir	ng to competi	tive bidding? If	N	33.00
	r-Based Physicians					
	vices furnished at the provider facility under an ar see instructions.	rangement with	n provider-ba	sed physicians?	Y	34.00
35.00   If Íin	34 is yes, were there new agreements or amended exi		nts with the	provi der-based	N	35. 00
[pnysi c	ans during the cost reporting period? If yes, see in	ISTRUCTIONS.		Y/N	Date	
ļu 0	<u> </u>			1. 00	2.00	
	fice Costs me office costs claimed on the cost report?			NI		36.00
	me office costs claimed on the cost report? 36 is yes, has a home office cost statement been pr	repared by the	home office?	N N		36.00
If yes	see instructions.  36 is yes, was the fiscal year end of the home off					38.00
the pr	vider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			
see in	36 is yes, did the provider render services to othe tructions.	•	,			39.00
40.00   flin  instru	36 is yes, did the provider render services to the tions.	home office?	If yes, see	N		40. 00
		1	00	2	00	
Cost Re	port Preparer Contact Information			2.		
11.00 Enter		DAVE		MCCLUNG		41.00
respec	i vel y.	RSM				42.00
	1 3 1 3	II OW				#2.00
prepar 43.00 Enter	he telephone number and email address of the cost	641-494-2144		DAVI D. MCCLUNG@		43.00

Heal th	Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der	CCN: 15-0026	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/28/2019 7:0	pared:
				3. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti		MANAGER				41. 00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos-	t report					42.00
	preparer.						
43.00	Enter the telephone number and email address	ss of the cost					43.00
	report preparer in columns 1 and 2, respec-	ti vel y.					

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

						3 12/31/2010	5/28/2019 7:0	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1.00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		110	40, 150	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO I RF Subprovi der							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			110	40 150	0.00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation			110	40, 150	0. 00	U	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		12	4, 380	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	32. 00		12	4, 300	0.00		9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00		0	l ĭ	0.00		10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00		11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)	54.00		J	· ·	0.00		12. 00
13. 00	NURSERY	43. 00					o	13. 00
14. 00	Total (see instructions)	10.00		122	44, 530	0.00		14. 00
15. 00	CAH visits				11,000	0.00	0	15. 00
16. 00	SUBPROVIDER - IPF	40. 00		0	0		o o	16. 00
17. 00	SUBPROVIDER - IRF	41. 00		0			l ol	17. 00
18. 00	SUBPROVI DER	42. 00		0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	0		0	19. 00
20.00	NURSING FACILITY	45. 00		0	0		0	20. 00
21.00	OTHER LONG TERM CARE	46. 00		0	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23.00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			122				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF			_	_			31. 00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
33.00	LTCH non-covered days LTCH site neutral days and discharges							33. 00
33.01	LIGHT SI LE HEULT AT UAYS AND UI SCHALGES			١	1		1	33.01

Provider CCN: 15-0026

						5/28/2019 7:0	3 pm
		I/P Days	3 / O/P Visits	/ Trips	Full Time I	Equi 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	
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)	6, 796	453	18, 155			1.00
2.00	HMO and other (see instructions)	1, 504	3, 850				2. 00
3.00	HMO IPF Subprovider	0	O				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	6, 796	453	18, 155			7. 00
8.00	INTENSIVE CARE UNIT	1, 242	80	3, 208			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		61	2, 452			13. 00
14. 00	Total (see instructions)	8, 038	594	23, 815		1, 059. 15	
15. 00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0			1
17. 00	SUBPROVIDER - I RF	0	U	0	0. 00 0. 00	l e	1
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	0	0	0	0.00		
20. 00	NURSING FACILITY	۷	0	0	0.00	0.00	
21. 00	OTHER LONG TERM CARE		U U	0	0.00		
22. 00	HOME HEALTH AGENCY	7, 193	0	14, 733		<b>l</b>	1
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	7,173	Ÿ	14, 733	0.00		
24. 00	HOSPI CE	0	0	0			
24. 10	HOSPICE (non-distinct part)	J	Ĭ	0	0.00		24. 10
25. 00	CWHC - CWHC	ol	o	0	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	o	o	0	0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	O	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 111. 20	27. 00
28. 00	Observation Bed Days		361	2, 726			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	128	277			32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	o					33. 01
					•	•	

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm

							5/28/2019 7:03	3 pm
		Full Time			Di sch	arges		
		Equi val ents	<b>-</b> 1 \		T		<b>-</b>	
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers	12.00	-	12.00	14.00	Pati ents	
1. 00	Hearital Adulta & Dada (aslumna E. / 7 and	11. 00	12. 00	0	13.00	14.00	15. 00	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and			۷	1, 752	232	6, 972	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)			ı	348	1, 615		2. 00
3.00	HMO I PF Subprovi der			ı	540	1, 019		3.00
4.00	HMO IRF Subprovider					0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					Ĭ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7. 00	Total Adults and Peds. (exclude observation							7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	0. 00		0	1, 752	232	6, 972	14. 00
15. 00	CAH visits							15. 00
16.00	SUBPROVI DER - I PF	0. 00		0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00		0	0	0	0	17. 00
18. 00	SUBPROVI DER	0. 00		0		0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00						19. 00
20. 00	NURSING FACILITY	0. 00						20. 00
21. 00	OTHER LONG TERM CARE	0. 00					0	21. 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)	0.00						24. 10
25. 00	CMHC - CMHC	0.00						25. 00
26. 00	RURAL HEALTH CLINIC	0.00		ı				26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00						26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00						28.00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 00
52.01	outpatient days (see instructions)							02.01
33. 00	LTCH non-covered days				0			33. 00
	LTCH site neutral days and discharges				Ō			33. 01
	1	1		'	-1	ı	'	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From CMS-2552-10 | Prepared: | Prepar Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0026

					10	0 12/31/2018	Date/lime Prep   5/28/2019 7:03	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200. 00	74, 537, 482	0	74, 537, 482	2, 311, 256. 00	32. 25	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0.00	3. 00
4. 00	B Physician-Part A -		252, 550	0	252, 550			
	Admi ni strati ve		232, 330		,			
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		5, 976, 105	0		0. 00 27, 495. 00	•	
6. 00	Physician-Part B Non-physician-Part B for hospital -based RHC and FQHC services		0	0	0	0.00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	0	0.00	0. 00	7. 01
8. 00	Home office and/or related		0	0	0	0. 00	0. 00	8. 00
9. 00	organization personnel	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		5, 801, 478	140, 019	5, 941, 497	202, 385. 00	29. 36	10. 00
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		73, 497	0	73, 497	1, 250. 00	58. 80	11. 00
12. 00	Care Contract Labor: Top Level		0	0	·	0.00		12. 00
12.00	management and other management and administrative services		C	S		0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		641, 148	0	641, 148	2, 998. 00	213. 86	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0. 00	14. 00
14. 01	Home office salaries		0	0	0	0.00	•	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	•	
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		26, 436, 276	0	26, 436, 276			17. 00
18. 00	instructions) Wage-related costs (other)		0		, , , , , ,			18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 564, 853 0	0	2, 564, 853 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		42, 973	0	42, 973			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23.00	Physician Part B		411, 325	0	411, 325			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	n	n			25. 52
	- Administrative - wage-related (core)		o o					
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	О	0			25. 53
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	715, 381	0	715, 381	19, 653. 00	26 40	26. 00
	Administrative & General	5. 00	12, 199, 590			365, 267. 00		27. 00
		<u> </u>			<u> </u>			

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018

							5/28/2019 7:0	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		940, 601	0	940, 601	4, 830. 00	194. 74	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	812, 713		812, 713	31, 743. 00		
31. 00	Laundry & Linen Service	8. 00		0	37, 176	2, 905. 00		
32.00	Housekeepi ng	9. 00	848, 905	0	848, 905	61, 622. 00	13. 78	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	769, 957	-513, 465	256, 492	18, 190. 00	14. 10	34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	513, 465	513, 465	36, 414. 00	14. 10	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	2, 236, 387	0	2, 236, 387	62, 699. 00	35. 67	38. 00
39. 00	Central Services and Supply	14. 00	227, 764	0	227, 764	12, 788. 00	17. 81	39. 00
40.00	Pharmacy	15. 00	1, 449, 132	0	1, 449, 132	34, 357. 00	42. 18	40.00
41.00	Medical Records & Medical	16. 00	1, 385, 403	0	1, 385, 403	53, 156. 00	26. 06	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	952, 353	0	952, 353	30, 359. 00	31. 37	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | To 12/31/201

							5/28/2019 7:0	3 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		69, 501, 978	0	69, 501, 978	2, 288, 591. 00	30. 37	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 801, 478	140, 019	5, 941, 497	202, 385. 00	29. 36	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		63, 700, 500	-140, 019	63, 560, 481	2, 086, 206. 00	30. 47	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		714, 645	0	714, 645	4, 248. 00	168. 23	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 479, 249	0	26, 479, 249	0.00	41. 66	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		90, 894, 394	-140, 019	90, 754, 375	2, 090, 454. 00	43. 41	6.00
7.00	Total overhead cost (see		22, 575, 362	-140, 019	22, 435, 343	733, 983. 00	30. 57	7. 00
	instructions)							

Health Financial Systems	GOSHEN HOSPI TAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0026	Peri od: Worksheet S-3
		From 01/01/2018 Part IV

	To 12/31/2018	Date/Time Pre 5/28/2019 7:0	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 564, 384	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2, 466, 802	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	17, 381, 415	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	391, 320	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	141, 376	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	233, 566	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	3, 124	14.00
15.00	'Workers' Compensation Insurance	796, 765	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00		4, 958, 349	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00		29, 240	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00		63, 164	
	Tuition Reimbursement	425, 923	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	29, 455, 428	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	GOSHEN HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Pre 5/28/2019 7:00	pared:
Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00	•
DART V Contract Labor and Ponofit Cost		_		

Cost Center Description   Contract Labor Benefit Cost   1.00   2.00	
PART V - Contract Labor and Benefit Cost	
Hospital and Hospital-Based Component Identification:	
1.00     Total facility's contract labor and benefit cost     1,014,098     29,455,428       2.00     Hospital     1,014,098     29,455,428       3.00     Subprovi der - IPF     0     0       4.00     Subprovi der - IRF     0     0       5.00     Subprovi der - (Other)     0     0       6.00     Swi ng Beds - SNF     0     0       7.00     Swi ng Beds - NF     0     0       8.00     Hospital - Based SNF     0     0	
2.00     Hospi tal     1,014,098     29,455,428       3.00     Subprovi der - I PF     0     0       4.00     Subprovi der - I RF     0     0       5.00     Subprovi der - (Other)     0     0       6.00     Swi ng Beds - SNF     0     0       7.00     Swi ng Beds - NF     0     0       8.00     Hospi tal - Based SNF     0     0	
3.00       Subprovi der - IPF       0       0         4.00       Subprovi der - IRF       0       0         5.00       Subprovi der - (0ther)       0       0         6.00       Swi ng Beds - SNF       0       0         7.00       Swi ng Beds - NF       0       0         8.00       Hospi tal -Based SNF       0       0	1.00
4.00       Subprovi der - IRF       0       0         5.00       Subprovi der - (0ther)       0       0         6.00       Swi ng Beds - SNF       0       0         7.00       Swi ng Beds - NF       0       0         8.00       Hospi tal -Based SNF       0       0	2.00
5.00       Subprovi der - (0ther)       0       0         6.00       Swi ng Beds - SNF       0       0         7.00       Swi ng Beds - NF       0       0         8.00       Hospi tal -Based SNF       0       0	3.00
6.00       Swi ng Beds - SNF       0       0         7.00       Swi ng Beds - NF       0       0         8.00       Hospi tal -Based SNF       0       0	4.00
7. 00 Swi ng Beds - NF 0 0 8. 00 Hospi tal -Based SNF 0 0 0	5.00
8.00 Hospi tal -Based SNF 0 0	6.00
	7.00
9.00 Hospi tal -Based NF	8.00
	9.00
10. 00 Hospi tal -Based OLTC	10.00
11. 00 Hospi tal -Based HHA 0 0	11.00
12.00   Separately Certified ASC   0   0	12.00
13. 00 Hospi tal -Based Hospi ce 0	13.00
14.00 Hospital-Based Health Clinic RHC 0 0	14.00
15.00 Hospital-Based Health Clinic FQHC 0 0	15.00
16.00 Hospi tal -Based-CMHC 0 0	16.00
17. 00   Renal Dialysis   0   0	17.00
18.00 Other 0 0	18.00

Heal th	Financial Systems	GOSHEN HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
	HEALTH AGENCY STATISTICAL DATA		Provi der C		eri od:	Worksheet S-4	
			Component		rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
					Home Health	5/28/2019 7: 0	3 pm
					Agency I		
					1	00	
0. 00	County				ELKHART		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1. 00 2. 00	Home Health Aide Hours	0.00	1, 002 370. 00		· ·		1. 00 2. 00
2.00	Unduplicated Census Count (see instructions)	0.00	370.00		oyees (Full Ti		2.00
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0	)	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 76 0. 96			3. 00 4. 00
5. 00	Other Administrative Personnel			0. 10			5. 00
6.00	Direct Nursing Service			10. 80			
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. 92 3. 44			7. 00 8. 00
9.00	Physical Therapy Supervisor			0.00			9. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 93 0. 00			1
12. 00	Speech Pathology Service			0. 40			12.00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 1. 99			1
15. 00	Medical Social Service Supervisor			0.00			1
16. 00	Home Heal th Aide			2. 08			
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			•
	HOME HEALTH AGENCY CBSA CODES					0.00	
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			3			19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			21140			20. 00
	contains the first code).						
20. 01 20. 02				23060 99915			20. 01 20. 02
20. 02		Full Ep	i sodes	99915			20.02
			With Outliers	LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21 00	PPS ACTIVITY DATA	2 027	F20	117	41	2 722	21 00
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	3, 037 586, 048	538 103, 637			3, 733 720, 634	1
23. 00	Physical Therapy Visits	1, 296	218	11		1, 534	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	277, 447 530	46, 731 128			328, 513 669	
26. 00	Occupational Therapy Visit Charges	110, 656	26, 554	1, 734		139, 594	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	63 14, 459	19 4, 361	0	0	82 18, 820	27. 00 28. 00
29. 00	Medical Social Service Visits	156	83	6	5	250	
30.00	Medical Social Service Visit Charges Home Health Aide Visits	42, 435 740	22, 533 160			67, 984 925	30.00
31. 00 32. 00	Home Health Aide Visit Charges	740	16, 320		23 2, 346		31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	5, 822	1, 146			7, 193	33. 00
34. 00	29, and 31) Other Charges	o	0	0	0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	1, 103, 892	220, 136				ł
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	367		53	5	425	36. 00
	outlier)	307					
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	147, 904	36 31, 855		1 1, 066	37 184, 574	37. 00 38. 00
55.00	1.010. Not hour no mour our suppry onar ges	177,704	31,000	J, 147	1,000	104, 3/4	1 55.50

Heal th	Financial Systems		GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED HOSPICE IDENTIFICATION DATA			Provi der Co	CN: 15-0026	Peri od:	Worksheet S-9		
				Hoopi oo CCI	N: 15-1527	From 01/01/2018 To 12/31/2018		GH IV
				nospi ce cci	N. 13-1327	10 12/31/2016	5/28/2019 7:03	
						Hospi ce I	0,20,201, ,10	<u> </u>
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
			0.00	Facility		5.00		
	DART I FURNIL MENT DAVIC FOR O	1.00	2.00	3.00	4.00	5. 00	6. 00	
1 00	PART I - ENROLLMENT DAYS FOR CO	JST REPORTING F	TERTODS BEGINNI	NG BEFORE OCTO	BER 1, 2015 T			1 00
1. 00 2. 00	Hospice Continuous Home Care Hospice Routine Home Care			•				1. 00 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
3.00	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGLNNLNG	BEFORE OCTOBER	1 2015			3.00
6. 00	Number of patients receiving	KEI OKTTNO TEKI	DEGITIMING	DEFORE GOTOBER	1, 2010			6. 00
0.00	hospice care							0.00
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1	, 2015		
10. 00				0		0 0	-	10. 00
11. 00				16, 414	•	0 2, 112	18, 526	
12.00	Hospice Inpatient Respite Care			55		0 5	60	
13.00				158		0 74	232	
14.00	Total Hospice Days	N DATA FOR CO.	ST DEDODTING DE	16, 627		0 2, 191	18, 818	14.00
15 00	PART IV - CONTRACTED STATISTICA		ST KEPUKTING PE	1				15 00
15.00	Hospice Inpatient Respite Care Hospice General Inpatient Care			0		0 0		
10.00	Thospice delieral impatrent care			1	1	Ol Ol	0	10.00

	Financial Systems GOSHEN H			In Lie	u of Form CMS-2	2552-10		
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0026	Peri od:	Worksheet S-10	0		
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 7:03			
					1. 00			
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	3 divided by li	ne 202 colum	n 8)	0. 266344	1.00		
2.00	Net revenue from Medicaid				9, 370, 019	2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid	?			Υ	3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supple			ai d?	Υ	4.00		
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental paymen Medicaid charges	is from Medical	a		0 69, 914, 397	5. 00 6. 00		
7. 00	Medicald cost (line 1 times line 6)				18, 621, 280	7.00		
8.00	Difference between net revenue and costs for Medicaid progr	ram (line 7 min	us sum of li	nes 2 and 5; if	9, 251, 261	8.00		
	< zero then enter zero)							
9. 00	Children's Health Insurance Program (CHIP) (see instruction Net revenue from stand-alone CHIP	is for each iin	e)		0	9.00		
10.00	Stand-alone CHIP charges				0	10.00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
12. 00	Difference between net revenue and costs for stand-alone Ch	HIP (line 11 mi	nus line 9;	if < zero then	0	•		
	enter zero)							
12 00	Other state or local government indigent care program (see				0	   13. 00		
13. 00 14. 00								
14.00	10)	care program (	Not Theradea	TIL TIMES 0 01	U	14. 00		
15. 00	State or local indigent care program cost (line 1 times lin	ne 14)			0	15. 00		
16. 00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.0							
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid,	CHIP and stat	e/local indi	gent care program	ıs (see			
17 00	instructions for each line)				0	17.00		
17. 00 18. 00	Private grants, donations, or endowment income restricted Government grants, appropriations or transfers for support				0	17. 00 18. 00		
19. 00				s (sum of lines	9, 251, 261	19.00		
	8, 12 and 16)			•				
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	pati ents 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 (see instructions)	e facility	7, 217, 2	26 1, 804, 047	9, 021, 273	20. 00		
21. 00	1.	scounts (see	1, 922, 2	1, 804, 047	3, 726, 312	21. 00		
22. 00	Payments received from patients for amounts previously wri	tten off as		0 0	0	22. 00		
23. 00	charity care Cost of charity care (line 21 minus line 22)		1, 922, 2	65 1, 804, 047	3, 726, 312	23. 00		
					1. 00			
24 00	Does the amount on line 20 column 2, include charges for pa	atient days bev	ond a Length	of stay limit	N N	24. 00		
	imposed on patients covered by Medicaid or other indigent of If line 24 is yes, enter the charges for patient days beyon	care program?	_	·	0			
	stay limit							
	Total bad debt expense for the entire hospital complex (see				984, 395	ı		
27. 00	·				210, 232			
27. 01 28. 00	· · ·	ev (266 LU2TLC	LI UIIS)		323, 434 660, 961	•		
20.00	· · · · · · · · · · · · · · · · · · ·	t expense (see	instructions	)	289, 245	•		
29.00								
29. 00 30. 00	Cost of uncompensated care (line 23 column 3 plus line 29)			,	4, 015, 557			

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-0026 F	Peri od:	Worksheet A	1002 10
					From 01/01/2018 To 12/31/2018	Date/Time Pre	pared.
						5/28/2019 7:0	3 pm
	Cost Center Description	Sal ari es	0ther	,	Reclassi 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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		13, 312, 440				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(		1	2.00
3. 00 4. 00	OO300 OTHER CAP REL COSTS   OO400 EMPLOYEE BENEFITS DEPARTMENT	715, 381	26, 905, 151	27, 620, 532	0 2 770, 496	1	3. 00 4. 00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	941, 886	1, 707, 809			2, 649, 695	5. 01
5. 02	00590 OTHER ADMIN & GENERAL	11, 257, 704	44, 227, 194				5. 02
6.00	00600 MAINTENANCE & REPAIRS	0	0	(	0	0	6. 00
7.00	00700 OPERATION OF PLANT	812, 713	2, 921, 629			3, 734, 342	7.00
8. 00 9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING	37, 176 848, 905	592, 497 625, 814			629, 673 1, 474, 719	
10. 00	01000 DI ETARY	769, 957	483, 520				
11. 00	01100 CAFETERI A	0	0	(	835, 912		
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	(	0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 236, 387	1, 018, 328				
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	227, 764 1, 449, 132	460, 087 9, 122, 370				
	01600 MEDICAL RECORDS & LIBRARY	1, 385, 403	2, 238, 282				
	01700 SOCIAL SERVICE	952, 353	31, 291			983, 644	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(	0	0	
	02000 NURSI NG SCHOOL	0	0	(	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	(	0	0	21. 00
22. 00	02300 PARAMED ED PRGM		0		286, 806	286, 806	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			200,000	200, 000	23.00
30.00	03000 ADULTS & PEDIATRICS	7, 693, 121	1, 111, 723	8, 804, 844	1, 076, 265	9, 881, 109	30.00
	03100 INTENSIVE CARE UNIT	2, 240, 727	455, 716	2, 696, 443	-176, 463	1	
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	
33. 00 34. 00	03300   BURN INTENSIVE CARE UNIT   03400   SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF		0			0	40.00
	04100 SUBPROVI DER - I RF	l o	0	d	o o	Ö	41. 00
42.00	04200 SUBPROVI DER	O	0	(	0	0	
	04300 NURSERY	3, 132, 232	549, 698	3, 681, 930	-3, 340, 884	l	
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	(	0	0	
	04600 OTHER LONG TERM CARE		0			0	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	4, 460, 297	14, 067, 695				
51. 00 52. 00	05100   RECOVERY ROOM   05200   DELIVERY ROOM & LABOR ROOM	675, 843	68, 077	743, 920	-38, 360 1, 827, 395		
53. 00	05300 ANESTHESI OLOGY		0		1, 627, 393	1, 027, 393	•
	05301 PAIN MANAGEMENT	O	1, 062, 657	1, 062, 657	0	· -	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 964, 954	2, 866, 046		-428, 922	6, 402, 078	54.00
55. 00		10, 342, 692	26, 347, 767			16, 066, 608	
56. 00 56. 01	05600 RADI OI SOTOPE   05601 CARDI AC CATH LAB	414, 256 1, 329, 220	1, 112, 775 5, 603, 390				
57. 00	05700 CT SCAN	506, 872	568, 901				
58. 00	05800 MRI	467, 804	122, 243				
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59. 00
60.00	06000 LABORATORY	2, 924, 222	4, 505, 206	7, 429, 428	-1, 639, 609	1	
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0			0	61. 00 62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.		636, 931	636, 931	-66, 816	570, 115	
64.00	06400 I NTRAVENOUS THERAPY	188, 572	39, 970			198, 146	
65. 00	06500 RESPI RATORY THERAPY	1, 597, 491	398, 741				
66.00	06600 PHYSI CAL THERAPY	3, 119, 752	519, 772	3, 639, 524			
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0	(	713, 036 405, 869		1
69. 00	06900 ELECTROCARDI OLOGY	233, 743	111, 239	344, 982			
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	9, 795, 218		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	8, 666, 589		
73. 00 74. 00	07300   DRUGS CHARGED TO PATIENTS   07400   RENAL DIALYSIS		237, 942	237, 942	29, 268, 443		
75. 00	07500 ASC (NON-DISTINCT PART)		237, 742	257, 942		1	•
76. 00	03950 NUTRITION THERAPY	204, 005	6, 575	210, 580			
00.00	OUTPATIENT SERVICE COST CENTERS				\	=	00.00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
	09000 CLINIC	446, 652	262, 897	709, 549	-62, 368	1	
				<u> </u>	<u> </u>	·	

Harlah Financial Contant	COCUEN HOC	CDI TAI		1 = 13 =	£ F CMC 3	NEE2 40
Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	GOSHEN HOS	Provider CC	N: 15_0026	eriod:	u of Form CMS-2 Worksheet A	2552-10
RECEASE FOR THE AND ADDUSTMENTS OF TREAD DALANCE OF	I EXI ENSES	Trovider co	F	rom 01/01/2018		
			1	o 12/31/2018	Date/Time Prep 5/28/2019 7:03	oared: 3 nm
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	5 piii
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
90. 02   09002   WOUND CLINIC	4, 010	1, 711, 699	1, 715, 709	-186, 800	1, 528, 909	90. 02
90. 03   09003   MOBILE CLINIC	0	0	1 010 700	0	0	90. 03
91. 00 09100 EMERGENCY	3, 154, 778	893, 961	4, 048, 739	-180, 290	3, 868, 449	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
99. 00 09900 CMHC	٥	O		ار	0	99. 00
101.00 10100 HOME HEALTH AGENCY	2, 591, 346	491, 540	3, 082, 886	-52, 446	3, 030, 440	
SPECIAL PURPOSE COST CENTERS	2, 371, 340	471, 540	3, 002, 000	-52, 440	3, 030, 440	101.00
113. 00 11300 I NTEREST EXPENSE		968, 455	968, 455	-968, 455	0	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	700, 433	700, 430	700, 435		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )		0	(	ol ol		115. 00
116. 00 11600 HOSPI CE	970, 052	1, 220, 922	2, 190, 974	-329, 163	1, 861, 811	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	72, 297, 402	169, 588, 950	241, 886, 352		241, 991, 859	
NONREI MBURSABLE COST CENTERS				· · · · ·		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 218, 938	628, 503	1, 847, 441	-20, 314	1, 827, 127	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	C	0	0	190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	C	0	0	190. 02
190. 03 19003 LI FELI NE	0	0	(	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	650, 007	4, 748, 677	5, 398, 684	-85, 193	5, 313, 491	
190. 05 19005 PRI VATE DUTY	0	0	C	0		190. 05
190.06 19006 PROFESSI ONAL DEVELOPMENT	9, 680	1, 578, 009	1, 587, 689	이	1, 587, 689	
190. 07 19007 FOUNDTI ON	0	0	(	이		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	1, 353	1, 353			190. 08
191. 00 19100 RESEARCH	361, 455	134, 777	496, 232		496, 232	
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	(			192.00
193. 00 19300 NONPALD WORKERS	74 527 400	174 400 240	051 017 751			193. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	74, 537, 482	176, 680, 269	251, 217, 751	ı <sub>l</sub> 0	251, 217, 751	200. UU

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 7:03 pm

Control   Cont					5/28/2019 7:0	)3 pm
		Cost Center Description				
EMBERIAL SERVICE COST CENT BIS  1. 00 DODGO OF PRIT COSTS BIS DE FIXT  2. 207, 856  5. 00 DOSGO OFFIRE LOS SERVICES DELIVATION 1  5. 01 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 02 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 02 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 02 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 03 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 04 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 05 DOSGO OFFIRE LOS SERVICES DELIVATION 1  7. 00 DOSGO OFFIRE LOS SERVICES DELIVER 1  7. 00 D						
1.00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 703, 476   500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 500, 577   2, 00   0.0000   CAP   REL DOSTS - PLUC & FIX   -4, 500, 577   2, 00   0.0000   CAP		OFNEDAL CEDIUSE COCT OFNEDO	6. 00	7.00		
2. 00   00200 CAP REL COSTS-WINEL EDUIT   -2, 297, 387   5, 0e5, 276   3, 0	1 00		4 702 47/	000 010		1 00
3.00   0.000			The state of the s	1		
4 00 0000 DERFORMER PRIFETTS DEPARTMENT - 1,075,330						1
0.0580   CASH JERNING ACCOUNTS RECOVERABLE   1,000   2,449,069   5,01			1	1		1
DOSED   CHERN ADMIN & CRINEDAL   -41,621,325   14,809,319   3,20   6,0   0,0		· ·	-1,0/5,330			
0.000   QUAD MAINTENANCE & REPAIRS   0   0   0   0   0   0   0   0   0			41 421 225	1		
0.000 0000 QUENTATION SERVICES 0.000 0000 0000 QUENTATION SERVICES 0.000 0000 0000 0000 QUENTATION SERVICES 0.000 0000 0000 0000 QUENTATION SERVICES 0.000 0000 0000 0000 0000 0000 0000 0			-41, 021, 325	1		1
0.00   0.000   DANION Y & LI NEN SERVICE   0   0.29, 673   9.0   0.0000   0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000000			1 205	1		1
9, 00   00000   MUSESTEPT PIN   0   1,474,719   9,00   11 00   01 1000   CAPETTER   0   1,474,719   10   10   10   11 00   01 1000   CAPETTER   0   337,528   498,884   11   10   10   13 00   01 1000   CAPETTER   0   0   707,362   11   10   14 00   01 4000   CENTRAL SERVI CES & SUPELY   0   0   707,362   11   10   15 00   01 500   CENTRAL SERVI CES & SUPELY   0   0   707,362   11   10   16 00   01 600   MIDICAL RECORDS & LIBRARY   -45,102   3.578,883   1   10   16 00   01 600   MIDICAL RECORDS & LIBRARY   -45,102   3.578,883   1   10   17 00   1700   020 61 & SERVI CES & SUPELY   0   0   0   0   0   17 00   1700   020 61 & SERVI CES & SUPELY   0   0   0   0   0   17 00   01 700   021 & SERVI CES & SUPELY   0   0   0   0   0   18 00   01 600   MIDICAL RECORDS & LIBRARY   -45,102   3.578,883   1   1   0   19 00   020 020   LES SERVI CES & SUPELY   0   0   0   0   0   22 00   02000   LES SERVI CES & SUPELY   0   0   0   0   22 00   02000   LES SERVI CES & SUPELY   0   0   0   0   22 00   02000   LES SERVI CES & SUPELY   0   0   0   0   23 00   03000				1		•
10 00   10000   10 FTARY			1			
11.00 0 1000 CAFETERIA			1			1
12.00   01200   MAINTERNACE OF PERSONNEL   0   0   12.00   13.00   1						1
13.00   0.1300   NURSH NO ADMINI STRATION   0   3, 250, 380   13.0			_			1
14. 00   01-000 (PENTRAL, SERVICES & SUPPLY   0   6.70, 36c				-		1
15.00   01500   PHARBARCY   0   1,725,289   115.00   17.00				1		
16. 0.0   1600 MEDICAL RECORDS & LIBRARY   -45. 102   3.578, 583   10. 0.0   17. 0.0   1700 SCIAL SERVICE   17. 0.0   1700 00   1700 MONPHYSICI AN AMESTHETISTS   0   0   0   0   0   0   0   0   22. 0.0   0   0   0   0   0   0   0   0		1		1		1
17. 00   01700   SOCIAL SERVICE   0   983, 644   17. 00   10. 00   20. 00		1				1
19. 00   01-000   NORPHYSICIAN AMESTHETISTS   0   0   0   0   0   20   00		1		1		1
20 00   02000 NURSING SCHOOL   0   0   0   22.00   0			1			
21.00     02100   RR SERVICES-SALARY & FRINCES APPRY   0   0   22.00   02200   RR SERVICES-CONTERN PRIMOSTS APPRY   0   121.00   0   22.00   02300   PARAMED FD PREM   02505 APPRY   0.165.502   121.304   0.300   NINSTRUMENTED FD PREM   0.300   0.3000   PARAMED FD PREM   0.300   0.3000   PARAMED FD PREM   0.300   0.3000   NINSTRUMENTED FD PREM   0.300   0.3000		1	i c	o		1
22.00   02200   RAT SERVICES-OTHER PROM OSTS APPRY   0   1.05,502   121,304   22.00   1.00		1	1	1		1
23 00   02300   PARAMED ED PROM   .165, 502   121, 304   23, 00				ol		
INPATI ENT ROUTH NE_SERVICE COST CENTERS   30,00   310,00   310,00   30100   AULTS & PEDIATRICS   30,00   310			-165, 502	121, 304		
30.00   30000   ADULTS & FEDIATRICS   0   9,881,109   31,00   31,00   310   01,00   1   NTENSINE CARE UNIT   0   0   0   0   32,00   320   03200   COROMARY CARE UNIT   0   0   0   0   33,00   330   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   34,00   03400   SURGICAL INTENSIVE CARE UNIT   0   0   0   0   0   44,00   04,00   04000   SURFORVIDER - IPF   0   0   0   0   0   0   0   0   0						
31.00	30.00		C	9, 881, 109		30.00
33.00   03300   BURN INTERSIVE CARE LINIT	31.00	03100 INTENSIVE CARE UNIT	-1, 010, 621	1, 509, 359		31.00
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT   0   0   0   40. 00   0400   03400   SURPROVIDER   FF   0   0   0   0   0   0   0   0	32.00	03200 CORONARY CARE UNIT	C	o		32. 00
40.00   04000   04000   04000   0410	33.00	03300 BURN INTENSIVE CARE UNIT	C	o		33. 00
41.00   04100   SUBPROVI DER   1RF	34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	o		34. 00
42.00   04200   04200   SUBPROVIDER   0 0 0   0   0   0   0   0   0   0	40.00	04000 SUBPROVI DER - I PF	C	o		40.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSING FACILITY 0 0 05 00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00	04100 SUBPROVI DER - I RF	C	o		41.00
44. 00   04400   SKILLED NURSING FACILITY	42.00	04200 SUBPROVI DER	C	o		42.00
45. 00 04500 NURSI NG FACI LITY	43.00	04300 NURSERY	-2, 795	338, 251		43.00
A6. 00   04600   DITER LONG TERM CAPE   0   0   0   0   0   0   0   0   0	44.00	04400 SKILLED NURSING FACILITY	C	0		44. 00
ANCILLARY SERVICE COST CENTERS	45.00	04500 NURSING FACILITY	C	0		45. 00
50.00   0500	46.00	04600 OTHER LONG TERM CARE	C	0		46. 00
51.00   05100   RECOVERY ROOM   Co.   Co						
52.00   05.200   DELIVERY ROOM & LABOR ROOM   0   1,827,395   52.00   05.30   ADESTHESIOLOGY   0   0   0   0   0   0   0   0   0	50.00		-11, 440	8, 401, 111		50.00
53. 00   05300   ANESTHESI OLOGY   0   0   53. 00			C			
53. 01   05.301   PAIN MANAGEMENT			C	1, 827, 395		1
54. 00   05400   RADI OLOGY-DI AGNOSTIC   -5, 033, 029   1, 369, 049   55. 00   05500   RADI OLOGY-THERAPEUTI C   -1, 088, 240   14, 978, 368   55. 00   05600   RADI OLOGY-THERAPEUTI C   0   1, 313, 929   56. 00   05600   RADI OLOGY-THERAPEUTI C   0   1, 313, 929   56. 00   05600   RADI OLOGY-THERAPEUTI C   0   1, 313, 929   56. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0		1	C	0		1
55.00   05500   RADI OLOCY-THERAPEUTI C		1	1	1		1
56. 00   05600   RADI OI SOTOPE   0   1, 313, 929   56. 00			1	1		
56. 01   05601   CARDI AC CATH LAB				1		
57. 00       05700   CT SCAN       0       1,007,756       57. 00         58. 00       05800   MRI       0       51,287       58. 00         59. 00       05900   CARDI AC CATHETERI ZATI ON       0       0       0         60. 01       06000   LABORATORY       -461,083   5,328,736       60. 00         60. 01       06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0       0       0         61. 00       06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0       0       0         63. 00       06300   BLOOD STORI NG   PROCESSI NG & TRANS.   0       0       570,115   0         64. 00       06400   INTRAVENOUS THERAPY   0       0       198,146   0         65. 00       06500   RESPI RATORY THERAPY   -5,596   1,976,881   0       65. 00         66. 00       06600   PHST CALL THERAPY   -5,596   1,976,881   0       65. 00         67. 00       06700   OCCUPATI ONAL THERAPY   -1,291   711,745   0       66. 00         68. 00       06800   SPEECH PATHOLOGY   -1,676   404,193   0       68. 00         70. 00       07000   ELECTROEARDI OLOGY   -1,676   404,193   0       69. 00         71. 00       07000   ELECTROEARDI OLOGY   -1,676   404,193   0       69. 00         72. 00       07000   ELECTROEARDI OLOGY   -1,676   404,193   0       70. 0         73. 00			1	1 1		
58. 00     05800 MRI     0 5800 CARDI AC CATHETERI ZATI ON     0 581, 287     58. 00       60. 00     06000 LABORATORY     -461, 083     5, 328, 736     60. 00       60. 01     06001 BLOOD LABORATORY     0 0     0     60. 01       61. 00     06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY     0 0     0     60. 01       62. 00     06200 WHOLE BLOOD & PACKED RED BLOOD CELL     0 0     0     62. 00       63. 00     06300 BLOOD STORI NG PROCESSI NG & TRANS.     0 570, 115     63. 00       64. 00     06400 I INTRAVENOUS THERAPY     0 198, 146     64. 00       65. 00     06500 RESPI RATORY THERAPY     -5, 596     1, 976, 881     65. 00       66. 00     06600 PHYSI CAL THERAPY     -5, 714     2, 508, 742     66. 00       67. 00     06700 OCCUPATI ONAL THERAPY     -1, 291     711, 745     67. 00       68. 00     06800 SPECH PATHOLOGY     -1, 676     404, 193     68. 00       69. 00     06900 ELECTROENCEPHALOGRAPHY     0     0     70. 00       70. 00     07000 ELECTROENCEPHALOGRAPHY     0     0     70. 00       71. 00     07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS     0 8, 666, 589     72. 00       73. 00     07200 IMPL DEV. CHARGED TO PATI ENTS     0 8, 666, 589     73. 00       75. 00<						1
59, 00     05900 (ARDI AC CATHETERI ZATI ON     0     59, 00       60, 00     06000 (ABORATORY     -461, 083     5, 328, 736     60. 00       60, 01     06001 (BLOOD LABORATORY)     0     0     0       61, 00     06100 (PBP CLI NI CAL LAB SERVI CES-PRGM ONLY)     0     0     0       62, 00     06200 (WHOLE BLOOD & PACKED RED BLOOD CELL     0     0     0       63, 00     06300 (BLOOD STORI NG PROCESSI NG & TRANS.     0     570, 115     63. 00       64, 00     06400 (I NTRAVENOUS THERAPY)     0     198, 146     64. 00       65, 00     06500 (RESPI RATORY THERAPY)     -5, 596     1, 976, 881     65. 00       66, 00     06600 (PMYSI CAL THERAPY)     -5, 5714     2, 508, 742     66. 00       67, 00     06700 (OCUPATI ONAL THERAPY)     -1, 291     711, 745     67. 00       68, 00     06800 (SPECCH PATHOLOGY)     -1, 676     404, 193     68. 00       69, 00     06900 (ELECTROCARDI OLOGY)     -285     343, 211     69. 00       70, 00     07000 (ELECTROCARDI OLOGY)     -285     343, 211     69. 00       71, 00     07100 (MEDI CAL SUPPLIES CHARGED TO PATI ENTS     0     8, 666, 589     72. 00       73, 00     07200 (I MPL. DEV. CHARGED TO PATI ENTS     0     29, 268, 443     73. 00			1			
60. 00   06000   LABORATORY   -461, 083   5, 328, 736   60. 00   60. 01   6						
60. 01 06001 BLOOD LABORATORY 0 0 0 0 61.00 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 63.00 06300 BLOOD STORI NG PROCESSI NG & TRANS. 0 570, 115 63.00 64.00 INTRAVENOUS THERAPY 0 198.146 64.00 66500 RESPI RATORY THERAPY -5, 576 1, 976, 881 65.00 66500 RESPI RATORY THERAPY -5, 714 2, 508, 742 66.00 66600 PHYSI CAL THERAPY -1, 291 711, 745 67.00 67.00 68.00 SPEECH PATHOLOGY -1, 676 404, 193 68.00 68600 SPEECH PATHOLOGY -1, 676 404, 193 68.00 6900 ELECTROCARDI OLOGY -285 343, 211 69.00 70.00 70.00 ELECTROCARDI OLOGY -285 343, 211 70.00 07000 ELECTROENCEPHALOGRAPHY 0 9, 795, 218 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 8, 666, 589 72.00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0 8, 666, 589 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 29, 268, 443 73.00 74.00 07400 ASC (NON-DI STI NCT PART) 0 0 237, 942 74.00 75.00 ASC (NON-DI STI NCT PART) 0 0 237, 942 74.00 75.00 ASC (NON-DI STI NCT PART) 0 0 210, 580 00 TERALLY OLD LINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		1		1
61. 00		1		1		1
62. 00		1	1	1		1
63. 00		1		1		1
64. 00				1		1
65. 00		· ·	_	1		
66. 00						
67. 00						
68. 00			The state of the s			
69. 00				1		
70. 00   70. 00   70. 00   70. 00   70. 00   70. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75.			The state of the s	1		
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   9, 795, 218   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   29, 268, 443   73. 00   74. 00   74. 00   74. 00   75. 00				1		
72. 00   07200   1MPL. DEV. CHARGED TO PATIENTS   0   8, 666, 589   72. 00   73. 00   73.00   73.00   73.00   74.00   74.00   74.00   74.00   75.00				-		1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   29, 268, 443   73. 00   74. 00   74. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   75. 00   76		1	1	1		1
74. 00   07400   RENAL DI ALYSI S   0   237, 942   74. 00   75. 00   75. 00   75. 00   76. 00   03950   NUTRI TI ON THERAPY   0   210, 580   76. 00				1		
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 00   76. 00						
76. 00 03950 NUTRITION THERAPY 0 210, 580 76. 00 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 89. 00 89. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 90. 00 09000 CLINIC -6, 119 641, 062 90. 00 90. 02 09002 WOUND CLINIC 0 1, 528, 909 90. 02		1		1		1
OUTPATI ENT SERVI CE COST CENTERS				1		1
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	, 0. 00			210,000		7 3. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0	88 00					88 00
90. 00   09000   CLI NI C   -6, 119   641, 062   90. 00   90. 02   09002   WOUND   CLI NI C   0   1, 528, 909   90. 02			1	1		1
90. 02   09002   WOUND CLINIC   0   1, 528, 909   90. 02				1		1
				1		
				1		1

 
 Health Financial
 Systems
 GOSHE

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0026

			5/28/2019	7: 03 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
91. 00   09100   EMERGENCY	-134, 039	3, 734, 410		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 00 09900 CMHC	0	0		99. 00
101.00 10100 HOME HEALTH AGENCY	0	3, 030, 440		101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	1, 861, 811		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-59, 666, 031	182, 325, 828		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	1, 827, 127		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0		190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0		190. 02
190. 03 19003  LI FELI NE	0	0		190. 03
190.04 19004 COMMUNITY RELATIONS	0	5, 313, 491		190. 04
190. 05 19005 PRI VATE DUTY	0	0		190. 05
190.06 19006 PROFESSIONAL DEVELOPMENT	0	1, 587, 689		190. 06
190. 07 19007 FOUNDTI ON	0	0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	1, 353		190. 08
191. 00 19100 RESEARCH	0	496, 232		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	-59, 666, 031	191, 551, 720		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026

					5/28/2019 7:	03 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - SUPPLIES	74 00	al	0.705.040		4
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	9, 795, 218		1. 00
2 00	PATI ENT	72.00		0 /// 500		2 00
2. 00	IMPL. DEV. CHARGED TO	72. 00	0	8, 666, 589		2. 00
3. 00	PATI ENTS	0. 00	0	0		2 00
7. 00		0.00	0	0		3.00
			0	0		7. 00
8.00		0.00				8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20.00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0. 00	0	0		25. 00
26. 00		0. 00	0	0		26. 00
27. 00		0. 00	0	0		27. 00
28. 00		0. 00	0	0		28. 00
31. 00		0. 00	0	0		31. 00
32.00		0. 00	0	0		32. 00
33.00		0. 00	0	0		33. 00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35. 00
36.00		0.00	0	0		36. 00
37.00		0.00	0	0		37. 00
39.00		0.00	0	0		39. 00
	0		0	18, 461, 807		
	B - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	29, 268, 443		1. 00
2.00	HOME HEALTH AGENCY	101.00	0	639		2. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
11.00		0.00	o	0		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	o	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	o	0		15. 00
16.00		0.00	o	0		16. 00
17.00		0.00	o	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	ol O	Ö		19. 00
20. 00		0.00	0	0		20. 00
23. 00		0.00	Ö	0		23. 00
24. 00		0.00	0	Ö		24. 00
25. 00		0.00	0	0		25. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
20.00			— — ŏ	29, 269, 082		20.00
	C - DI ETARY			27, 207, 002		+
1.00	CAFETERI A	11. 00	513, 465	322, 447		1. 00
1.00	<u> </u>		513, 465	322, 447		1.00
	D - CAPITAL INSURANCE		313, 403	322, 447		-
1.00	OTHER ADMIN & GENERAL	5. 02	ما	138, 046		1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	813, 149		2.00
3.00	OTHER ADMIN & GENERAL	5. 02	0	998, 983		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	346		4. 00
4. 00 5. 00	OTHER ADMIN & GENERAL	5. 02	0	16, 392		5. 00
5.00	OTTLE ADWIN & GENERAL		— — — <del>0</del>	1 <u>6, 3</u> 92 1, 966, 916		3.00
	E - CAPITAL INTEREST		U	1, 700, 710		-
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	ما	968, 455		1.00
1.00	ON NEE COSTS-DEDG & FIXT		0	968, 455 968, 455		1.00
	I <sup>O</sup>	l	Ч	700, 400		1

					10	0 12/31/2018	5/28/2019 7:0	
		Increases						ļ
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	F - CAPITAL DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7, 385, 316				1. 00
2.00		0.00	0	0				2. 00
	0		0	7, 385, 316				
	G - CIRCLE OF CARE							
1.00	ADULTS & PEDIATRICS	30.00	1, 236, 292	177, 691				1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 597, 752	229, 643				2. 00
	0		2, 834, 044	407, 334				
	H - COMMUNITY HEALTH							
1.00	COMMUNITY RELATIONS	1 <u>90.</u> 04	14 <u>0, 0</u> 19	6 <u>3, 1</u> 18				1. 00
	0		140, 019	63, 118				
	I - EMT							
1.00	PARAMED ED PRGM	23. 00	15 <u>3, 7</u> 52	13 <u>3, 0</u> 54				1. 00
	0		153, 752	133, 054				
	J - THERAPY							
1. 00	OCCUPATI ONAL THERAPY	67.00	658, 438	54, 598				1. 00
2.00	SPEECH PATHOLOGY		353, 676	5 <u>2, 1</u> 93				2. 00
	0		1, 012, 114	106, 791				
500.00	Grand Total: Increases		4, 653, 394	59, 084, 320				500.00

Provider CCN: 15-0026

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 7:03 pm

						5/28/2019 7:0	03 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1 00	A - SUPPLIES  EMPLOYEE BENEFITS DEPARTMENT	4.00	٥	7			1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	0	0		1.00
3. 00	OTHER ADMINI & CENERAL	5. 02	0				3. 00
3. 00 7. 00	OTHER ADMIN & GENERAL DIETARY	•	0	5, 542 95			7. 00
	NURSING ADMINISTRATION	10.00	0		-		1
8. 00 9. 00	1	13.00	0	3, 544	-		8. 00 9. 00
10. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	17, 489 25, 934			10.00
13. 00	ADULTS & PEDIATRICS	30.00	0	337, 450	-		13. 00
14. 00	INTENSIVE CARE UNIT	31.00	0	176, 205	0		14. 00
15. 00	NURSERY	43. 00	0	99, 436			15. 00
16. 00	OPERATING ROOM	50.00	0	10, 114, 634	1		16. 00
17. 00	RECOVERY ROOM	51.00	o	38, 360	o		17. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54. 00	O	401, 342			19. 00
20. 00	RADI OLOGY-THERAPEUTI C	55. 00	Ö	255, 982	o		20.00
21. 00	RADI OI SOTOPE	56.00	Ö	5, 860	o		21. 00
22. 00	CARDI AC CATH LAB	56. 01	Ö	4, 688, 035	o		22. 00
23. 00	CT SCAN	57. 00	o	66, 594			23. 00
24. 00	MRI	58. 00	o	4, 483	O		24. 00
25. 00	LABORATORY	60.00	o	1, 639, 545	0		25. 00
26. 00	BLOOD STORING PROCESSING &	63.00	o	66, 816	O		26. 00
	TRANS.			·			
27.00	RESPIRATORY THERAPY	65. 00	o	13, 684	o		27. 00
28.00	PHYSI CAL THERAPY	66.00	o	6, 106	o		28. 00
31.00	ELECTROCARDI OLOGY	69. 00	О	1, 486	0		31.00
32.00	CLINIC	90.00	o	3, 663	o		32. 00
33.00	WOUND CLINIC	90. 02	0	176, 514	0		33.00
34.00	EMERGENCY	91.00	0	176, 962	0		34.00
35.00	HOME HEALTH AGENCY	101.00	0	53, 085	0		35. 00
36.00	HOSPI CE	116. 00	0	81, 407	0		36. 00
37.00	GIFT FLOWER COFFEE SHOP &	190. 00	0	23	0		37. 00
	CANTEEN						
39. 00	COMMUNITY RELATIONS	1 <u>90.</u> 04	0_	1, 524			39. 00
	0		0	18, 461, 807			
	B - PHARMACY		ما	10 (1)			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42, 646			1.00
2.00	NUDCING ADMINISTRATION	0.00	0	0			2.00
4.00	NURSI NG ADMI NI STRATI ON	13.00	0	791	0		4. 00
5.00	PHARMACY	15. 00	0	8, 820, 279	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	268			6.00
7.00	INTENSIVE CARE UNIT	31.00	0	258			7.00
8. 00 9. 00	NURSERY OPERATING ROOM	43.00	0	70 807	0		8. 00 9. 00
9. 00 11. 00	RADI OLOGY-DI AGNOSTI C	50.00	0				11. 00
12. 00	RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	19, 620 19, 800, 197	0		12.00
13. 00	RADI OI SOTOPE	56. 00	0	207, 242	0		13. 00
14. 00	CARDI AC CATH LAB	56. 00 56. 01	0	250	0		14. 00
15. 00	CT SCAN	57. 00	0	1, 423			15. 00
16. 00	MRI	58. 00	0	4, 277	0		16. 00
17. 00	LABORATORY	60.00	0	64			17. 00
18. 00	INTRAVENOUS THERAPY	64. 00	O	30, 396			18. 00
19. 00	RESPIRATORY THERAPY	65. 00	0	71	0		19. 00
20. 00	PHYSI CAL THERAPY	66.00	0	57			20.00
23. 00	CLINIC	90.00	O O	58, 705			23. 00
24. 00	WOUND CLINIC	90. 02	O O	10, 286			24. 00
25. 00	EMERGENCY	91.00	o o	3, 328			25. 00
27. 00	HOSPI CE	116.00	o o	247, 756			27. 00
28. 00	GIFT FLOWER COFFEE SHOP &	190.00	0	20, 291			28. 00
	CANTEEN			·			
	0		0	29, 269, 082			
	C - DIETARY						
1.00	DI ETARY	10.00	513, 465	322, 447	0		1. 00
	0		513, 465	322, 447			
	D - CAPITAL INSURANCE						
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	7, 960			1. 00
2.00	RADI OLOGY-THERAPEUTI C	55. 00	0	138, 046			2. 00
3.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 820, 910			3. 00
4.00		0. 00	0	0			4. 00
5. 00		0.00	•	0	0		5. 00
	0		0	1, 966, 916			_
4 05	E - CAPITAL INTEREST		. 1	0/			
1. 00	INTEREST EXPENSE	113.00		968, 455			1. 00
	ĮV		O	968, 455			I

Heal th Financial Systems GOSHEN HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0026 Period: From 01/01/2018 From 01/01/2018 Pata/Time Propagation

					То		e Prepared: 9 7:03 pm
		Decreases		<u> </u>		· ·	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	F - CAPITAL DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6, 955, 690	9		1.00
2.00	RADI OLOGY-THERAPEUTI C	5500	0	429, 626			2. 00
	0		0	7, 385, 316			
	G - CIRCLE OF CARE						
1.00	NURSERY	43.00	2, 834, 044	407, 334	0		1. 00
2.00		0.00	0	0	0		2. 00
	0		2, 834, 044	407, 334			
	H - COMMUNITY HEALTH						
1. 00	OTHER ADMIN & GENERAL		14 <u>0, 0</u> 19	6 <u>3, 1</u> 18			1.00
	0		140, 019	63, 118			
	I - EMT						
1.00	COMMUNITY RELATIONS	190.04	153, 752	13 <u>3, 0</u> 54			1. 00
	0		153, 752	133, 054			
	J - THERAPY						
1. 00	PHYSI CAL THERAPY	66.00	1, 012, 114	106, 791	0		1.00
2.00		0.00		0	0		2. 00
	0		1, 012, 114	106, 791			
500.00	Grand Total: Decreases		4, 653, 394	59, 084, 320			500.00

					To 12/31/2018	Date/Time Prep 5/28/2019 7:03	
				Acqui si ti ons		072072017 7:0	<b>У</b>
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	4, 027, 467	0		0 0	0	1.00
2.00	Land Improvements	2, 736, 366	0		0 0	0	2.00
3.00	Buildings and Fixtures	104, 838, 283	5, 187, 575		0 5, 187, 575	65, 460	3.00
4.00	Building Improvements	36, 948	0		O C	0	4. 00
5.00	Fi xed Equipment	17, 570, 878	1, 227, 818		0 1, 227, 818		5. 00
6.00	Movable Equipment	93, 146, 892	7, 759, 530		0 7, 759, 530	3, 956, 624	6. 00
7. 00	HIT designated Assets	0	0		O C	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	222, 356, 834	14, 174, 923		0 14, 174, 923	4, 052, 393	8. 00
9.00	Reconciling Items	0	0		O C	0	9. 00
10.00	Total (line 8 minus line 9)	222, 356, 834	14, 174, 923		0 14, 174, 923	4, 052, 393	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANNUALO OF OURNOSS IN OARLEN AGES	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	4, 027, 467	0				1. 00
2.00	Land Improvements	2, 736, 366	0				2. 00
3.00	Buildings and Fixtures	109, 960, 398	0				3. 00
4.00	Building Improvements	36, 948	0				4. 00
5.00	Fi xed Equi pment	18, 768, 387	0				5. 00
6.00	Movable Equipment	96, 949, 798	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	232, 479, 364	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	232, 479, 364	0				10. 00

Health Financial Systems GOSHEN HOSPITAL In Lieu of For	In Lieu of Form CMS-2552-10					
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0026 Period: Worksho	t A-7					
From 01/01/2018   Part       To 12/31/2018   Date/Ti	o Droparodi					
	9 7:03 pm					
SUMMARY OF CAPITAL						
Cost Center Description Depreciation Lease Interest Insurance (see Taxes	see					
instructions) instruc						
9.00 10.00 11.00 12.00 13.	)					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 CAP REL COSTS-BLDG & FIXT   11,357,409   0   1,955,031	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) 11,357,409 0 0 1,955,031	0 3.00					
SUMMARY OF CAPITAL						
Cost Center Description Other Total (1) (sum						
Capi tal -Rel ate   of col s. 9						
d Costs (see   through 14)						
i nstructi ons)						
14. 00 15. 00						
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 CAP REL COSTS-BLDG & FIXT 0 13, 312, 440	1. 00					
2.00 CAP REL COSTS-MVBLE EQUIP 0 0	2. 00					
3.00  Total (sum of lines 1-2)   0  13,312,440	3.00					

Health Financial Systems	GOSHEN HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre 5/28/2019 7:0	pared:
	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPIT				OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FLXT	135, 529, 566		135, 529, 56			1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	96, 949, 798		96, 949, 79			2.00
3.00 Total (sum of lines 1-2)	232, 479, 364		232, 479, 36			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NIERS		1	0 054 500		
1. 00 CAP REL COSTS-BLDG & FLXT	0	0		0 2, 954, 582		1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0		0 7, 385, 316		2.00
3.00 Total (sum of lines 1-2)	0	<u>U</u>	IMMADY OF CADI	0 10, 339, 898	0	3. 00
	SUMMARY OF CAPITAL					
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	10.00	40.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12.00	13. 00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FIXT	-2, 287, 884	134, 121	1	0 0	800, 819	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	-2, 329, 387			0 0	· ·	2.00
3.00 Total (sum of lines 1-2)	-2, 329, 367 -4, 617, 271			0 0		
3.00   10tai (Suiii 01 111165 1-2)	-4,017,271	134, 407	I	<b>υ</b>	5, 657, 094	3.00

					To 12/31/2018	Date/Time Prep 5/28/2019 7:03	
				Expense Classification of	n Worksheet A	1 37 207 2019 7.0	3 PIII
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-3, 256, 339	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	Investment income - CAP REL	В	-2 329 387	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		2,027,007		2.00		2.00
3.00	Investment income - other		0		0.00	0	3. 00
4 00	(chapter 2)	D.	02 200	OTHER ARMIN & CENERAL	F 02	0	4 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-83, 208	OTHER ADMIN & GENERAL	5. 02	0	4. 00
5.00	Refunds and rebates of	В	-1, 330, 722	OTHER ADMIN & GENERAL	5. 02	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by	В	-1, 447, 137	CAP REL COSTS-BLDG & FIXT	1.00	9	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		0		0.00	ŭ	7.00
	21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provider-based physician	A-8-2	-12, 633, 626		0.00	Ö	10. 00
	adjustment						
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
12.00	transactions (chapter 10)	701	O			Ü	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00	Cafeteria-employees and guests		-337, 528	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than					-	
47.00	patients						47.00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-45, 102	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts						
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of	В	-392, 546	OTHER ADMIN & GENERAL	5. 02	0	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		Ü		0.00	O	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of						
05.00	limitation (chapter 14)			LITTLE ZATION DEVICES ONE	444.00		05.00
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FIXT		_			_	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
-2. //	instructions)		0		33.30		, ,
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
02.00	Depreciation and Interest		0		3.00	Ĭ	52.00
		'			·		

					o 12/31/2018	Date/Time Pre 5/28/2019 7:0	
	·			Expense Classification on			
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 00
	(3)		4/5 500	5.5.455 55 5504			
33. 01	EMT CLASS TUITION	В		PARAMED ED PRGM	23.00	0	00.0.
33. 02		В	· ·	RADI OLOGY-THERAPEUTI C	55. 00	0	33. 02
33. 03		В		OTHER ADMIN & GENERAL	5. 02	0	33. 03
33. 04		A		OTHER ADMIN & GENERAL	5. 02	0	33. 04
33. 05	ALCOHOLI C BEVERAGE	A		OTHER ADMIN & GENERAL	5. 02	0	33. 05
33. 06	LOBBYI NG EXPENSE	A		OTHER ADMIN & GENERAL	5. 02	0	33. 06
33. 07		A		OTHER ADMIN & GENERAL	5. 02	0	33. 07
33. 08		A	-27, 112, 532	OTHER ADMIN & GENERAL	5. 02	0	33. 08
	(PHYSI CI ANS)						
33. 09		В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 09
33. 10	CARDIAC REHAB MISC INCOME	В	-285	ELECTROCARDI OLOGY	69.00	0	33. 10
33. 11	MISC LAB REV	В	-9, 576	LABORATORY	60.00	0	33. 11
33. 12	NUTRITION EDUCATION MISC		0		0.00	0	33. 12
	INCOME						
33. 13	HAF OFFSET	A	-8, 378, 328	OTHER ADMIN & GENERAL	5. 02	0	33. 13
33. 14	MISC OPERATING ROOM REVENUE	В	-9, 440	OPERATING ROOM	50.00	0	33. 14
33. 15	MISC PLANT OPERATIONS REVENUE	В	-1, 295	OPERATION OF PLANT	7.00	0	33. 15
33. 16	MISC RESPIRATORY THERAPY	В	-5, 596	RESPIRATORY THERAPY	65.00	0	33. 16
	REVENUE						
33. 17	GOSH CCB REVENUE PRENATAL	В	-2, 795	NURSERY	43.00	0	33. 17
	CLASSES						
33. 18	GOSH REHAB - PEDLATRIC MISC	В	-5, 714	PHYSI CAL THERAPY	66.00	0	33. 18
	INCOME						
33. 19	GOSH REHAB - PEDLATRIC MISC	В	-1, 291	OCCUPATI ONAL THERAPY	67.00	0	33. 19
	INCOME						
33. 20	GOSH REHAB - PEDLATRIC MISC	В	-1, 676	SPEECH PATHOLOGY	68.00	0	33. 20
	INCOME						
33. 21	ENDOSCOPY MISC INOME	В	-2, 000	OPERATING ROOM	50.00	0	33. 21
33. 22	CATH LAB MISC INOME	В	-484	CARDIAC CATH LAB	56. 01	0	33. 22
33. 23	· ·		0		0.00	0	
	INCOM						
33. 24	1	В	-6, 119	CLINIC	90.00	0	33. 24
50. 00	1		-59, 666, 031				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0026

Worksheet A-8-2 From 01/01/2018 12/31/2018 Date/Time Prepared:

5/28/2019 7:03 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7.00 5. 02 OTHER ADMIN & GENERAL 2, 468, 790 49, 484 1. 00 1.00 2, 518, 274 211, 500 586 179, 066 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 3, 171, 205 2, 992, 138 271, 900 1, 331 2.00 3.00 60. 00 LABORATORY 476, 507 451, 507 25,000 260, 300 956 3.00 4.00 0.00 4.00 0 31.00 INTENSIVE CARE UNIT 5.00 1, 057, 700 984, 700 73,000 211, 500 463 5.00 6.00 91. 00 EMERGENCY 180,000 180,000 211, 500 452 6.00 7.00 53. 01 PALN MANAGEMENT 1, 096, 668 1, 024, 668 72,000 211, 500 795 7.00 54. 00 RADI OLOGY-DI AGNOSTI C 141, 187 1,870,415 681 8.00 2, 011, 602 27, 100 8.00 9.00 55. 00 RADI OLOGY-THERAPEUTI C 948, 069 773, 109 174, 960 271, 900 607 9.00 10.00 0 00 0 10.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 1, 675, 336 1, 675, 336 11.00 11.00 0 894, 697 200.00 13, 135, 361 12, 240, 663 5.871 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Limit Unadjusted RCE Memberships & Component of Mal practice Conti nui ng Share of col. Insurance Limit Educati on 12 14.00 2.00 9.00 1.00 8.00 12.00 13.00 1.00 5. 02 OTHER ADMIN & GENERAL 59, 586 2, 979 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 173, 990 8,700 0 0 2.00 5, 982 60. 00 LABORATORY 0 0 0 0 3.00 119, 638 3.00 4.00 0. 00 0 0 4 00 5.00 31.00 INTENSIVE CARE UNIT 47,079 2, 354 0 5.00 6.00 91. 00 EMERGENCY 45, 961 2, 298 0 0 6.00 0 0 0 53. 01 PALN MANAGEMENT 0 7.00 80,838 4,042 0 7.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 8.00 8,873 444 8.00 9.00 55. 00 RADI OLOGY-THERAPEUTI C 79, 348 3, 967 0 0 9.00 0 0 0 10.00 0.00 10.00 0 0 11.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 0 C 11.00 0 200.00 615, 313 30, 766 200.00 Cost Center/Physician Provi der Adjusted RCE RCE Wkst. A Line # Adjustment I denti fi er Component Limit Di sal I owance Share of col 14 1.00 2.00 15.00 16.00 17.00 18.00 59, 586 1.00 5. 02 OTHER ADMIN & GENERAL 2, 468, 790 1.00 54. 00 RADI OLOGY-DI AGNOSTI C 173, 990 2, 997, 215 2.00 0 5.076 2.00 3.00 60. 00 LABORATORY 0 119, 638 451, 507 3 00 4.00 0.00 0 4.00 5.00 31. 00 I NTENSI VE CARE UNIT 0 47,079 25, 921 1,010,621 5.00 91. 00 EMERGENCY 0 6.00 45, 961 6.00 134, 039 134, 039 53. 01 PAIN MANAGEMENT 0 7.00 80, 838 1,024,668 7.00 8.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 8,873 132, 314 2,002,729 8.00 0 9.00 55. 00 RADI OLOGY-THERAPEUTI C 79, 348 868, 721 9.00 95, 612 0 10.00 0.00 0 0 10.00 11.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 0 1,675,336 11.00 200.00 615, 313 392, 962 12, 633, 626 200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0026 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 7:03 pm CAPITAL RELATED COSTS CASHI ERI NG/ACC Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** for Cost **BENEFITS** OUNTS RECEI VABLE DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 800, 819 00100 CAP REL COSTS-BLDG & FLXT 800 819 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 5, 056, 275 5, 056, 275 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 26, 715, 692 9, 197 26, 726, 255 4.00 1, 366 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 13, 219 340, 997 3, 003, 911 5 01 2, 649, 695 5 01 00590 OTHER ADMIN & GENERAL 5.02 14, 808, 315 55, 691 1, 480, 981 4, 024, 998 0 5.02 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 7.00 00700 OPERATION OF PLANT 3, 733, 047 53, 939 80,098 294, 231 0 7.00 00800 LAUNDRY & LINEN SERVICE 3, 751 8 00 629, 673 8 00 13, 459 0 9.00 00900 HOUSEKEEPI NG 1, 474, 719 973 7,896 307, 334 0 9.00 01000 DI ETARY 417, 470 3, 637 10.00 10.00 4.369 92, 859 01100 CAFETERI A 8, 746 11.00 498, 384 7, 281 185, 893 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 3, 250, 380 3, 079 384, 440 809, 653 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 670, 362 5, 230 46, 270 82, 459 14.00 01500 PHARMACY 4, 314 15.00 1, 725, 289 70, 722 524, 638 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 3, 578, 583 9,069 54, 201 501, 566 0 16.00 17.00 01700 SOCIAL SERVICE 983, 644 2, 169 958 344, 786 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING SCHOOL 20.00 0 0 20.00 C 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 C 0 02300 PARAMED ED PRGM 121, 304 457 55, 664 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 881, 109 78, 995 134, 627 3, 232, 769 214, 147 30.00 03100 INTENSIVE CARE UNIT 31.00 1,509,359 20, 230 63,848 811, 224 57, 267 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 Ω 0 0 Ω 40.00 41 00 0 C 0 0 Ω 41 00 04200 SUBPROVI DER 42.00 0 42.00 04300 NURSERY 338, 251 10,066 107, 955 8,500 43.00 43.00 3, 012 04400 SKILLED NURSING FACILITY 44.00 44.00 0 04500 NURSING FACILITY 45.00 0 0 Λ 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 8 401 111 121 702 987 142 1 614 788 304 436 50 00 51.00 05100 RECOVERY ROOM 705, 560 6, 439 16, 797 244, 679 53, 713 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 827, 395 16, 139 53, 935 578, 444 39, 622 52.00 05300 ANESTHESI OLOGY 53.00 C 0 12, 110 53.00 C 05301 PAIN MANAGEMENT 37, 989 53 01 53 01 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 369, 049 64, 943 538, 907 1, 435, 456 172, 537 54.00 05500 RADI OLOGY-THERAPEUTI C 14, 978, 368 88, 978 222, 908 3, 744, 427 629, 854 55.00 55.00 56, 00 05600 RADI OI SOTOPE 1, 313, 929 4, 834 64, 872 149, 976 71, 720 56, 00 05601 CARDI AC CATH LAB 314, 889 56.01 2, 243, 841 5, 582 481, 225 56.01 141, 902 57.00 05700 CT SCAN 1,007,756 1, 355 218 183, 506 188, 801 57.00 05800 MRI 58.00 581, 287 3,067 181, 848 169, 362 35, 791 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 C 0 06000 LABORATORY 5, 328, 736 11, 799 82, 287 1, 058, 674 182, 973 60.00 60.00 60.01 06001 BLOOD LABORATORY 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 62 00 0 0 0 63.00 06300 BLOOD STORING PROCESSING & TRANS. 570, 115 841 7, 467 63.00 198, 146 06400 INTRAVENOUS THERAPY 64.00 679 68, 270 22, 364 64.00 06500 RESPIRATORY THERAPY 1, 976, 881 5, 303 72, 392 578, 349 29, 129 65.00 65.00 06600 PHYSI CAL THERAPY 31, 235 763, 041 32, 300 2, 508, 742 66.00 13, 836 66.00 67.00 06700 OCCUPATIONAL THERAPY 711, 745 4, 351 1, 435 238, 378 11, 443 67.00 06800 SPEECH PATHOLOGY 68 00 404, 193 1,076 300 128, 043 7, 930 68 00 06900 ELECTROCARDI OLOGY 9.909 37, 863 69.00 343, 211 9, 514 84, 623 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 795, 218 136, 613 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 666, 589 C 0 0 108, 348 72.00 07300 DRUGS CHARGED TO PATIENTS 29, 268, 443 73.00 C 0 0 249, 960 73.00 07400 RENAL DIALYSIS 0 74.00 237, 942 566 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 03950 NUTRITION THERAPY 210, 580 9, 364 73, 857 7<u>36</u> 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00

			Fi	rom 01/01/2018 o 12/31/2018		pared:
					5/28/2019 7:0	
		CAPITAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	
	0	1.00	2.00	4. 00	5. 01	
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC	0 641, 062	0 4, 428		·	7, 334	89. 00 90. 00
90. 02   09002   WOUND CLINIC	1, 528, 909	39, 757	3, 175	1, 452	1	90. 02
90. 03   09003   MOBILE CLINIC 91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	3, 734, 410	41, 512	71, 051	1, 142, 143	0 184, 441	90. 03 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	3, 030, 440	10, 410	-	938, 161	11, 278	
SPECIAL PURPOSE COST CENTERS			• - 1		· · ·	
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	1, 861, 811	0	0	351, 194		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	182, 325, 828	759, 069	5, 021, 374	25, 920, 237	3, 003, 911	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 827, 127	22, 783	20, 513	441, 299		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	0	0		190. 01
190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	0		190. 02
190. 03 19003 LI FELI NE	5 242 424	45.044	14 222	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	5, 313, 491	15, 311	14, 388	230, 354		190. 04
190. 05 19005 PRI VATE DUTY 190. 06 19006 PROFESSI ONAL DEVELOPMENT	1 507 (00	0	0	2 505		190. 05 190. 06
190. 06 19006 PROFESSIONAL DEVELOPMENT 190. 07 19007 FOUNDTION	1, 587, 689	3, 656	0	3, 505		190. 06
190. 07 19007 FOUND IT ON 190. 08 19008 GOSHEN GACC CLINIC	1, 353	3, 000	0	0		190. 07
191. 00 19100 RESEARCH	496, 232	0	0	130, 860		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	470, 232	0	0	130, 000		192. 00
193. 00 19300 NONPALD WORKERS		0	0	0		193. 00
200.00 Cross Foot Adjustments		J		O	١	200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	191, 551, 720	800, 819	5, 056, 275	26, 726, 255		

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026

COMPAND   SERVICE COST CENTERS   SA O1   S. O2   S. O3   S.								5/28/2019 7:0	
			Cost Center Description	Subtotal			OPERATION OF PLANT	LAUNDRY &	
1.00   000000   000000   0000000   0000000				5A. 01					
2.00   000000   00000   000000   000000   000000	1 00					I			1 00
0.000   DOUGO DENI-LOYEE SIRENEN IS DENAMINEN   20, 300, 985   20, 360, 985   2									
5.02   000-900 (IHER AMINI & GENENAL   20.389, 9915   0.00									
0.00 000000 MAINTENANCE & REPAIR IS 0.00 00000 DEPARTON OF PERSONNET 1.00 000000 DEPARTON OF PERSO									
2.00   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000				20, 369, 985	20, 369, 985	1			
8 00 00 000000000000000000000000000000				4 161 315	495 180	1			
10.00   01000   DETARY			1			1		749, 980	
11.00 0 11000 CAFETERIA 700,304 83,333 0 0 60,806 0 11.00 12.00 130.00 NIRSING ADMINISTRATION 4.447,552 5.99,211 0 21,440 0 13.00 130.00 NIRSING ADMINISTRATION 4.447,552 5.99,211 0 21,440 0 13.00 130.00 NIRSING ADMINISTRATION 4.447,552 5.99,211 0 21,440 0 13.00 130.00 NIRSING ADMINISTRATION 4.447,552 5.99,211 0 33,440 0 13.00 10.00 10.00 NIRSING ADMINISTRATION 4.447,552 5.99,211 0 33,440 0 13.00 10.00 NIRSING ADMINISTRATION 4.447,340 0 0 0 0 0 0 0 0 0 10.00 NIRSING ADMINISTRATION 4.413,419 493,050 0 0 0 0 0 0 0 10.00 NIRSING ADMINISTRATION 4.413,419 493,050 0 0 0 0 0 0 15.104 0 17.00 NIRSING ADMINISTRATION 4.413,419 493,050 0 0 15.104 0 17.00 NIRSING ADMINISTRATION 4.413,419 493,050 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			•						
12.00   01200   MARTENINGE OF PRESONREL   0 0 0 0 12.00		1	l e e e e e e e e e e e e e e e e e e e					_	
13.00 (0.1300) MIRSING ADMINISTRATION		1	l e e e e e e e e e e e e e e e e e e e	700, 304				_	
15.00   01500   PHARMACY   2, 224, 903   276, 661   0   30, 038   0   15.00				4, 447, 552	_		-	_	
16. 00   1000   MEDICAL RECORDS & LIBRARY   4, 143, 419   493, 050   0   63, 145   0   10   00   19. 00   19. 00   19. 00   19. 00   19. 00   0   0   0   0   0   0   0   0   19. 00   19. 00   19. 00   19. 00   0   0   0   0   0   0   0   0   19. 00   19						1			
17. 00 0 1700 SCICLAL SERVICE STARLAY & FRINCES APPRY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	•		· ·				
19.00 0   1900   MONPHYSICI AN AMESTHETISTS   0   0   0   0   0   0   0   0   0						1		_	
21.00   02100   IAS SERVICES-SALARY & FRINCES APPRV   0   0   0   0   0   0   0   0   0				0		1	0		
22.00   02000   IAR SERVICES-OTHER PROX COSTS APPRV   0   0   0   0   0   22.00				0	0	0	0		
23 00   03300   PARAMED ED PRIGN				0	0		_	_	
INPATI ENT ROUTINE SERVICE COST CENTERS   13,541,647   1,611,402   0   550,019   190,555   30,00   31.00   3000 ADUITS & PEDIATRICS   13,541,647   1,611,402   0   550,019   190,555   30,00   31.00   31.00   31.00   31.00   32.00   62.00				177, 425		•			
31. 00   03700   INTENSI VE CARE UNIT   2, 461,928   292,960   0   140,856   72,930   31. 00   32. 00   33. 00   03300   0300   0300   070   0   0   0   0   0   0   0   0					,		,		
32 00   03200   COROMARY CARE UNIT   0   0   0   0   0   0   33 00   33 00   330 00   330 00   8URN INTENSIVE CARE UNIT   0   0   0   0   0   0   34 00   034 00   034 00   034 00   034 00   034 00   034 00   044 00   040 00   040   041 00   040 00   041						1		•	
33.00     03300   BURN INTERSIVE CARE UNIT   0   0   0   0   0   0   33.00				2, 461, 928		1			
34. 00   03400   SURPICH DEFE   F   0				0	_	1	0		
11. 00   04100   SUBPROVI DER   1 IFF   0   0   0   0   0   0   0   0   0	34.00	1	•	0	0	0	0	0	
42 00   04-200   SUBROVI DER				0	0	0	0	_	
43.00   04300   NURSERY   467,784   55,664   0   20,973   5,392   43.00     44.00   04500   O4500   SILLLER DIVISING FACILITY   0   0   0   0   0   0   0   0     44.00   04500   O4500   OTHER LONG TEM CARE   0   0   0   0   0   0   0   0     ANCILLARY SERVICE COST CENTERS				0	_	1	0		
44. 00   04400   SALLED NURSING FACILITY				467, 784	_	1	20, 973		
Accord   Oxford   Carrier   Carrie		04400	SKILLED NURSING FACILITY	0		1	0		
ANCILLARY SERVICE COST CENTERS   11,429,179   1,360,027   0 847,388   143,630   50.00   51.00   51.00   62000   0252000   025200   025200   025200   025200   025200   025200   025200   025200   025200   025200   025200   025200   025200   02520				0					
50.00   05000  05000  05000   05000	46.00			0		) 0	0	0	46. 00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   2,515,535   299,339   0   112,374   28,889   52.00   53.00   05300   ANSTHESIS LOGY   12,110   1,441   0   0   0   0   0   53.00   53.00   53.01   05301   PAIN MANAGEMENT   37,989   4,521   0   0   0   0   53.00   53.01   54.00   05400   ANSTHESIS LOGY   2452,183   38,672   54.00   05500   RADIOLOGY-THERAPEUTIC   19,664,535   2,340,001   0   619,528   26,792   55.00   05500   RADIOLOGY-THERAPEUTIC   19,664,535   2,340,001   0   619,528   26,792   55.00   05600   RADIOLOGY-THERAPEUTIC   1,664,535   2,340,001   0   0   33,658   16,075   56.00   05600   RADIOLOGY-THERAPEUTIC   1,664,535   2,340,001   0   0   0   9,433   42,317   57.00   0   0   0   0   0   0   0   0   0	50.00			11, 429, 179	1, 360, 027	' 0	847, 388	143, 630	50. 00
12.110									
53.01   05301   PAIN MANAGEMENT   37,989   4,521   0   0   0   53.01						1			
54.00   05400   RADI OLOGY-DI AGNOSTI C   3, 580, 892   426, 112   0   452, 183   38, 672   54.00		1	l .		· ·		0		
56. 01   05600   RADI OI SOTOPE   1, 605, 331   191, 028   0   33, 658   16, 075   56. 00		1	l .			1	452, 183		
56.01   05601   CARDI AC CATH LAB   3, 187, 439   379, 292   0   38, 863   4, 191   56.01				l ' '		1			
57. 00   05700   CT SCAN   1, 381, 636   164, 409   0   9, 433   42, 317   57. 00   58. 00   05800   MRI     971, 355   115, 587   0   21, 355   8, 022   58. 00   05900   CARDIAC CATHETERIZATION   0   0   0   0   0   0   0   0   0		1	•			1			
58. 00   05800   MRI   971, 355   115, 587   0   21, 355   8, 022   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   59. 00   60. 01   06000   LABORATORY   6, 664, 469   793, 045   0   82, 152   0   60. 00   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   63. 00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   578, 423   68, 830   0   5, 855   0   63. 00   64. 00   06400   INTRAVENOUS THERAPY   289, 459   34, 444   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   2, 662, 054   316, 774   0   36, 925   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   3, 349, 154   398, 536   0   217, 479   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   967, 352   115, 111   0   30, 293   0   67. 00   68. 00   08800   SPEECH PATHOLOGY   541, 542   64, 441   0   7, 495   0   68. 00   69. 00   07000   ELECTROENCEPHALLOGRAPHY   0   0   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATI ENT   9, 931, 831   1, 181, 848   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   29, 518, 403   3, 512, 617   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   238, 508   28, 381   0   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   294, 537   35, 049   0   65, 196   0   76. 00   76. 00   08900   PEDERALLY CUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   EDECTRALLY CUALIFIED HEALTH CENTER   0   0   0   0   0   89. 00   08900   CEDERALLY CUALIFIED HEALTH CENTER   0   0   0   0   89. 00   08900   CEDERALLY CUALIFIED HEALTH CENTER   0   0   0   0   90. 00   09000   CLINIC   1,593, 178   189, 582   0   276, 820   0   90. 00   09000   CUNIC CLINIC   1,593, 178   189, 582   0   276, 820   0   90. 02   09000   UNID CLINIC   1,593, 178   189, 582   0   276, 820   0   90. 02   09000   UNID CLINIC   1,593, 178   189, 582   0   276, 820   0   90. 02   09						1			
60. 00   06000   LABORATORY   6, 664, 469   793, 045   0   82, 152   0   60. 00   0   0   0   0   0   0   0   0						1			
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   61.00   61.00   62.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   0   0   0   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   0   62.00   06300   BLOOD STORI NG   PROCESSI NG & TRANS.   578, 423   68, 830   0   5, 855   0   63. 00   64.00   64.00   64.00   1 NTRAVENOUS THERAPY   2,899,459   34, 444   0   0   0   0   64.00   65.00   66.00   66.00   06600   PHYSI CAL THERAPY   2,662,054   316,774   0   36,925   0   65.00   65.00   06600   PHYSI CAL THERAPY   967,352   115,111   0   30,293   0   67.00   68.00   6800   SPECH PATHOLOGY   541,542   64,441   0   7,495   0   68.00   69.00   06900   ELECTROCARDI OLOGY   485,120   57,727   0   66,242   0   69.00   0700   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0				0	0	0	0		
61. 00		1	•	6, 664, 469	793, 045	0	82, 152		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62. 00 63. 00 64300 BLOOD STORING PROCESSING & TRANS. 578, 423 68, 830 0 5,855 0 63. 00 6400 INTRAVENOUS THERAPY 289, 459 34, 444 0 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 2,662,054 316,774 0 36,925 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 3,349, 154 398, 536 0 217, 479 0 66. 00 66. 00 06700 OCCUPATI ONAL THERAPY 967, 352 115, 111 0 30, 293 0 67. 00 66. 00 06900 ELECTROCARDI OLOGY 541,542 64, 441 0 7,495 0 68. 00 06900 ELECTROCARDI OLOGY 485, 120 57, 727 0 66, 242 0 69. 00 07000 ELECTROCARDI OLOGY 485, 120 57, 727 0 66, 242 0 69. 00 0710 MEDI CAL SUPPLIES CHARGED TO PATI ENT 9, 931, 831 1, 181, 848 0 0 0 0 71. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 8, 774, 937 1, 044, 182 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 29, 518, 403 3, 512, 617 0 0 0 0 0 733. 00 07300 DRUGS CHARGED TO PATI ENTS 29, 518, 403 3, 512, 617 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	i e	0		,	J	O	
64. 00		1	i e	0	O	0	0	0	
65. 00		1	l e e e e e e e e e e e e e e e e e e e				5, 855		
66. 00   06600   PHYSI CAL THERAPY   3, 349, 154   398, 536   0   217, 479   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   967, 352   115, 111   0   30, 293   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   541, 542   64, 441   0   7, 495   0   68. 00   6900   ELECTROCARDI OLOGY   485, 120   57, 727   0   66, 242   0   69. 00   69. 00   0   0   0   0   0   0   0   0   0							26 025	_	
67. 00									
69. 00		1	l .						
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         9, 931, 831         1, 181, 848         0         0         0         0         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         8, 774, 937         1, 044, 182         0         0         0         0         72. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         29, 518, 403         3, 512, 617         0         0         0         0         73. 00           74. 00         07400         RENAL DI ALYSI S         238, 508         28, 381         0         0         0         74. 00           75. 00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0         0         0         75. 00           76. 00         03950         NUTRI TI ON THERAPY         294, 537         35, 049         0         65, 196         0         76. 00           0UTPATI ENT SERVI CE COST CENTERS         8. 00         0         0         0         0         0         0         0         89. 00           89. 00		1	l .						
71. 00		1	l .	485, 120			66, 242		
72. 00				9, 931, 831	_		0	_	
74. 00 07400 RENAL DI ALYSI S 238, 508 28, 381 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 76. 00 03950 NUTRI TI ON THERAPY 294, 537 35, 049 0 65, 196 0 76. 00  OUTPATI ENT SERVI CE COST CENTERS  88. 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 09000 CLINI C 830, 753 98, 856 0 30, 830 0 90. 00 90. 02 09002 WOUND CLINI C 1, 593, 178 189, 582 0 276, 820 0 90. 02		1	•				0	_	
75. 00				l ' '		1	0	_	
76. 00 03950 NUTRITION THERAPY 294, 537 35, 049 0 65, 196 0 76. 00  OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00  89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00  90. 00 09000 CLINIC 830, 753 98, 856 0 30, 830 0 90. 00  90. 02 09002 WOUND CLINIC 1, 593, 178 189, 582 0 276, 820 0 90. 02				238, 508		1	0		
OUTPATIENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         0         0         0         0         88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         0         89.00           90.00         09000 CLINIC         830,753         98,856         0         30,830         0         90.00           90.02         09002 WOUND CLINIC         1,593,178         189,582         0         276,820         0         90.02				294. 537	_		_		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 0 90. 00	. 5. 55			271,007	30,047		33, 170		
90. 00 09000 CLINIC 830, 753 98, 856 0 30, 830 0 90. 00 90. 02 09002 WOUND CLINIC 1, 593, 178 189, 582 0 276, 820 0 90. 02				0		1	_	_	
90. 02 09002 WOUND CLINIC 1, 593, 178 189, 582 0 276, 820 0 90. 02				0 0 7 5 2	_		J		
						1		_	
	90. 03	09003	MOBILE CLINIC	0	0	0	0	0	90. 03
91. 00   09100   EMERGENCY   5, 173, 557   615, 633   0   289, 039   172, 715   91. 00	91. 00	09100	EMERGENCY	5, 173, 557	615, 633	0	289, 039	172, 715	91. 00

			1'	0 12/31/2018	5/28/2019 7:0	
Cost Center Description	Subtotal	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	LAUNDRY &	
		GENERAL	REPAI RS	PLANT	LINEN SERVICE	
	5A. 01	5. 02	6. 00	7. 00	8. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 00   09900   CMHC	0	0	0	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	4, 012, 467	477, 468	0	72, 479	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	2, 235, 886		0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	181, 443, 159	19, 167, 107	0	4, 365, 802	749, 980	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 311, 722	275, 086	0	158, 633		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	0	0		190. 01
190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	0		190. 02
190. 03 19003 LI FELI NE	0	0	0	0		190. 03
190. 04 19004 COMMUNI TY RELATI ONS	5, 573, 544	663, 229	0	106, 604		190. 04
190. 05 19005 PRI VATE DUTY	0	0	0	0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	1, 591, 194			0		190. 06
190. 07 19007 FOUNDTI ON	3, 656		0	25, 456		190. 07
190. 08 19008 GOSHEN GACC CLINIC	1, 353		0	0		190. 08
191. 00 19100 RESEARCH	627, 092	74, 621	0	0		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
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)	191, 551, 720	20, 369, 985	0	4, 656, 495	749, 980	202. 00

Provider CCN: 15-0026

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm

				' '		5/28/2019 7:0	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF		
		9.00	10.00	11. 00	PERSONNEL 12.00	ADMI NI STRATI ON 13. 00	
	GENERAL SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	10.00	
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. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02 6. 00	00590 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5. 02 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	2, 010, 809					9. 00
10.00	01000 DI ETARY	13, 230	623, 665				10.00
11. 00	01100 CAFETERI A	26, 484	0	871, 017	,		11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	C	0		12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	9, 324	0	12, 795		5, 020, 352	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	15, 837	0	23, 950		0	14.00
15. 00	01500 PHARMACY	13, 064	0	16, 724		37, 885	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	27, 462 6, 569	0	25, 874 14, 778		36, 095 158, 178	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0, 307	0	14, 770		130, 170	19. 00
20. 00	02000 NURSI NG SCHOOL		o	C	o o	ő	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	o	o	C	Ö	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	1, 384	0	C	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	239, 204	531, 213	160, 818			30.00
31.00	03100   NTENSI VE CARE UNI T	61, 259	92, 452	33, 754		526, 245	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	C		0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT		0	(	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF		0	C	0	Ö	40. 00
41. 00	04100 SUBPROVI DER - I RF	o	o	C	0	0	41. 00
42.00	04200 SUBPROVI DER	O	0	C	0	0	42. 00
43.00	04300 NURSERY	9, 121	0	5, 016	0	671, 238	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	C	1	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	368, 529	ol	72, 395	0	718, 542	50.00
51. 00	05100 RECOVERY ROOM	19, 497	0	8, 520		159, 758	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	48, 872	0	26, 876		0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	o	C		0	53. 00
53. 01	05301 PAIN MANAGEMENT	0	0	C	0	0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	196, 655	0	167, 144	0	368, 892	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	269, 434	0	6, 641	0	17, 442	55. 00
56. 00	05600 RADI OI SOTOPE	14, 638	0	0	1	0	56. 00
56. 01	05601 CARDI AC CATH LAB	16, 901	0	16, 662		158, 292	56. 01
57. 00 58. 00	1	4, 102 9, 287	0	C		0 0	57. 00 58. 00
59. 00	1 1	9, 207	0	(		0	59.00
60. 00	06000 LABORATORY	35, 728	0	39, 459	o o	Ö	60.00
60. 01	06001 BLOOD LABORATORY	0	o	C	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.	2, 546	0	C	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	16, 059	0	18, 440		0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	94, 582 13, 174	U O	48, 461	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 260	0	(	0	0	68. 00
69. 00	1	28, 809	0	C	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	C	o o	Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
76. 00		28, 354	0	6, 787	1 0	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS		ام				00 00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	(		0	88. 00 89. 00
90.00	09000 CLINIC	13, 408	0	6, 774	, 0	0	90.00
90.00	09002 WOUND CLINIC	120, 389	0	116		0	90.00
90. 03	09003 MOBILE CLINIC	0	ol	. 10	o o	0	90. 03
91. 00	1 1	125, 703	o	60, 553	s o	560, 689	91. 00
	·						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0026

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

					5/28/2019 7:0	3 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
				PERSONNEL	ADMI NI STRATI ON	
	9. 00	10.00	11.00	12.00	13.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	C	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	31, 521	0	37, 695	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	C	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	15, 039	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 884, 386	623, 665	825, 271	0	5, 020, 352	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	68, 990	0	22, 405	0	0	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	O	0	2, 860	0	0	190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	C	0	0	190. 02
190. 03 19003 LI FELI NE	o	0	Ö	0	0	190. 03
190. 04 19004 COMMUNITY RELATIONS	46, 362	0	13, 688	0	0	190. 04
190. 05 19005 PRI VATE DUTY	O	0	C	0	0	190. 05
190.06 19006 PROFESSIONAL DEVELOPMENT	o	0	1	0	0	190. 06
190. 07 19007 FOUNDTI ON	11, 071	0	Ö	0	0	190. 07
190. 08 19008 GOSHEN GACC CLINIC	O	0	5	0	0	190. 08
191. 00 19100 RESEARCH	o	0	6, 787	0	0	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	o	o	· c	0	0	192. 00
193. 00 19300 NONPALD WORKERS	ol	o	C	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	ol	o	C	0	l .	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 010, 809	623, 665	871, 017	0	5, 020, 352	202.00
				1		

Provider CCN: 15-0026

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm

					0 12/31/2018	5/28/2019 7:0	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES &		RECORDS &		ANESTHETI STS	
		SUPPLY 14.00	15. 00	LI BRARY 16. 00	17. 00	19. 00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	17.00	
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. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5.02	00590 OTHER ADMIN & GENERAL						5. 02
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	O1100   CAFETERI A   O1200   MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	976, 235					14. 00
15. 00	01500 PHARMACY	1, 236	2, 700, 571				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2	0	4, 789, 047			16. 00
17. 00	01700 SOCIAL SERVICE	44	O	0	1, 684, 680		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	О	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	o	0	0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0		23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 500	al	0.11 100			
30.00	03000 ADULTS & PEDI ATRI CS	26, 598	0	341, 433		0	
31.00	03100 INTENSIVE CARE UNIT	7, 320	0	91, 305 0	142, 198	0	
32. 00 33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF		0	0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF		0	0	0	0	41.00
42. 00	04200 SUBPROVI DER		o	0	0	Ö	1
43.00	04300 NURSERY	1, 034	O	13, 552	5, 495	0	1
44.00	04400 SKILLED NURSING FACILITY	O	o	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	0, 475	ما	105 007			
50.00	05000 OPERATI NG ROOM	86, 475	0	485, 387	0	0	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	699 5, 542	0	85, 640 63, 173		0 1 0	
53. 00	05300 ANESTHESI OLOGY	5, 542	0	19, 307	29, 300	0	1
53. 00	05301 PAIN MANAGEMENT		0	17, 307	0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 707	Ö	275, 090	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 406	o	1, 003, 889	0	0	1
56.00	05600 RADI OI SOTOPE	25, 328	o	114, 350	0	0	56. 00
56. 01	05601 CARDI AC CATH LAB	7, 229	o	226, 246	0	0	56. 01
57.00	05700 CT SCAN	7, 282	0	301, 022	0	0	57. 00
58. 00	05800 MRI	3, 451	0	57, 065	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	20, 097	0	291, 729	0	0	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.	21, 203	0	11, 906	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	131	0	35, 657	0	0	1
65. 00	06500 RESPIRATORY THERAPY	6, 490	Ö	46, 442	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	407	Ö	51, 498	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	142	0	18, 245	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	33	0	12, 644	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	295	O	60, 368	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	O	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	365, 605	0	217, 813	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	323, 480	0	172, 749	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 700, 571	398, 531	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	O	903	0	0	
75. 00 76. 00	O7500   ASC (NON-DISTINCT PART)   O3950   NUTRITION THERAPY	0	0	0 1, 173	0	0 0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	1, 1/3			1 70.00
88. 00	08800 RURAL HEALTH CLINIC	O	ol	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	ől	0	0	0	
90. 00	09000 CLINIC	382	o	11, 694	0	0	1
90. 02	09002 WOUND CLINIC	5, 803	o	31, 705		0	
90. 03	09003 MOBILE CLINIC	0	0	0	0	0	90. 03

Health Financial Systems	GOSHEN HOSPITAL		In Lieu of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0026	Peri od:	Worksheet B	

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/28/2019 7:0	pared:
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		J pili
oust center beserveron	SERVICES &	THANWAOT	RECORDS &	SOCIAL SERVICE	ANESTHETI STS	
	SUPPLY		LI BRARY		72011.211.010	
	14.00	15. 00	16. 00	17. 00	19. 00	
91. 00   09100   EMERGENCY	18, 575	0	294, 06	9 204, 362	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 00   09900   CMHC	0	0		0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	1, 430	0	17, 98.	2 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	115. 00
116. 00 11600 H0SPI CE	21, 420	0	36, 48			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	975, 847	2, 700, 571	4, 789, 04	7 1, 684, 680	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	198	0	•	이		190. 00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	•	이		190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	•	이		190. 02
190. 03 19003 LI FELI NE	0	0	•	이		190. 03
190. 04 19004 COMMUNITY RELATIONS	83	0	•	이		190. 04
190. 05 19005 PRI VATE DUTY	0	0	•	이		190. 05
190.06 19006 PROFESSI ONAL DEVELOPMENT	1	0	•	이		190. 06
190. 07 19007 FOUNDTI ON	0	0	•	이		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	•	이		190. 08
191. 00 19100 RESEARCH	106	0	•	이		191. 00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	•	이		192. 00
193. 00 19300 NONPALD WORKERS	0	0	(	이		193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0		201. 00
202.00   TOTAL (sum lines 118 through 201)	976, 235	2, 700, 571	4, 789, 04	7 1, 684, 680	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Date/Time Prepared: | Da Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0026

COST CENTER* DESCRIPTION					11	J 12/31/2016	Date/lime Pre   5/28/2019 7:0	
CENIENT SERVICE COST CENTERS				INTERNS &	RESI DENTS		,	
DESIRAL SERVICE COST CENTERS		Cost Center Description	NURSI NG SCHOOL	Y & FRINGES	PRGM COSTS		Subtotal	
1.00			20.00			23. 00	24.00	
2.00			T	Г	T			
4.00   0.000   DEPLOYUE BEKEFTS   DEPARTWENT		1 1						1
0.0086  CASHI ERINA/ACQUINTS RECEIVABLE		i i						1
0.0090   OURSPOOL MITER AGENT & SERVICE   0.0000   0.0000   OURSPOOL OF PLANT   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.0000   0.00000   0.00000   0.00000000		1 1						1
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000								1
0.00   00000   LANDREY & LINEN SERVICE     0.00								1
9.00   0.0900   MUSEREEP IN	7.00	00700 OPERATION OF PLANT						7. 00
10.00   0.000   DETARY	8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
11-10 00 11000 (AFFERIA   11-20 00 12000 (AFFERIA   12-00 1300 (ARSING ABININISTRATION   13-00 1300 (ARSING ABININISTRATION ABININISTRATION   13-00 1300 (ARSING ABININISTRATION ABININISTRATION   13-00 1300 (ARSING ABININISTRATION ABININISTRAT		l l						1
12.00   10.00   MINISTRAM SERVICES & SUPPLY		l l						1
13.00   1300   NURSI NG ADMINISTRATION		1 1						1
14.00   1400 CENTRAL SERVICES & SUPPLY   15.00   150.00   1600 MEDICAL RECORDS & LIBRARY   15.00   17.00   170.00   17								
15.00								1
10.00   01000   MEDICAL RECORDS & LISHARY     10.00   17.00   170.00   17								1
19.00   01900   NONINYSICI AN AMESTHETISTS		01600 MEDICAL RECORDS & LIBRARY						1
20.00   02000   NURS INS SCHOOL     20.00   220   00   00	17. 00							17. 00
21.00								1
22.00   02200   RAY SERVI CES-OTHER PROM COSTS APPRV   0   203,104   22.00   RAY SERVI CES OST CENTERS   0   0   0   0   0   0   0   0   0		i i	C	)				
23.00				C				
INPATI ENT ROUTH NE SERVICE COST CENTERS		1 1			0	202 104		1
30. 00   030000   ADULTS & PEDIATRICS   0   0   0   0   20, 103, 104   30. 00   32. 00   33	23.00					203, 104		23.00
31.00   03100   INTENSI VE CARE UNIT	30 00				0	O	20 103 104	30 00
32 00   03200   0300ABY CARE UNIT					1	- 1		
34. 00   03400   SURGICAL INTENSIVE CARE UNIT   0   0   0   0   0   34. 00						ō		
40.00   04000   04000   04000   0   0   0	33.00	03300 BURN INTENSIVE CARE UNIT	C	) c	0	O	0	33. 00
41.00   04100   SUBPROVIDER - 1 IRF	34.00		C	) c	0	0	0	34. 00
42.00   04200   SUBPROVIDER			C	) C	0	0		1
43. 00   04300   NURSERY		1 1	0	0	0	0		1
44. 00   04400   SAILLED NURSING FACILITY		1 1			0	0		1
45.00   04500   NURSI NG FACILITY		1 1				0		1
A6. 00   046.00   O160   TERM CARE   0   0   0   0   0   0   0   0   0						0		1
ANCILLARY SERVICE COST CENTERS		l l		1		o		1
51.00   05100   RECOVERY ROOM   0   0   0   0   1,468,364   51.00		ANCILLARY SERVICE COST CENTERS						
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   3, 129, 906   52, 00			C	) c		0		
53.00   05300   ANESTHESI OLOGY   0   0   0   0   32, 858   53.00		1 1	C	0	0	0		
53.01   05301   PAI N MANAGEMENT		1 1			0	0		1
54. 00   05400   RADI OLOGY-DI AGNOSTI C						0		1
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   23, 957, 668   55. 00		1 1				0		1
56. 00   05600   RADI OI SOTOPE   0   0   0   0   2,000,408   56. 00   56. 01   05601   CARDI AC CATH LAB   0   0   0   0   0   4,035,115   56. 01   57. 00   05700   CT SCAN   0   0   0   0   0   1,916,120   57. 00   58. 00   05800   MRI   0   0   0   0   0   0   1,186, 122   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   60. 01   06000   LABORATORY   0   0   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   61. 00   06000   LABORATORY   0   0   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   63. 00   06300   BLOOD STORI NG   PROCESSI NG & TRANS.   0   0   0   0   0   64. 00   06400   NTRAVENOUS THERAPY   0   0   0   0   0   359,691   64, 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   3, 103, 184   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   4, 160, 117   66. 00   67. 00   06700   OCCUPATI IONAL THERAPY   0   0   0   0   0   0   4, 160, 117   66. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   698, 561   69. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   698, 561   69. 00   71. 00   07000   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   351, 30, 122   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   341, 309, 77. 76. 00   76. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   75. 00   77. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   75. 00   77. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00   08900   FEDERALLY						Ö		1
56. 01   05601   CARDI AC CATH LAB   0   0   0   0   4,035,115   56. 01     57. 00   05700   CT SCAN   0   0   0   0   0   1,910,201   57. 00     58. 00   05800   MRI   0   0   0   0   0   1,186,122   58. 00     59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0     59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0     60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0     61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   0     62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0     63. 00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   0   0   0   0   0   0     64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   359, 691   64. 00     65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   3, 103, 184   65. 00     66. 00   06600   PRISTI CAL THERAPY   0   0   0   0   0   0   1, 144, 317   67. 00     67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   1, 144, 317   67. 00     68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   698, 561   69. 00     70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   0     70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   0     70. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0     70. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0     70. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0     70. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0     70. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0     88. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0     89. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0     89. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0     89. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0     89. 00   08900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0     89. 00   08900   EDERRALLY QUALIFIE			d		o	ō		
58. 00			C	o c	0	o		1
59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0		05700 CT SCAN	C	o c	0	0	1, 910, 201	57. 00
60. 00   06000   LABORATORY   0 0 0 0 0 0 7, 926, 679   60. 00   60. 01   60. 01   BLOOD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			C	) C	0	0		
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1		0	0	0		
61. 00		i i			0	0		
62. 00					,	ď		
63. 00		1 1				0		
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   359, 691   64. 00   65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   3, 103, 184   65. 00   066. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   4, 160, 117   66. 00   07. 00   07. 00   07. 00   0   0   0   0   0   0   0   0   0					o o	o		
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   4, 160, 117   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   1, 144, 317   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   629, 415   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   698, 561   69. 00   70. 00   07000   ELECTROECPHALOGRAPHY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0   0   0   0   11, 697, 097   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   10, 315, 348   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   36, 130, 122   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   267, 792   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   75. 00   76. 00   08900   RURAL HEALTH CLI NI C   0   0   0   0   0   88. 00   89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER   0   0   0   0   0   89. 00		i i	C	o c	0	o		1
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 1, 144, 317 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 629, 415 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 698, 561 69. 00 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 11, 697, 097 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 11, 697, 097 77. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 10, 315, 348 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 10, 315, 348 72. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 267, 792 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 267, 792 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 75. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	C	) c	0	o	3, 103, 184	65. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   629, 415   68. 00   690. 00   0   0   698, 561   69. 00   0   0   0   0   698, 561   69. 00   0   0   0   0   0   0   0   0   0	66. 00	06600 PHYSI CAL THERAPY	C	o c	0	0	4, 160, 117	66. 00
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   698, 561   69. 00   70. 00   7			C	) C	0	0		1
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0         11, 697, 097         71. 00           72. 00         07200         I MPL. DEV. CHARGED TO PATI ENTS         0         0         0         0         10, 315, 348         72. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         0         36, 130, 122         73. 00           74. 00         07400         RENAL DI ALYSI S         0         0         0         0         267, 792         74. 00           75. 00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0         0         0         75. 00           76. 00         03950         NUTRI TI ON THERAPY         0         0         0         0         431, 097         76. 00           0UTPATI ENT SERVI CE COST CENTERS         0         0         0         0         0         0         88. 00           89. 00         08900         FEDERALLY QUALI FI ED HEALTH CENTER         0         0         0			C	0	0	0		1
71. 00		1 1			0	0		1
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   10, 315, 348   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   36, 130, 122   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   267, 792   74. 00   075. 00   075. 00   0850   NUTRI TI ON THERAPY   0   0   0   0   0   431, 097   76. 00   00   00   00   00   00   00   00		1 1				0		1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   36, 130, 122   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   267, 792   74. 00   75. 00   07500   ASC (NON-DI STINCT PART)   0   0   0   0   0   0   0   75. 00   03950   NUTRI TI ON THERAPY   0   0   0   0   0   431, 097   76. 00   0   0   0   0   0   0   0   0   0		1 1				0		
74. 00						0		1
76. 00 0 950 NUTRÎTI ON THERAPY 0 0 0 0 431, 097 76. 00 0 0 0 431, 097 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	C	o c	0	o		
OUTPATI ENT SERVI CE COST CENTERS           88. 00         08800 RURAL HEALTH CLINIC         0         0         0         0         0         88. 00           89. 00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         89. 00		1 1		) c	0	o		1
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   89. 00	76. 00	03950 NUTRITION THERAPY	C	) <u> </u>	0	0	431, 097	76. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   89. 00			_					
		1	1			0		1
70. 00  07000 0L1 N1 0   0  0  0  992, 697   90. 00			1			- 1		
	70.00	03000  CET INT C	1	ή <u></u>	η υ	υĮ	772, 097	70.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I Provider CCN: 15-0026

			To	12/31/2018	Date/Time Prep 5/28/2019 7:03	pared: 3 pm
		INTERNS &	RESI DENTS			
Cost Center Description	NURSING SCHOOL			PARAMED ED	Subtotal	
		Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM		
	20.00	21. 00	22. 00	23. 00	24.00	
90. 02   09002   WOUND   CLI NI C	0	0	0	0	2, 217, 593	90. 02
90. 03   09003   MOBI LE CLINI C	0	0	0	o	0	90. 03
91. 00 09100 EMERGENCY	o	0	0	203, 104	7, 717, 999	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					ļ	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	0	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	4, 651, 042	101. 00
SPECIAL PURPOSE COST CENTERS	1					
113. 00 11300   INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		202 104	2, 574, 886	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	U U	0	0	203, 104	179, 777, 031	118.00
190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN		<u> </u>	0	٥	2, 837, 034	100 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	0	0		190. 00
190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	0		190. 01
190. 03 19003 LI FELI NE	0	0	0	0		190. 02
190. 04 19004 COMMUNITY RELATIONS	0	0	0	0	6, 403, 510	
190. 05 19005 PRI VATE DUTY	0	0	0	0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0	o o	0	1, 780, 542	
190. 07 19007 FOUNDTI ON	0	0	0	0	40, 618	
190. 08 19008 GOSHEN GACC CLINIC	0	0	0	o		190. 08
191. 00 19100 RESEARCH	O	0	0	О	708, 606	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	O	0	0	o	0	192. 00
193.00 19300 NONPALD WORKERS	o	0	0	o	0	193. 00
200.00 Cross Foot Adjustments	0	0	0	O	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	-	201. 00
202.00   TOTAL (sum lines 118 through 201)	0	0	0	203, 104	191, 551, 720	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0026

						To 12/31/2018	B   Date/lime Prepared:   5/28/2019 7:03 pm
		Cost Center Description	Intern &	Total			
			Residents Cost				
			& Post Stepdown				
			Adjustments				
			25. 00	26.00			
4 00		AL SERVICE COST CENTERS					1.00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	1	CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 01
5. 02	1	OTHER ADMIN & GENERAL					5. 02
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT					6. 00
8. 00	1	LAUNDRY & LINEN SERVICE					8.00
9. 00	1	HOUSEKEEPI NG					9. 00
10.00	1	DIETARY					10.00
11. 00 12. 00	1	CAFETERIA   MAINTENANCE OF PERSONNEL					11. 00
13. 00	1	NURSING ADMINISTRATION					13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1	PHARMACY					15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY   SOCIAL SERVICE					16.00
17.00	1	NONPHYSICIAN ANESTHETISTS					17. 00 19. 00
20. 00	1	NURSI NG SCHOOL					20. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV					21. 00
22. 00	1	&R SERVICES-OTHER PRGM COSTS APPRV					22. 00
23. 00		PARAMED ED PRGM IENT ROUTINE SERVICE COST CENTERS					23. 00
30.00		ADULTS & PEDIATRICS	0	20, 103, 104			30.00
31. 00	1	INTENSIVE CARE UNIT	0	3, 923, 207			31. 00
32. 00 33. 00	1	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0			32. 00 33. 00
34. 00	1	SURGICAL INTENSIVE CARE UNIT		0			34.00
40.00	1	SUBPROVI DER - I PF	0	0			40.00
41.00	1	SUBPROVIDER - IRF	0	0			41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY	0	0 1, 255, 269			42. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY	0	1, 233, 207			44. 00
45. 00	1	NURSING FACILITY	0	0			45. 00
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	0	0			46. 00
50.00		OPERATING ROOM	0	15, 511, 552			50.00
51.00		RECOVERY ROOM	0	1, 468, 364			51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	3, 129, 906			52.00
53. 00 53. 01	1	ANESTHESI OLOGY PAIN MANAGEMENT	0	32, 858 42, 510			53. 00 53. 01
54. 00		RADI OLOGY-DI AGNOSTI C	Ö	5, 514, 347			54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	23, 957, 668			55. 00
		RADI OI SOTOPE	0	2, 000, 408			56.00
57. 00		CARDIAC CATH LAB  CT SCAN	0	4, 035, 115 1, 910, 201			56. 01 57. 00
58. 00	05800		o	1, 186, 122			58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0			59. 00
60. 00 60. 01	1	LABORATORY   BLOOD LABORATORY	0	7, 926, 679 0			60. 00 60. 01
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY		0			61. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			62. 00
63.00	1	BLOOD STORING PROCESSING & TRANS.	0	688, 763			63. 00
64. 00 65. 00		I NTRAVENOUS THERAPY   RESPI RATORY THERAPY	0	359, 691 3, 103, 184			64. 00 65. 00
66. 00		PHYSICAL THERAPY	0	4, 160, 117			66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	1, 144, 317			67. 00
68.00		SPEECH PATHOLOGY	0	629, 415			68.00
69. 00 70. 00		ELECTROCARDI OLOGY   ELECTROENCEPHALOGRAPHY	0	698, 561 0			69. 00 70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT		11, 697, 097			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10, 315, 348			72. 00
	1	DRUGS CHARGED TO PATIENTS	0	36, 130, 122			73.00
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)		267, 792 0			74. 00 75. 00
76. 00	1	NUTRITION THERAPY		431, 097			75. 00
	OUTPA	TIENT SERVICE COST CENTERS					
		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00 89. 00
		CLINIC		992, 697			90.00
					•		•

Health Financial Systems	GOSHEN HOSPI TAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0026	Peri od: Worksheet B
		From 01/01/2018   Part

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCI	N: 15-0026	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre	nared:
				10 12/31/2010	5/28/2019 7:0	
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
90. 02   09002   WOUND CLINIC	0	2, 217, 593				90. 02
90. 03   09003   MOBI LE CLINI C	0	0				90. 03
91. 00   09100   EMERGENCY	0	7, 717, 999				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 00  09900 CMHC	0	0				99. 00
101.00 10100 HOME HEALTH AGENCY	0	4, 651, 042				101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0				115. 00
116. 00 11600 HOSPI CE	0	2, 574, 886				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	179, 777, 031				118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	2, 837, 034				190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	2, 860				190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0				190. 02
190. 03 19003 LI FELI NE	0	0				190. 03
190. 04 19004 COMMUNITY RELATIONS	0	6, 403, 510				190. 04
190. 05 19005 PRI VATE DUTY	0	0				190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	1, 780, 542				190. 06
190. 07 19007 FOUNDTI ON	0	40, 618				190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	1, 519				190. 08
191. 00 19100 RESEARCH	0	708, 606				191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0				192. 00
193. 00 19300 NONPALD WORKERS	0	0				193. 00
200.00 Cross Foot Adjustments	0	0				200. 00
201.00 Negative Cost Centers	0	0				201. 00
202.00   TOTAL (sum lines 118 through 201)	0	191, 551, 720				202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepare Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0026

				Io	12/31/2018	Date/lime Pre   5/28/2019 7:0	
			CAPI TAL REI	LATED COSTS		1072072017 7.0	O PIII
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		11.00	2.00			
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	0	9, 197	1, 366	10, 563	10, 563	4. 00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	13, 219	0	13, 219	135	5. 01
5.02	00590 OTHER ADMIN & GENERAL	0	55, 691	1, 480, 981	1, 536, 672	1, 598	5. 02
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00	00700 OPERATION OF PLANT	0	53, 939	80, 098	134, 037	116	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 751	0	3, 751	5	8. 00
9.00	00900 HOUSEKEEPI NG	0	973		8, 869	121	9. 00
10. 00	01000 DI ETARY	0	4, 369		8, 006	37	10. 00
11. 00	01100 CAFETERI A	0	8, 746	7, 281	16, 027	73	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSI NG ADMINI STRATI ON	0	3, 079		387, 519	320	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	5, 230		51, 500	33	14. 00
15. 00	01500 PHARMACY	0	4, 314		75, 036	207	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	9, 069		63, 270	198	16. 00
17. 00	01700 SOCIAL SERVICE	0	2, 169	958	3, 127	136	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	457	0	457	22	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		70.005	1 404 407	040 (00		
30.00	03000 ADULTS & PEDIATRICS	0	78, 995		213, 622	1, 277	30.00
31.00	03100   NTENSIVE CARE UNIT	0	20, 230	63, 848	84, 078	320	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	3, 012	10, 066	13, 078	43	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY		3,012	10,000	13,076	0	44. 00
45. 00	04500 NURSING FACILITY		0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE		0		0	0	46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		0	<u> </u>	0	40.00
50. 00	05000 OPERATING ROOM	O	121, 702	987, 142	1, 108, 844	638	50. 00
51. 00	05100 RECOVERY ROOM	o	6, 439		23, 236	97	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	16, 139		70, 074	228	52. 00
53. 00	05300 ANESTHESI OLOGY	o		0	0	0	53. 00
53. 01	05301 PAI N MANAGEMENT	ol	0	0	0	0	53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	ol	64, 943	538, 907	603, 850	567	54.00
55. 00	1	ol	88. 978		311, 886	1, 479	
	05600 RADI OI SOTOPE	ol	4, 834	,	69, 706	59	56. 00
56. 01	05601 CARDI AC CATH LAB	o	5, 582		320, 471	190	56. 01
57.00	05700 CT SCAN	o	1, 355	218	1, 573	72	57. 00
58.00	05800 MRI	o	3, 067	181, 848	184, 915	67	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	0	0	0	59. 00
60.00	06000 LABORATORY	o	11, 799	82, 287	94, 086	418	60.00
60. 01	06001 BLOOD LABORATORY	o	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				o		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	0	O	0	62. 00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	841	0	841	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	679	679	27	64.00
65.00	06500 RESPI RATORY THERAPY	0	5, 303	72, 392	77, 695	228	65. 00
66.00	06600 PHYSI CAL THERAPY	0	31, 235	13, 836	45, 071	301	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	4, 351	1, 435	5, 786	94	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	1, 076	300	1, 376	51	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	9, 514	9, 909	19, 423	33	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	О	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	О	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	О	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	o	0	75. 00
76. 00	03950 NUTRITION THERAPY	0	9, 364	0	9, 364	29	76. 00
	OUTPATIENT SERVICE COST CENTERS	,		,	,		
88. 00	08800 RURAL HEALTH CLINIC	0	0	-	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00

	From 01/01/2018	Part II
		Date/Time Prepared:
		5/28/2019 7:03 pm

			Ic	12/31/2018	Date/lime Pre   5/28/2019 7:0	
		CAPI TAL REL	ATED COSTS		3/20/2019 7.0	3 pili
		CALLIAL KEL	AILD COSTS			
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
oost conten beschiptron	Assigned New	DEBO W TTAT	MIVEL EQUIT	Subtotal	BENEFI TS	
	Capi tal				DEPARTMENT	
	Rel ated Costs				DEI / III III EI II	
	0	1.00	2. 00	2A	4. 00	
90. 00   09000   CLI NI C	0	4, 428	16, 225	20, 653	64	90.00
90. 02 09002 WOUND CLINIC	o	39, 757	3, 175	42, 932	1	90. 02
90. 03 09003 MOBILE CLINIC	o	0	0	o	0	90. 03
91. 00 09100 EMERGENCY	o	41, 512	71, 051	112, 563	451	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		·	·	o		92.00
OTHER REIMBURSABLE COST CENTERS			<u>'</u>			
99. 00 09900 CMHC	0	0	0	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	0	10, 410	22, 178	32, 588	371	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	139	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	759, 069	5, 021, 374	5, 780, 443	10, 245	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	22, 783	20, 513	43, 296		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	0	0	0	190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	0		190. 02
190. 03 19003 LI FELI NE	0	0	0	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	0	15, 311	14, 388	29, 699		190. 04
190. 05 19005 PRI VATE DUTY	0	0	0	0	0	190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0	0	0	1	190. 06
190. 07 19007 FOUNDTI ON	0	3, 656	0	3, 656	0	190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	0	0		190. 08
191. 00 19100 RESEARCH	0	0	0	0	52	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	800, 819	5, 056, 275	5, 857, 094	10, 563	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0026

						Ic	12/31/2018	Date/lime Pre 5/28/2019 7:0	
		Cost Center Description	CASHI ERI NG/ACC			&	OPERATION OF	LAUNDRY &	
			OUNTS	GENERAL	REPAI RS		PLANT	LINEN SERVICE	
			RECEI VABLE 5. 01	5. 02	6. 00	_	7. 00	8. 00	
	GENER	AL SERVICE COST CENTERS							
1.00	1	CAP REL COSTS-BLDG & FIXT							1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP							2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT CASHI ERING/ACCOUNTS RECEIVABLE	13, 354						4. 00 5. 01
5. 02		OTHER ADMIN & GENERAL	13, 334	1, 538, 270					5. 02
6. 00		MAINTENANCE & REPAIRS	0	0	1	0			6. 00
7.00	00700	OPERATION OF PLANT	0	37, 394		0	171, 547		7. 00
8.00		LAUNDRY & LINEN SERVICE	0	5, 813		0	962	10, 531	8. 00
9.00	1	HOUSEKEEPI NG	0	16, 093	1	0	250	0	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0	4, 658 6, 293	1	0	1, 121 2, 243	0 0	10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0	0, 273	1	0	2, 243	0	12. 00
13. 00	1	NURSING ADMINISTRATION	0	39, 966		0	790	0	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	7, 228	1	0	1, 342	0	14. 00
15. 00	1	PHARMACY	0	20, 892	1	0	1, 107	0	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	37, 233	1	0	2, 326 556	0 0	16. 00 17. 00
17.00		NONPHYSICIAN ANESTHETISTS	0	11, 965	1	0	220	0	17.00
20. 00	1	NURSI NG SCHOOL	0	ĺ		0	0	Ö	20.00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	0	O		0	0	0	21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	0	22. 00
23. 00		PARAMED ED PRGM	0	1, 594		0	117	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	962	121, 685	I	0	20, 263	2, 672	30. 00
31. 00		INTENSIVE CARE UNIT	257			0	5, 189	1, 024	
32. 00		CORONARY CARE UNIT	0	0	1	0	0, .07	0	32. 00
33.00	03300	BURN INTENSIVE CARE UNIT	0	o	)	0	0	0	33. 00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	0	0	)	0	0	0	34. 00
40.00	1	SUBPROVIDER - I PF	0	0	1	0	0	0	40. 00
41. 00 42. 00	1	SUBPROVI DER - I RF SUBPROVI DER	0		1	0	0	0	41. 00 42. 00
43. 00		NURSERY	38	4, 204	1	0	773	76	42.00
44. 00	1	SKILLED NURSING FACILITY	0	1, 201	1	0	0	0	44. 00
45.00		NURSING FACILITY	0	0	)	0	0	0	45. 00
46. 00		OTHER LONG TERM CARE	0	0		0	0	0	46. 00
FO 00		LARY SERVICE COST CENTERS	1 2/0	102 702		0	21 21/	2 017	F0 00
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	1, 368 241	102, 703 9, 230	1	0	31, 216 1, 652	2, 017 0	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	178	1	1	0	4, 140	406	
53. 00		ANESTHESI OLOGY	54	109	1	0	0	0	53. 00
53. 01		PAIN MANAGEMENT	0	341		0	0	0	53. 01
54. 00		RADI OLOGY-DI AGNOSTI C	775		1	0	16, 659	543	
55. 00		RADI OLOGY-THERAPEUTI C	2, 686	1	1	0	22, 824	376	
56. 00 56. 01		RADI OI SOTOPE CARDI AC CATH LAB	322 638	14, 426 28, 642	1	0	1, 240 1, 432	226 59	
		CT SCAN	849			0	348		57. 00
	05800		161	8, 729		0	787	113	1
59. 00		CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60.00		LABORATORY	822	59, 887		0	3, 027	0	60.00
60. 01 61. 00		BLOOD LABORATORY	0	0	1	O	0	0	60. 01 61. 00
62. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63. 00	1	BLOOD STORING PROCESSING & TRANS.	34	5, 198		0	216	Ö	63. 00
64. 00	1	INTRAVENOUS THERAPY	101	2, 601	1	0	0	0	64. 00
65. 00		RESPI RATORY THERAPY	131	23, 921	1	0	1, 360	0	65. 00
66. 00		PHYSI CAL THERAPY	145		1	0	8, 012	0	66. 00
67.00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	51	8, 693	1	0	1, 116	0	67. 00 68. 00
68. 00 69. 00		ELECTROCARDI OLOGY	36 170	1		0	276 2, 440	0	69.00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	1, 337	1	0	2, 110	ő	70.00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	614	89, 247		0	0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	487	78, 852	1	0	0	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	1, 123	1		0	0	0	73. 00
74.00		RENAL DIALYSIS	3	2, 143	1	0	0	0	74. 00
75. 00 76. 00		ASC (NON-DISTINCT PART) NUTRITION THERAPY	3	2, 647	1	0	2, 402	0 0	75. 00 76. 00
, 5. 55		TIENT SERVICE COST CENTERS		2,047		J	2, 402		, 5. 55
88. 00		RURAL HEALTH CLINIC	0	C		0	0	0	
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0	0	89. 00
90.00		CLINIC	33	1	1	0	1, 136	0	90.00
90. 02 90. 03		WOUND CLINIC MOBILE CLINIC	89		1	0	10, 198 0	0	90. 02 90. 03
75.00	10,000	1	1 0		I .	٦	0		, , , , , , ,

Health Financial Systems	GOSHEN HOSPI TAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0026	Peri od: Worksheet B

01/01/2018 12/31/2018 Part II Date/Time Prepared: 5/28/2019 7:03 pm CASHIERING/ACC OTHER ADMIN & MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & OUNTS GENERAL REPAI RS PLANT LINEN SERVICE RECEI VABLE 5. 02 6.00 7. 00 8. 00 5.01 91. 00 09100 EMERGENCY 46, 490 91. 00 829 10, 648 2, 425 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 99.00 101. 00 10100 HOME HEALTH AGENCY 0 51 36, 056 2, 670 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 103 20, 092 0 0 116. 00 10, 531 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 354 0 160, 838 118.00 1, 447, 435 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 20, 773 0 5, 844 0 190. 00 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 0 0 0 0 190. 01 0 190. 02 190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE 0 0 190. 03 19003 LI FELI NE 0 190. 03 0 190. 04 19004 COMMUNITY RELATIONS 50,084 3, 927 0 190. 04 190. 05 19005 PRI VATE DUTY 0 0 190. 05 0 0 190. 06 19006 PROFESSI ONAL DEVELOPMENT 0 190. 06 14, 298 0 190. 07 19007 FOUNDTI ON 33 938 0 190. 07 190. 08 19008 GOSHEN GACC CLINIC 0 0 190. 08 12 0 0 o 0 191.00 191. 00 19100 RESEARCH 5, 635 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 0 193. 00 19300 NONPALD WORKERS 0 C 0 193. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 0 13, 354 1, 538, 270 10, 531 202. 00 202.00 TOTAL (sum lines 118 through 201) 171, 547

Provider CCN: 15-0026

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 7:03 pm

Case-and Service Corp (SWIES)		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	5/28/2019 7: 0 NURSI NG	
ENTIREM. SERVICE COST CENTESS 1 00 0000 CAP REL COSTS-EQUE & FIXT   1 00 0000 CAP REL COSTS-EQUE & FIXT   1 00 0000 CAP REL COSTS-EQUE & FIXT   1 00 0000 CARL FIRM STATE & EXPERIENCE   2 0 0000 CARL FIRM STATE & EXPERIENCE   3 0 00 0000 CARL FIRM STATE & FIXT   3 0 0 0000 CARL FIRM STATE & EXPERIENCE   3 0 0 0000 CARL FIRM STATE & EXPERIENCE   3 0 0 0000 CARL FIRM STATE & EXPERIENCE   3 0 0 0000 CARL FIRM STATE & EXPERIENCE   3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						PERSONNEL	ADMI NI STRATI ON	
1.00   1.00		GENERAL SERVICE COST CENTERS	9.00	10.00	11. 00	12. 00	13. 00	
0.000   OUND   SUPLY   OUND	1.00							1. 00
5.00	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
5.00								
0.000   0.0000   MAINTENINGE & REPAIRS								
7. 00 00000 QUOSENTON OF PLANT 8. 00 00000 QUOSENTON OF PLANT 9. 00 00000 QUOSENTON SERVICE 9. 00 00000 QUOSENTON OF PERSONNET 10. 00 10100 QUOSENTON OF PERSONNET 11. 00 10100 QUOSENTON OF PERSONNET 12. 00 10200 QUAL INTERNACE OF PERSONNET 13. 00 10300 QUAL INTERNACE OF PERSONNET 14. 00 10200 QUAL INTERNACE OF PERSONNET 15. 00 10200 QUAL INTERNACE OF PERSONNET 16. 00 10200 QUAL INTERNACE OF PERSONNET 17. 00 10200 QUAL INTERNACE OF PERSONNET 18. 00 10200 QUAL INTERNACE OF PERSONNET 18		1 1						
8 00 00800 (AUNIONY & LINEN SERVICE								
10.00   01000   DI FLARY								
11.00 0 1100 (CAFETERIA ) 334 0 24.70 1 11.00 1 20.01 12.00 1300 (MRS) NO AGMI NITAMOL OF PRESIDENT   11.70 0 367 0 429.07 13.00 0 1300 (MRS) NO AGMI NITAMOL OF PRESIDENT   11.70 0 367 0 429.07 13.00 13.00 (MRS) NO AGMI NITAMOL OF PRESIDENT   11.70 0 10.01 12.00 13.00 (MRS) NO AGMI NITAMOL OF PRESIDENT   11.70 0 10.00 0 10.00 (MRS) NO AGMI NITAMOL OF PRESIDENT   12.00 1 10.00 13.00 (MRS) NO AGMI NITAMOL OF PRESIDENT   12.00 0 10.00 (MRS) NO AGMI NITAMOL OF PRESIDENT   12.00 0 10.00 (MRS) NO AGMI NITAMOL N			1					
12.00   01200   MA NTENANCE OF PERSONNEL   0			1		04.070			
13.00   0300   NURSIN SAMMIN STRATION		1	1	0		0		
14.00 0 10400/FRMEMOY 0 0 0.223 15.00 0 1.00		1 1	1	0		0	429, 079	
10 00   01600 MEDICAL RECORDS & LIBRARY   346		1 1	1	O		0		1
17. 00 0 1700 (SOCIAL SERVICE 81 0 0 0 0 0 0 0 0 0 17. 00 19. 00	15.00		165	0		0	3, 238	15. 00
19. 00   01900   NOMPHYSI CI AM AMESINE ISISS   0   0   0   0   0   0   0   0   2.00			1	-		0		
20.00   0.0000 NURSING SCHOOL   0   0   0   0   0   0   0   0   0		1 1	83	0	424	0		1
22.00   02700   RR SERVICES-SALARY & FRINCES APPRV   0				0	0	0		•
23.00   02300  PARAMED ED PRGM		1 1	o	o	0	0		
INPATIENT ROUTINE SERVICE COST CENTERS   3,014   11,915   4,610   0   137,356   30,00   330,00   300,00   301,00   311	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
30,00   03000   JULTES S PEDI ATRICS   3,014   11,915   4,610   0   137,356   30,00   31,00   3310   01,100   171,001   171,	23. 00		17	0	0	0	0	23. 00
33.00   03300   INTENSIVE CARE UNIT   0 0 0 0 0 0 32.00   33.00   3300	20.00		2 014	11 015	4 (10		127.25/	20.00
32. 00   03200   03200   0300   0400   0   0   0   0   0   0   0		1	1		·			
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33. 00 40. 00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 33. 00 40. 00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			-		
40. 00   0.000   0.000   0.0			o	O	0	0		
41.00   04100   SUBPROVI DER   1RF   0	34.00	03400 SURGICAL INTENSIVE CARE UNIT	O	0	0	0	0	34. 00
42.00   04200   SUBROVI DER   0 0 0 0 0 0 42.00		1 1	0	0	0	0	_	
43.0 0 04300 NURSERY 44.00 0 1400 SKILLED NURSING FACILITY 9 0 0 0 0 0 0 0 0 0 0 0 44.00 45.00 0 4600 ONTER LONG TERM CARE 9 0 0 0 0 0 0 0 0 0 0 0 46.00    ANGILLARY SERVICE COST CENTERS				0	0	0	_	
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 45 00 45 00 46.00 04600 NURSING FACILITY 0 0 0 0 0 0 0 0 45 00 45 00 46.00 04600 NURSING FACILITY 0 0 0 0 0 0 0 0 0 45 00 45 00 45 00 45 00 0 0 0			-	0	-	0		
46. 00   04600   04600   05   0   0   0   0   0   0   0   0			1	o		0		
ANCILLARY SERVICE COST CENTERS	45.00	1 1	0	0	0	0	0	45. 00
50.00   0500	46. 00		0	0	0	0	0	46. 00
51.00	FO 00		4 (41	٥	2.075		(1, 412	F0 00
52.00   05.20   05.20   05.20   05.20   05.20   05.3		1	1 ' 1	-		-		
53.00   05.300   ANESTHESI OLOCY   0   0   0   0   53.00   0.0   0   0   0   0   53.00   0.0		1 1	1	-		0		1
54. 00   05400   RADI OLOGY-THERAPEUTI C   2, 478   0   4, 792   0   31,528   54. 00		1 1	1	0		0	0	1
55.00   05500   RADI OLOGY-THERAPEUTI C   3,394   0   190   0   1,491   55.00		1	-	-	O	0		
56. 00   05600   RADI OI SOTOPE   184		1 1	1	0		0		1
56. 01   05601   CARDI AC CATH LAB   213   0   478   0   13,529   56. 01     57. 00   05700   05800   CT SCAN   52   0   0   0   0   0     59. 00   05800   MRI   117   0   0   0   0   0     59. 00   05800   MRI   117   0   0   0   0   0     59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0     60. 01   06001   BLOOD LABORATORY   450   0   1,1311   0   0   0     60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0     61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 000     62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0     63. 00   06300   BLOOD STORI NG   PROCESSI NG & TRANS.   32   0   0   0   0   0     64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0     65. 00   05500   RESPI RATORY THERAPY   202   0   529   0   0   65. 00     66. 00   06600   PHYSI CAL THERAPY   1, 192   0   1, 389   0   0   66. 00     67. 00   06700   CCUPATI ONAL THERAPY   1, 192   0   1, 389   0   0   66. 00     68. 00   06800   SPECCH PATHOLOGY   41   0   0   0   0     69. 00   06900   ELECTROCARDI OLOGY   363   0   0   0   0   0     69. 00   06900   ELECTROCARDI OLOGY   363   0   0   0   0   0     70. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0     72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0     74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0     75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0     76. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0     76. 00   07500   RURAL HEALTH CLINIC   0   0   0   0   0     90. 02   09002   CLINIC CLINIC CONTROLE   0   0   0   0   0     90. 00   09000   CLINIC CLINIC CONTROLE   0   0   0   0     90. 00   09000   CLINIC CLINIC CONTROLE   0   0   0   0     90. 00   09000   O9000   CLINIC CLINIC CONTROLE   0   0   0   0     90. 00   09000   CLINIC CONTROLE   0   0   0   0     90. 00   09000   CLINIC CONTROLE   0   0   0   0     90. 00   09000   CLINIC CLINIC CO			1	0		0		
57.00		1 1	1	0		0		
59.00   05900   CARDIAC CATHETERIZATION   0   0   0   0   0   0   0   0   0		1 1	1	0	0	0		
60.00   06000   LABORATORY			1	-	0	0	_	
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   60. 01   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   63. 00   06300   BLOOD STORI NG   PROCESSI NG & TRANS.   32   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65. 00   06400   INTRAVENOUS THERAPY   202   0   529   0   0   64. 00   66. 00   06600   PHYSI CAL THERAPY   1, 192   0   1, 389   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   166   0   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   41   0   0   0   0   67. 00   69. 00   06900   ELECTROCARDI OLOGY   363   0   0   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   363   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   75. 00   07500   ASC. (NON-DI STI NCT PART)   0   0   0   0   0   75. 00   07500   ASC. (NON-DI STI NCT PART)   0   0   0   0   0   75. 00   07500   ASC. (NON-DI STI NCT PART)   0   0   0   0   76. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   88. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09000   CLI NI C   0   0   90. 00   09000   CLI NI C   0   0   90. 00   0000   0000   0   90. 00   00000   00000   0   90. 00   00000   00000   000		1	1	-	0	0		
61. 00		1 1	450	0	1, 131	0	0	
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   62.00   63.00   06300   BLOOD STORING   PROCESSING & TRANS.   32   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65.00   06500   RESPIRATORY THERAPY   202   0   529   0   0   65.00   66.00   06600   PHYSI CAL THERAPY   1,192   0   1,389   0   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   166   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   41   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   363   0   0   0   0   0   70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   0   0   0   0   0   75.00   07500   ASC (NON-DI STINCT PART)   0   0   0   0   0   76.00   03950   NUTRI TION THERAPY   357   0   195   0   88.00   08800   RURAL HEALTH CLINI C   0   0   0   0   90.00   09000   CLINI C   169   0   194   0   0   90.02   90.03   09003   MOBI LE CLINI C   0   0   0   0   90.03   09003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   090003   MOBI LE CLINI C   0   0   0   0   90.00   09000   00000   000000   0   0   0				U	U	U	U	
64. 00		1	o	0	0	0	0	
65. 00	63.00	06300 BLOOD STORING PROCESSING & TRANS.	32	0	0	0	0	63. 00
66. 00 06600 PHYSICAL THERAPY 1, 1, 192 0 1, 389 0 0 66. 00 67. 00 670 0CCUPATI ONAL THERAPY 166 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 41 0 0 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 363 0 0 0 0 0 69. 00 69. 00 61. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1 -1	0	0	0		
67. 00   06700   0CCUPATI ONAL THERAPY   166   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   41   0   0   0   0   0   68. 00   68. 00   06900   ELECTROCARDI OLOGY   363   0   0   0   0   0   0   0   69. 00   07000   ELECTROCARDI OLOGY   363   0   0   0   0   0   0   0   0   0		1 1		0		0	0	
68. 00   06800   SPEECH PATHOLOGY   41   0   0   0   0   0   68. 00   69. 00   69. 00   69. 00   69. 00   69. 00   70. 0		1 1	1	0	1, 309	0	0	
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   074. 00   074. 00   074. 00   074. 00   074. 00   075. 00			1	o	0	0	0	
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75.	69. 00	06900 ELECTROCARDI OLOGY	363	0	0	0	0	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0		1 1	0	0	0	0	0	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   75. 00   07500   ASC (NON-DI STINCT PART)   0   0   0   0   0   76. 00   07500   NUTRI TI ON THERAPY   0   0   0    OUTPATIENT SERVICE COST CENTERS  88. 00   08900   RURAL HEALTH CLINI C   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   90. 00   09000   CLI NI C   169   0   194   0   0   90. 02   09002   WOUND CLINI C   1,517   0   3   0   0   90. 03   09003   MOBI LE CLINI C   0   0   0   0   90. 03   09003   MOBI LE CLINI C   0   0   0   0   90. 03		1	0	O	0	0	0	
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   74. 00   075. 00		1 1	0	0	0	0		
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 00   03950   NUTRITION THERAPY   357   0   195   0   0   76. 00   0   0   0   0   0   0   0   0   0		1 1		0	0	0		
76. 00 03950 NUTRITION THERAPY 357 0 195 0 0 76. 00 0 76. 00 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1		o	0	ő	_	
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 88. 00 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 0 0 0 89. 00 90. 00 90. 00   09000   CLINIC   169 0 194 0 0 0 90. 0			1	- 1	195	0		
89. 00     08900   FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0     0     89. 00       90. 00     09000   CLINIC     169     0     194     0     0     90. 00       90. 02     09002   WOUND CLINIC     1,517     0     3     0     0     90. 02       90. 03     09003   MOBILE CLINIC     0     0     0     0     0     90. 03								
90. 00   09000   CLINIC   169   0   194   0   0   90. 00   90. 02   90. 03   09003   MOBILE CLINIC   0   0   0   0   0   0   90. 03   09003   MOBILE CLINIC   0   0   0   0   0   0   0   0   0			0	0	0	0	0	
90. 02   09002   WOUND CLINIC		1 1	140	0	104	0	0	
90. 03   09003   MOBILE CLINIC   0 0 0 0 90. 03		1 1	1	0	3	ol O	0	
91. 00  09100  EMERGENCY   1, 584   0   1, 736   0   47, 921   91. 00		09003 MOBILE CLINIC	0	Ō	0	O	0	
	91. 00	09100  EMERGENCY	1, 584	O	1, 736	0	47, 921	91.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Part | I | Part | I | Prepared: | To 12/31/2018 | Part | I | Prepared: | To 12/31/2018 | Part | I | Prepared: | To 12/31/2018 | Part | I | Prepared: | To 12/31/2018 | Part | I | Prepared: | To 12/31/2018 | Part | Prepared: | To 12/31/2018 | Part | Prepared: | Part | Part

			''	0 12/31/2010	5/28/2019 7:0	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
				PERSONNEL	ADMI NI STRATI ON	
	9. 00	10.00	11. 00	12.00	13.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 00  09900  CMHC	0	0	0	0	0	
101.00 10100 HOME HEALTH AGENCY	397	0	1, 081	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	431	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23, 741	13, 989	23, 659	0	429, 079	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	869	0	642	0		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	82	0		190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	0		190. 02
190. 03 19003 LI FELI NE	0	0	0	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	584	0	392	0		190. 04
190. 05 19005 PRI VATE DUTY	0	0	0	0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0	0	0		190. 06
190. 07 19007 FOUNDTI ON	139	0	0	0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	0	0		190. 08
191. 00 19100 RESEARCH	0	0	195	0		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	25, 333	13, 989	24, 970	0	429, 079	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0026

				'	o 12/31/2018	Date/lime Pre 5/28/2019 7:0	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES &		RECORDS &		ANESTHETI STS	
		SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	19. 00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	17.00	
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. 01 5. 02	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO590   OTHER ADMI N & GENERAL						5. 01 5. 02
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A						10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	60, 990					14. 00
15. 00	01500 PHARMACY	77	101, 201	107 200			15.00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	0	0	107, 200 0			16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0		0	19.00
20. 00	02000 NURSI NG SCHOOL	o	0	0	0	_	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
23. 00	O2300   PARAMED ED PRGM   INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0		23. 00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 662	0	7, 652	23, 065		30.00
31. 00	03100 INTENSIVE CARE UNIT	457	0			l	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0			33.00
34. 00 40. 00	03400  SURGICAL INTENSIVE CARE UNIT   04000  SUBPROVIDER - IPF	0	0	0	_		34. 00 40. 00
41.00	04100 SUBPROVI DER – TFI		0	0			41.00
42. 00	04200 SUBPROVI DER	l o	Ö	0			42. 00
43.00	04300 NURSERY	65	0	304	97		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0			44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0		1	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	0			1 40.00
50.00	05000 OPERATING ROOM	5, 403	0	10, 878	0		50.00
51. 00	05100 RECOVERY ROOM	44	0	1, 919		l .	51.00
52.00	O5200   DELI VERY ROOM & LABOR ROOM	346	0	1, 416			52.00
53. 00 53. 01	05300   ANESTHESI OLOGY   05301   PAI N MANAGEMENT	0	0	433 0			53. 00 53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	544	Ö	6, 165	_		54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	588	0	22, 372	0		55. 00
56. 00	05600 RADI OI SOTOPE	1, 582	0	2, 563			56.00
56. 01	O5601   CARDI AC CATH LAB   O5700   CT SCAN	452 455	0	5, 070		l .	56. 01 57. 00
	05800 MRI	216	0	6, 746 1, 279	_		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö	0			59. 00
60.00	06000 LABORATORY	1, 256	0	6, 538	0		60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0		60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0		61. 00 62. 00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	1, 325	0	267			63.00
64.00	06400 I NTRAVENOUS THERAPY	8	0	799			64.00
65. 00	06500 RESPI RATORY THERAPY	405	0	1, 041	0		65. 00
66.00	06600 PHYSI CAL THERAPY	25	0	1, 154			66.00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	9	0	409 283			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	18	0	1, 353			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 839	0	4, 881	0		71. 00
72.00	07200 DRUCS CHARGED TO PATIENTS	20, 210	101 201	3, 871	0		72.00
73. 00 74. 00	07300   DRUGS CHARGED TO PATIENTS   07400   RENAL DI ALYSI S	0	101, 201 0	8, 931 20			73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0			75.00
76. 00	03950 NUTRI TI ON THERAPY	0	0	26			76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0			88. 00
90.00	08900   FEDERALLY QUALIFIED HEALTH CENTER   09000   CLINIC	24	O O	0 262			89. 00 90. 00
	09002 WOUND CLINIC	363	ol	711	0		90.02
	09003 MOBI LE CLINI C	0	o	0	0		90. 03

Health Financial Systems	GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0026	Peri od: Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/28/2019 7:0	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
	SERVICES &		RECORDS &		ANESTHETI STS	
	SUPPLY		LI BRARY			
	14. 00	15. 00	16. 00	17. 00	19. 00	
91. 00   09100   EMERGENCY	1, 161	0	6, 59	0 3, 616		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 00  09900  CMHC	0	0		0 0		99. 00
101.00 10100 HOME HEALTH AGENCY	89	0	40	3 0		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115. 00
116. 00 11600 H0SPI CE	1, 338	0	81	8 0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	60, 966	101, 201	107, 20	0 29, 813	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	12	0		0 0		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0		0 0		190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0		0 0		190. 02
190. 03 19003 LI FELI NE	0	0		0 0		190. 03
190. 04 19004 COMMUNITY RELATIONS	5	0		0 0		190. 04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190. 05
190.06 19006 PROFESSIONAL DEVELOPMENT	0	0		0 0		190. 06
190. 07   19007   FOUNDTI ON	0	0		0 0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190. 08
191. 00 19100 RESEARCH	7	0		0 0		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0 0		192. 00
193.00 19300 NONPALD WORKERS	0	0		0 0		193. 00
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)	60, 990	101, 201	107, 20	0 29, 813	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepare Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0026

Cont. Center Prescription					10	5 12/31/2018	Date/lime Pre 5/28/2019 7:0	
ARRENUL SERVICE COST CENTERS				INTERNS &	RESI DENTS		10,20,20., ,.0	, p
CHRIGHE SERVICE DIST CHATEST CHATEST   1.00   22.00   23.00   24.00   2.00		Cost Center Description	NURSI NG SCHOOL	Y & FRINGES	PRGM COSTS		Subtotal	
1.00   001000 CAP REL COSTS-RIDE & FIXT   1.00			20.00			23. 00	24. 00	
2.00 00000CAR REL COSTS-AVMILE EQUIP		GENERAL SERVICE COST CENTERS						
0.0400   DRILOYDE BRIEFITS DEPARTMENT	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
0.0880   CASHI ERING/ACQUINTS RECEIVABLE		i i						1
5.02   0.0090   OTHER ABBIN & CENERAL     5.00		1 1						1
0.000   0.00		1 1						1
2,00   00700   DOPEDATION OF PLANT		i i						1
8.00   00800   LANDRY & LINEN SERVICE   9,00   9,00   00900   DISTARY   1,00   10,00		1 1						1
0.00 0.0000   DUSTEREY NO.00   0.0000   DUSTERNY   0.0000   11.00 0.0000   DUSTERNY   0.00000   11.0000   DUSTERNY   0.00000   11.0000   DUSTERNY   0.0000		i i						1
10.00   01000   DETARY		1 1						1
11-10 00 11-00 (AFFERTIA		l l						•
12.00   07000   MAINTENANCE OF PERSONNÉE   13.00   1300   01400   CENTRAL SERVI CES & SUPPLY   1.4.00   15.0		l l						•
13.00   1300   IURIS INC ADMIN STRATION     14.00   1400		1 1						•
14.00   1400   CENTRAL SERVICES & SUPPLY     14.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   18.00		1 1						
15.00								•
10.00   10.00   MEDICAL RECORDS & LIBRARY     10.00		1 1						ł
17. 00   01700   SOCIAL SERVICE     17. 00   17.00		1						•
19.00   1900   NONINYSICI AN ARESTHETISTS     2.00   2.00   2.00   2.00   18.7 SERVICES-SALARY & FRINCES APPREV   0   2.1.00   2.00   2.00   2.00   18.7 SERVICES-SALARY & FRINCES APPREV   0   2.1.00   2.2.00		l l						1
21.00		1 1						•
22.00   02200   RAS SERVI CES-OTHER PROM COSTS APPRV   0   22.00   1   22.00   1   23.00   1   23.00	20.00	02000 NURSI NG SCHOOL						20.00
23.00   ADAMED ED PROM   2.2.07   23.00	21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV		0				21. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS   549,755 30.00   33.00   33.00   30.00   30.100   AULTS & PEDIATRI CS   549,755 30.00   33.00   34.00   33.00   33.00   34.00   33.00   34.00   33.00   34	22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			0			22. 00
30.00	23. 00	02300 PARAMED ED PRGM				2, 207		23. 00
31 00   03100   INTENSIVE CARE UNIT   0   32 00   03200   03300   03300   03400   03		INPATIENT ROUTINE SERVICE COST CENTERS						
22.00   03200   03000ABY CARC UNIT   0   32.00   33.00   33.00   03300   03000   0300   0300   0300   0300   0300   0300   0300   0300   030		1 1						
33.00   03200   BURN INTERSIVE CARE UNIT		1 1						1
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT   0   04. 00   04		i i						1
40.00   0.00		1 1						1
14.0		1 1						1
42 00   04200   SUBROVI DER   0   42 00   43 00   44300   04400   SAT LLED NURSING FACILITY   0   044 00   44 00   04400   SAT LLED NURSING FACILITY   0   045 00   45 00   04500   NURSING FACILITY   0   045 00   04500   NURSING FACILITY   0   046 00   046 00   04600   OTHER LONG TERM CARE   0   046 00   04600   OTHER LONG TERM CARE   0   046 00   046 00   OTHER LONG TERM CARE   0   046 00   OTHER LONG TERM CARE   0   046 00   OTHER LONG TERM CARE   0   05 00   SODO   OPERATIN ROOM   50, 663   51 00   SODO   OTHER LONG YEAR CONSTRUCTION   0   50, 663   51 00   SODO   DELIVERY ROOM   LABOR ROOM   50, 663   51 00   SODO   DELIVERY ROOM   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   4   50 00   4   4   50 00   4   50 00   4   50 00   4   50 00   5   50 00   5   5   5   5   5		1 1						1
43. 00   04300 NURSERY		1 1						1
44. 00   04400   SAILLED NURSING FACILITY   0   45. 00     45. 00   04500   NURSING FACILITY   0   045. 00     46. 00   04600   OHDRO TERM CARE   0   046. 00     46. 00   04600   OHDRO TERM CARE   0   046. 00     50. 00   GOOGO   OFERATING ROOM   1,331,195   50. 00     50. 00   GOOGO   OFERATING ROOM   50. 563   51. 00     50. 00   SOOGO   OFERATING ROOM   50. 563   51. 00     50. 00   SOOGO   DELIVERY ROOM & LABOR ROOM   101,298   52. 00     50. 00   SOOGO   DELIVERY ROOM & LABOR ROOM   101,298   52. 00     50. 00   SOOGO   DELIVERY ROOM & LABOR ROOM   101,298   52. 00     50. 00   SOOGO   DELIVERY ROOM & LABOR ROOM   101,298   52. 00     50. 00   SOOGO   PAN JAMANGEMENT   341   53. 01     50. 00   SOOGO   RADIOLOGY-DIAGNOSTIC   700,079   54. 00     50. 00   SOOGO   RADIOLOGY-THERAPEUTI C   543,992   55. 00     50. 00   SOOGO   CATHLETER ZATION   0   59. 00     50. 00   SOOGO   LABORATORY   0   167. 05     60. 00   SOOGOO   LABORATORY   0   59. 00     60. 00   SOOGOO   LABORATORY   0   69. 00     60. 00   SOOGOO   LABORATORY   0   69. 00     60. 00   SOOGOO   HOLDE ELOOD & PACKED RED BLOOD CELL   0   60. 00     60. 00   SOOGOO   HOLDE ELOOD & PACKED RED BLOOD CELL   0   60. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   69. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   69. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   69. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   70. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   70. 00     60. 00   SOOGO   PHYSICAL HERAPY   0   70. 00     60. 00   SOOGO   PHYSICAL HERAPY   0		1 1						1
45. 00   04500 NURSI NG FACILITY   0   45. 00   46. 00   46.00   46.00   46.00   ANCILLARY SERVICE COST CENTERS   0   46. 00   ANCILLARY SERVICE COST CENTERS   1,331,195   50. 00   50.00		1 1						1
46. 00   04600   O1600   O16		1 1						•
ANCILLARY SERVICE COST CENTERS   1,331,195   50,00		l l						•
50.00   050000   05000   050000   050000   050000   05000   050000   05000								10.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   101, 298   52.00   05300   05300   ANESTHESI OLOGY   596   53.00   53.00   05300   ANESTHESI OLOGY   341   53.01   53.01   05301   PAIN MANAGEMENT   341   53.01   54.00   05400   RADI OLOGY-DI AGNOSTI C   700, 079   54.00   55.00   05500   RADI OLOGY-THERAPEUTI C   543, 992   55.00   05500   RADI OLOGY-THERAPEUTI C   543, 992   55.00   05500   RADI OLOGY-THERAPEUTI C   90, 308   56.00   05500   RADI OLOGY-THERAPEUTI C   90, 308   56.00   05500   RADI OLOGY-THERAPEUTI C   90, 308   56.00   05500   RADIO OLOGY-THERAPEUTI C   90, 308   56.00   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   56.01   371, 174   371, 1	50.00						1, 331, 195	50.00
53. 00   05300   ANESTHESI OLOGY   596   53. 00     53. 01   05300   ANESTHESI OLOGY - DI ACNOSTI C   700, 077     54. 00   05400   RADI OLOGY - DI ACNOSTI C   700, 077     55. 00   05500   RADI OLOGY - DI ACNOSTI C   700, 077     55. 00   05500   RADI OLOGY - DI ACNOSTI C   700, 077     56. 00   05600   RADI OLOGY - DI ACNOSTI C   700, 077     57. 00   05500   RADI OLOGY - DI ACNOSTI C   700, 078     57. 00   05700   CT SCAN   9, 08   56   00     56. 01   05601   CARDI AC CATH LAB   9, 11, 14   56   01     57. 00   05700   CT SCAN   23, 104   57, 00     58. 00   05800   MRI   196, 384   58   00     59. 00   05800   MRI   196, 384   58   00     59. 00   05900   CARDI AC CATHETERI ZATI ON   0   59, 00     60. 01   06000   LABORATORY   167, 615   60     60. 01   06000   LABORATORY   167, 615   60     60. 01   06000   PPP CLINI CAL LAB SERVI CES-PRGM ONLY   61, 00     61. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   61, 00     63. 00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   7, 913   63, 00     64. 00   06400   INTRAVROUS THERRAPY   105, 512   65, 00     65. 00   06500   RESPI RATORY THERRAPY   105, 512   65, 00     66. 00   06600   PHYSI CAL THERRAPY   105, 512   65, 00     67. 00   06700   CCUPATI ONAL THERAPY   16, 324   67, 00     68. 00   06600   PHYSI CAL THERRAPY   105, 512   65, 00     69. 00   06900   ELECTROCARDI OLOGY   28, 159   69, 00     69. 00   06900   ELECTROCARDI OLOGY   28, 159   69, 00     70. 00   07000   ELECTROCARDI OLOGY   28, 159   69, 00     70. 00   07000   ELECTROCARDI OLOGY   28, 159   69, 00     70. 00   07000   MIDLE SUPPLIES CHARGED TO PATI ENTS   103, 420   72, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   74, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   74, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   74, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   75, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   75, 00     70. 00   07000   RUBS CHARGED TO PATI ENTS   103, 420   75, 00     70. 0	51.00	05100 RECOVERY ROOM					50, 563	51.00
53.01   05301   PAI N MANAGEMENT   34.1   53.01   54.00   05400   RADI OLOGY-J HERAPEUTI C   543,992   55.00   55.00   05500   RADI OLOGY-J HERAPEUTI C   543,992   55.00   56.01   05600   RADI OLOGY-J HERAPEUTI C   543,992   55.00   65.01   05601   05601   05010   050	52.00	05200 DELIVERY ROOM & LABOR ROOM					101, 298	52.00
54.00   05400   RADI OLOGY-JI AGNOSTI C   53.00   755.0	53.00	05300 ANESTHESI OLOGY					596	53.00
55. 00   05500   RADI OLOGY-THERAPEUTI C   543, 992   55. 00   56. 00   05600   RADI OIS OTOPE   90, 308   56. 00   56	53. 01	05301 PAIN MANAGEMENT					341	53. 01
56. 00   05600   RADI OI SOTOPE   90, 308   56. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C					700, 079	54.00
56. 01   05601   CARDI AC CATH LAB   371, 174   56. 01   23, 104   57. 00   57. 00   05700   CT SCAN   23, 104   57. 00   58. 00   05800   MR    196, 384   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   59. 00   06000   LABORATORY   0   60. 01   06001   BLOOD LABORATORY   0   60. 01   06001   BLOOD LABORATORY   0   60. 01   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   7, 913   63. 00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   7, 913   63. 00   64. 00   06400   INTRAVENOUS THERAPY   105, 512   65. 00   65. 00   06500   RESPI RATORY THERAPY   105, 512   65. 00   66. 00   06600   PHYSI CAL THERAPY   16, 324   67. 00   67. 00   06700   OCCUPATI ONAL THERAPY   16, 324   67. 00   68. 00   SPECH PATHOLOGY   6. 931   68. 00   68. 00   6900   ELECTROCARDI OLOGY   28. 159   69. 00   06900   ELECTROCARDI OLOGY   28. 159   69. 00   07								
57.00   05700   CT SCAN   23, 104   57.00     58.00   05800   MRI   196, 384   58.00     59.00   05900   CARDI AC CATHETERI ZATI ON   0 59.00     60.00   06000   LABORATORY   167, 615   60.00     60.01   06000   BLOOD LABORATORY   0 60.01     61.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61.00     62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0 62.00     63.00   06300   BLOOD STORI NG PROCESSI NG & TRANS.   7, 913   63.00     64.00   06400   INTRAVENOUS THERAPY   64.00     65.00   06500   RESPI RATORY THERAPY   105, 512   65.00     66.00   06600   PHYSI CAL THERAPY   87, 384   66.00     67.00   06700   OCCUPATI ONAL THERAPY   87, 384   66.00     68.00   06800   SPEECH PATHOLOGY   6, 931   68.00     69.00   06900   ELECTROCARDI OLOGY   28, 159   69.00     70.00   07000   ELECTROCARDI OLOGY   28, 159   69.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   117, 581   71.00     72.00   07200   IMPL. DEV. CHARGED TO PATI ENT   103, 420   72.00     73.00   07300   RUNGS CHARGED TO PATI ENTS   2, 166   74.00     74.00   07400   RENAL DI ALYSI S   2, 166   74.00     75.00   07500   ASC (NON-DI STI NCT PART)   75.00     76.00   03950   NUTRI TI ON THERAPY   15, 023     00   08900   FEDERALLY QUALIFIED   88.00     88.00   08900   FEDERALLY QUALIFIED   88.00     89.00   08900   08900   FEDERALLY QUALIFIED   88.00     80.00   08900								1
58. 00       05800 MRI       196, 384 58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0 59. 00         60. 00       06000 LABORATORY       167, 615 60. 00         60. 01       06001 BLOOD LABORATORY       0 60. 01         61. 00       06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       61. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELL       0 62. 00         63. 00       06300 BLOOD STORI NG PROCESSI NG & TRANS.       7, 913 63. 00         64. 00       06400 I INTRAVENOUS THERAPY       4, 215 64. 00         65. 00       06500 RESPI RATORY THERAPY       105, 512 65. 00         66. 00       06500 RESPI RATORY THERAPY       105, 512 65. 00         67. 00       06600 PYSI CAL THERAPY       15, 324 66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       16, 324 67. 00         68. 00       06800 SPEECH PATHOLOGY       6, 931 68. 00         69. 00       06900 ELECTROCARDI OLOGY       28, 159 69. 00         70. 00       07000 ELECTROCARDI OLOGY       28, 159 69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       117, 581 71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       376, 537 73. 00         74. 00       07400 RENAL DI ALYSIS       2, 166 74. 00 <td></td> <td>1 1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		1 1						
59.00   05900   CARDI AC CATHETERI ZATI ON   0   59.00								
60. 00   06000   LABORATORY   167, 615   60. 00		1 1						
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI IN CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06600 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 00 07000 CELECTROENCEPHALOGRAPHY 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 67. 00 07200 I MPL DEV. CHARGED TO PATI ENTS 67. 00 07400 RENAL DI ALYSI S 67. 00 07500 ASC (NON-DI STI NCT PART) 67. 00 07500 ASC (NON-DI STI NCT PART) 67. 00 08800 RURAL HEALTH CLI NI C 68. 00 08800 FEDERALLY QUALI FIED HEALTH CENTER 69. 00 08800 FEDERALLY QUALI FIED HEALTH CENTER		1 1						1
61. 00		1 1						
62. 00							U	1
63. 00		1 1					0	1
64. 00   06400   INTRAVENOUS THERAPY								1
65. 00		i i						1
66. 00   06600   PHYSI CAL THERAPY   87, 384   66. 00		1 1						
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 07500 ASC (NON-DI STI NCT PART) 77. 00 07500 ASC (NON-DI STI NCT PART) 78. 00 07500 ASC (NON-DI STI NCT PART) 79. 00 07500 ASC (NON-DI STI NCT PART) 79. 00 07500 ASC (NON-DI STI NCT PART) 70. 00 07500 ASC (NON-DI STI NCT PART) 71. 00 07500 ASC (NON-DI STI NCT PART) 72. 00 07500 ASC (NON-DI STI NCT PART) 73. 00 07500 ASC (NON-DI STI NCT PART) 74. 00 07500 ASC (NON-DI STI NCT PART) 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 07500 ASC (NON-DI STI NCT PART) 77. 00 07500 ASC (NON-DI STI NCT PART) 78. 00 07500 ASC (NON-DI STI NCT PART) 79. 00 07500 ASC (NON-DI STI								
69. 00   06900   ELECTROCARDI OLOGY   28, 159   69. 00   70. 00	67.00	06700 OCCUPATI ONAL THERAPY						1
69. 00   06900   ELECTROCARDI OLOGY   28, 159   69. 00   70. 00								1
71. 00	69.00	06900 ELECTROCARDI OLOGY					28, 159	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   103, 420   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   376, 537   73. 00   74. 00   07400   RENAL DI ALYSIS   2, 166   74. 00   75. 00   075. 00		07000 ELECTROENCEPHALOGRAPHY					0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 376, 537 73. 00 74. 00 07400 RENAL DIALYSIS 2, 166 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 75. 00 76. 00 07500 NUTRITION THERAPY 15, 002 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 98. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00		1 1						
74. 00   07400   RENAL DI ALYSI S   2, 166   74. 00   75.								
75. 00   07500   ASC (NON-DISTINCT PART)   0   75. 00   76. 00   7		1 1						
76. 00   03950   NUTRÎ TI ON THERAPY   15, 023   76. 00		1 1					•	ł
OUTPATI ENT SERVI CE COST CENTERS           88. 00         08800 RURAL HEALTH CLINIC         0 88. 00           89. 00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0 89. 00		1 1 7						•
88. 00   08800   RURAL HEALTH CLINIC   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   89. 00	76. 00						15, 023	76. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   89.00	00.00					1	_	00.00
								•
70. 00   07000   021 101 0       30,000   90. 00								•
	70.00	10,000   OE1 IN O	<u> </u>	1	1	<u> </u>	30, 000	70.00

				To 12/31/2018	Part II Date/Time Pre 5/28/2019 7:0	pared:
		INTERNS &	RESI DENTS		10, 20, 20, 7, 7, 0	, p
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHE PRGM COSTS APPRV	R PARAMED ED PRGM	Subtotal	_
	20.00	21. 00	22.00	23. 00	24. 00	
90. 02   09002   WOUND   CLI NI C					70, 130	90. 02
90. 03   09003   MOBI LE CLI NI C					0	90. 03
91. 00   09100   EMERGENCY					236, 014	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		Г				
99. 00 09900 CMHC					0	99. 00
101. 00 10100 HOME HEALTH AGENCY					73, 706	101.00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE		I				l 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)					0	115. 00
116. 00 11600 H0SPI CE					22, 921	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0			ol ol	5, 673, 447	
NONREI MBURSABLE COST CENTERS		_	1	-		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN					71, 610	190. 00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED					82	190. 01
190.02 19002 GIFT FLOWER COFFEE SHOP & CANTEE					0	190. 02
190. 03 19003 LI FELI NE					-	190. 03
190. 04 19004 COMMUNITY RELATIONS					84, 782	
190. 05 19005 PRI VATE DUTY					-	190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT					14, 299	
190. 07 19007 FOUNDTI ON						190. 07
190. 08 19008 GOSHEN GACC CLINIC						190. 08
191. 00 19100 RESEARCH						191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES						192.00
193. 00 19300 NONPAI D WORKERS		,	,	2 207		193. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0		()	0 2, 207		200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)			()	0 2, 207	5, 857, 094	
202.00   TOTAL (Suil TITIES TTO CHIOUGH 201)	1	ı	1	2, 20/	5, 657, 094	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 7:03 pm Provider CCN: 15-0026

				5/28/2019 7:0	03 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	5, 25, 25, 7, 7, 7	į piii
		Adj ustments			
	CENEDAL CEDULCE COCT CENTEDO	25. 00	26. 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				4. 00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 01
5. 02	00590 OTHER ADMIN & GENERAL				5. 02
6.00	00600 MAINTENANCE & REPAIRS				6. 00
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL				12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00					14. 00
15.00	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16. 00 17. 00
	01900 NONPHYSICIAN ANESTHETISTS				19.00
					20. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV				21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV				22. 00
23.00	02300 PARAMED ED PRGM				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	0	549, 755		30. 00
31. 00		0	166, 801		31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	·	32.00
33. 00 34. 00		0	0	•	33.00
40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	l .	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00	04200 SUBPROVI DER	0	l o	l .	42. 00
43. 00		0	76, 306	l .	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	O		44. 00
45.00	04500 NURSING FACILITY	0	0	l .	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
EO 00	ANCILLARY SERVICE COST CENTERS	0	1 221 105		E0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	1, 331, 195 50, 563	l .	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o o	101, 298		52. 00
53. 00	05300 ANESTHESI OLOGY	0	596	l .	53. 00
53. 01	05301 PAI N MANAGEMENT	0	341		53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	700, 079		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	543, 992		55. 00
56.00	05600 RADI 0I SOTOPE	0	90, 308		56. 00
	05601 CARDI AC CATH LAB	0			56. 01
57. 00	05700 CT SCAN	0	23, 104		57. 00
58. 00	05800 MRI	0	196, 384		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 167, 615		59. 00 60. 00
60. 00	06001 BL00D LABORATORY	0	107, 013	<u> </u>	60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o		62. 00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	7, 913		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	4, 215		64. 00
65.00	06500 RESPI RATORY THERAPY	0	105, 512		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	87, 384		66. 00
67. 00		0	16, 324		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	6, 931		68. 00
	06900 ELECTROCARDI OLOGY	0	28, 159		69.00
		0	0 117, 581		70. 00 71. 00
		0	103, 420		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		376, 537		73. 00
74. 00	07400 RENAL DIALYSIS	0	2, 166		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00	03950 NUTRITION THERAPY	0	15, 023		76. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0		l .	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		l .	89.00
90.00	09000  CLI NI C	0	30, 000	1	90.00

Health Financial Systems	GOSHEN HOS	PI TAL		In Lieu	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 1	15-0026	From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prep 5/28/2019 7:03	
Cost Center Description	Intern & Residents Cost & Post	Total				

			To 12/31/2018 Part II To 12/31/2018 Date/Time Prepared:   5/28/2019 7:03 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	3726/201 <del>7</del> 7.03 piii
	25. 00	26. 00	
90. 02   09002   WOUND CLINIC 90. 03   09003   MOBILE CLINIC 91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	0 0	70, 130 0 236, 014	90. 02 90. 03 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	-1		
99.00   09900   CMHC 101.00   10100   HOME   HEALTH   AGENCY	0	0 73, 706	99. 00 101. 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   114.00   11400   11500   11500   AMBULATORY SURGICAL CENTER (D. P. )   116.00   11600   HOSPICE   118.00   SUBTOTALS (SUM OF LINES 1 through 117)	0 0	0 22, 921 5, 673, 447	113. 00 114. 00 115. 00 116. 00 118. 00
NONREI MBURSABLE COST CENTERS	-	5, 5, 5, 1, 1, 1	
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0 0	71, 610 82 0	190. 00 190. 01 190. 02
190. 03 19003 LIFELINE 190. 04 19004 COMMUNITY RELATIONS 190. 05 19005 PRIVATE DUTY 190. 06 19006 PROFESSIONAL DEVELOPMENT	0	84, 782 0 14, 299	190. 03 190. 04 190. 05 190. 06
190. 00 19000 FROI ESSIGNAL DEVELOFMENT 190. 07 19007 FOUNDTI ON 190. 08 19008 GOSHEN GACC CLINIC 191. 00 19100 RESEARCH	0	4, 766 12 5, 889	190. 00 190. 07 190. 08 191. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 193. 00 19300 NONPAI D WORKERS 200. 00 Cross Foot Adjustments	0 0	0 0 0 2, 207	191. 00 192. 00 193. 00 200. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0	0 5, 857, 094	201. 00 202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0026 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** CASHI ERING/ACC Reconciliation (SQUARE FEET) (DOLLAR VALUE) BENEFITS OUNTS DEPARTMENT RECEI VABLE (GROSS (GROSS SALARI ES) CHARGES) 1.00 2.00 5A. 02 4.00 5. 01 GENERAL SERVICE COST CENTERS 1 00 394 273 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 7, 200, 432 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4,528 1, 945 73, 822, 101 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 01 6 508 941, 886 674, 981, 625 5 01 5.02 00590 OTHER ADMIN & GENERAL 27, 419 2, 109, 003 11, 117, 685 -20, 369, 985 5.02 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 7.00 00700 OPERATION OF PLANT 26, 556 812, 713 0 7.00 114, 064 0 00800 LAUNDRY & LINEN SERVICE 0 8 00 37 176 1,847 0 8 00 9.00 00900 HOUSEKEEPI NG 479 11, 244 848, 905 0 9.00 01000 DI ETARY 5, 179 256, 492 10.00 10.00 2.151 0 0 01100 CAFETERI A 513, 465 11.00 4, 306 10, 369 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 1,516 547, 465 2, 236, 387 0 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 227, 764 14.00 2,575 65, 891 14.00 01500 PHARMACY 2, 124 100, 712 1.449.132 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 4.465 77, 186 1, 385, 403 0 16.00 0 01700 SOCIAL SERVICE 1,068 1, 364 952, 353 0 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 19.00 0 02000 NURSING SCHOOL 20.00 0 20.00 0 C 0 02100 I &R SERVICES-SALARY & FRINGES APPRV O 21.00 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 02300 PARAMED ED PRGM 225 153, 752 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38, 892 191, 717 8, 929, 413 48, 123, 008 0 30.00 03100 INTENSIVE CARE UNIT 31.00 9,960 90, 924 2, 240, 727 12, 868, 886 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF o 40.00 0 C 0 O 40.00 41 00 0 0 0 0 41 00 04200 SUBPROVI DER 42.00 0 0 42.00 04300 NURSERY 298, 188 1, 910, 109 43.00 43.00 1, 483 14, 334 0 04400 SKILLED NURSING FACILITY 44.00 44.00 0 04500 NURSING FACILITY 45.00 0 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 59, 919 50.00 50 00 05000 OPERATING ROOM 1, 405, 748 4 460 297 68 412 613 0 51.00 05100 RECOVERY ROOM 3, 170 23, 920 675, 843 12, 070, 415 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 7, 946 76, 806 1, 597, 752 8, 903, 841 0 52.00 53.00 05300 ANESTHESI OLOGY C 2, 721, 244 0 53.00 0 05301 PAIN MANAGEMENT 53 01 53 01 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 31, 974 767, 435 3, 964, 954 38, 772, 386 0 54.00 05500 RADI OLOGY-THERAPEUTI C 43, 807 317, 434 10, 342, 692 141, 485, 340 55.00 55.00 0 56, 00 05600 RADI OI SOTOPE 2,380 92, 382 414, 256 16, 116, 924 0 56.00 05601 CARDIAC CATH LAB 2, 748 1, 329, 220 31, 888, 034 56.01 448, 420 0 56.01 57.00 05700 CT SCAN 667 310 506, 872 42, 427, 274 0 57.00 05800 MRI 58.00 1,510 258, 963 467, 804 8, 043, 002 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 06000 LABORATORY 5.809 117, 182 2, 924, 222 60 00 41, 117, 489 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 Ω 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 62 00 0 C 0 63.00 06300 BLOOD STORING PROCESSING & TRANS. 414 1, 678, 086 0 63.00 188, 572 06400 I NTRAVENOUS THERAPY 5, 025, 696 64.00 967 64.00 06500 RESPIRATORY THERAPY 2,611 103, 090 1, 597, 491 65.00 6, 545, 789 0 65.00 06600 PHYSI CAL THERAPY 2, 107, 638 7, 258, 365 66.00 15.378 19, 703 0 66.00 06700 OCCUPATIONAL THERAPY 2, 142 2,044 658, 438 2, 571, 531 67.00 67.00 0 06800 SPEECH PATHOLOGY 68 00 530 427 353, 676 1, 782, 132 68.00 06900 ELECTROCARDI OLOGY 4,684 233, 743 8, 508, 458 69.00 14, 111 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 30, 699, 489 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 24, 347, 930 0 72.00 07300 DRUGS CHARGED TO PATIENTS 56, 170, 710 73.00 0 C 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 0 127, 296 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 03950 NUTRITION THERAPY 204, 005 165, 299 76.00 76.00 4.610 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 | Peri od: | Worksheet B-1 | To | 12/31/2010 | From 01/01/2018 | To | 12/31/2010 | From CMS-2552-10

				o 12/31/2018	Date/Time Prep 5/28/2019 7:03	pared:
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/ACC	Reconciliation	
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	OUNTS		
			DEPARTMENT	RECEI VABLE		
			(GROSS	(GROSS		
			SALARI ES)	CHARGES)		
	1.00	2. 00	4. 00	5. 01	5A. 02	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	_	_	- 1	89. 00
90. 00  09000   CLI NI C	2, 180	23, 105			l .	90.00
90. 02   09002   WOUND CLINIC	19, 574	4, 522	4, 010	4, 468, 608	0	90. 02
90. 03  09003   MOBILE CLINIC	0	0	0	0	0	90. 03
91. 00   09100   EMERGENCY	20, 438	101, 181	3, 154, 778	41, 447, 422	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS				1		
99. 00 09900 CMHC	0	0	_	_	- 1	99. 00
101.00 10100 HOME HEALTH AGENCY	5, 125	31, 583	2, 591, 346	2, 534, 391	0	101. 00
SPECIAL PURPOSE COST CENTERS				T		
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	_	0		115. 00
116. 00 11600 H0SPI CE	0	0	970, 052			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	373, 718	7, 150, 730	71, 595, 754	674, 981, 625	-20, 369, 985	118. 00
NONREI MBURSABLE COST CENTERS				_	_	
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	11, 217	29, 212			1 - 1	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	_			190. 01
190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0	0	_		190. 02
190. 03 19003 LI FELI NE	7 500	00 400	0	_		190. 03
190. 04 19004 COMMUNITY RELATIONS	7, 538	20, 490	· ·			190. 04
190. 05 19005 PRI VATE DUTY	0	0	0			190. 05
190. 06 19006 PROFESSIONAL DEVELOPMENT	1 000	0	9, 680			190. 06
190. 07 19007 FOUNDTI ON	1, 800	0	0	_		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	0	_		190. 08 191. 00
191. 00 19100 RESEARCH	0	0	361, 455			191.00 192.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	_	l .	
193.00 19300 NONPAID WORKERS 200.00  Cross Foot Adjustments	0	U	U	0		193. 00
, ,					l .	200. 00 201. 00
1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	000 010	E 0E/ 27E	2/ 72/ 255	2 002 011	l	
202.00   Cost to be allocated (per Wkst. B, Part I)	800, 819	5, 056, 275	26, 726, 255	3, 003, 911		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 031128	0. 702218	0. 362036	0. 004450		203. 00
204.00 Cost to be allocated (per Wkst. B,	2. 031120	0. 702210	10, 563			204. 00
Part II)			10, 303	13, 334		204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 000143	0. 000020		205. 00
II)			0.000143	0.000020		200.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,	1					207. 00
Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	GOSHEN H		CN: 15 0024		u of Form CMS-2	
CUST F	MELOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Pre	
		OTHER ARMIN A	IMALNITENANOE O			5/28/2019 7:0	
	Cost Center Description	GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	
		5. 02	6. 00	7. 00	LAUNDRY) 8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	OO580   CASHI ERI NG/ACCOUNTS   RECEI VABLE   OO590   OTHER   ADMI N & GENERAL	171, 181, 735					5. 01 5. 02
6.00	00600 MAI NTENANCE & REPAI RS	0	C				6. 00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	4, 161, 315 646, 883		329, 262 1, 847			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 790, 922	l .	479		326, 936	
10.00	01000 DI ETARY	518, 335	l .	_,		2, 151	1
11. 00 12. 00	O1100   CAFETERI A   O1200   MAI NTENANCE OF PERSONNEL	700, 304	l .	4, 306		4, 306 0	1
13. 00	01300 NURSING ADMINISTRATION	4, 447, 552		1, 516		1, 516	1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	804, 321 2, 324, 963		2, 575 2, 124		2, 575 2, 124	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 143, 419	O	4, 465	0	4, 465	16. 00
17. 00 19. 00	01700   SOCIAL SERVICE   01900   NONPHYSICIAN ANESTHETISTS	1, 331, 557		1, 068		1, 068 0	
20. 00	02000 NURSI NG SCHOOL	0	O	C	0	0	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21.00
22. 00 23. 00	O2200   1 & R SERVI CES-OTHER PRGM COSTS APPRV   O2300   PARAMED ED PRGM	177, 425	_	1	5 0	0 225	22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	13, 541, 647 2, 461, 928		1		38, 892 9, 960	30.00
32. 00	03200 CORONARY CARE UNIT	2, 401, 720	l .	7, 700		9, 700	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34. 00 40. 00
41.00	04100 SUBPROVI DER - I RF	0	_	c	<u> </u>	0	41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	467, 784	_	1, 483	1	0 1, 483	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		1, 100	1	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	_	· ·	_	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS				, 0	U	40.00
50.00	05000 OPERATING ROOM	11, 429, 179	l .	1		59, 919	
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	1, 027, 188 2, 515, 535	l .	3, 170 7, 946		3, 170 7, 946	1
53.00	05300 ANESTHESI OLOGY	12, 110		C	0	0	
	05301   PALN MANAGEMENT   05400   RADI OLOGY-DI AGNOSTI C	37, 989 3, 580, 892		31, 974	0 40, 050	0 31, 974	53. 01 54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	19, 664, 535	0	43, 807	27, 747	43, 807	55. 00
56. 00 56. 01	05600   RADI OI SOTOPE   05601   CARDI AC   CATH   LAB	1, 605, 331 3, 187, 439		2, 380 2, 748		2, 380 2, 748	
57. 00	05700 CT SCAN	1, 381, 636				667	
58. 00 59. 00	05800 MRI	971, 355		1, 510		1, 510	1
60.00	O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY	6, 664, 469	_	5, 809	1	0 5, 809	60.00
60. 01	06001 BLOOD LABORATORY	0	O	C	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.	578, 423	_	414		414	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	289, 459 2, 662, 054		2, 611	0	0 2, 611	
66. 00	06600 PHYSI CAL THERAPY	3, 349, 154		15, 378		15, 378	
67.00	1 1	967, 352	l .	2, 142		2, 142	
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	541, 542 485, 120	l .	530 4, 684		530 4, 684	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 931, 831 8, 774, 937			0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	29, 518, 403	0	ď	o o	0	73. 00
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	238, 508	l .	C	0	0	74. 00 75. 00
	03950 NUTRITION THERAPY	294, 537		1	_	4, 610	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	_			0	88. 00 89. 00
90.00	09000 CLI NI C	830, 753	0	2, 180	0	2, 180	90.00
90. 02	09002 WOUND CLINIC	1, 593, 178	0	19, 574	0	19, 574	90. 02

Health Financial Systems	GOSHEN H	JSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
			F	rom 01/01/2018		
			T	o 12/31/2018	Date/Time Pre	
					5/28/2019 7:0	3 pm
Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	
	GENERAL	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	
	(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		
				LAUNDRY)		
	5. 02	6. 00	7. 00	8. 00	9. 00	
90. 03   09003   MOBI LE   CLINI C	0	0	C	0	0	90. 03
91. 00 09100 EMERGENCY	5, 173, 557	0	20, 438	178, 871	20, 438	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	., .,	_				92.00
OTHER REIMBURSABLE COST CENTERS						72.00
99. 00 09900 CMHC	0	0	C	0	0	99. 00
101.00 10100 HOME HEALTH AGENCY	4, 012, 467		•			101. 00
	4, 012, 467		5, 125	l U	5, 125	101.00
SPECIAL PURPOSE COST CENTERS		Г				
113. 00 11300   NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(	0	-	115. 00
116. 00 11600 HOSPI CE	2, 235, 886	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	161, 073, 174	0	308, 707	776, 712	306, 381	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 311, 722	0	11, 217	0	11, 217	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	l	o	0	190. 01
190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE	0	0		0		190. 02
190. 03 19003 LI FELI NE	0	0		0	-	190. 03
190. 04 19004 COMMUNITY RELATIONS	5, 573, 544	١	7, 538	0		190. 04
190. 05 19005 PRI VATE DUTY	0, 373, 344	0	7,330	0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	1, 591, 194			0		190. 06
190. 07 19007 FOUNDTION	3, 656	l .	1, 800	0		190. 00
		l .	1, 600	0		
190. 08 19008 GOSHEN GACC CLINIC	1, 353			0		190. 08
191. 00 19100 RESEARCH	627, 092	0	0	0	-	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	(	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	( C	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	20, 369, 985	0	4, 656, 495	749, 980	2, 010, 809	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 118996	0. 000000	14. 142218	0. 965583	6. 150467	203. 00
204.00 Cost to be allocated (per Wkst. B,	1, 538, 270		1		25, 333	
Part II)	.,,	_			,	
205.00 Unit cost multiplier (Wkst. B, Part	0. 008986	0. 000000	0. 521005	0. 013558	0. 077486	205 00
II)	0.000700	0.00000	0. 32 1003	0.013330	0.077400	200.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						200.00
(per wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
						207.00
Parts III and IV)	ļ	l	l			

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0026 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Cost Center Description DI ETARY MAINTENANCE OF NURSI NG CAFETERI A CENTRAL PERSONNEL (MEALS SERVED) (MANHOURS) ADMI NI STRATI ON SERVICES & (NUMBER **SUPPLY** (DIRECT NRSING HOUSED) (COSTED HRS) REQUIS. 1 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 00590 OTHER ADMIN & GENERAL 5.02 5.02 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 90,070 10.00 11.00 01100 CAFETERI A 1, 789, 409 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 0 01300 NURSING ADMINISTRATION 571, 930 26, 285 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 49, 202 26, 155, 103 14.00 01500 PHARMACY 15.00 00000 34, 357 4, 316 33, 105 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 53 156 4 112 16 00 46 17.00 01700 SOCIAL SERVICE 30, 359 18, 020 1, 186 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 20.00 02000 NURSING SCHOOL 0 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21 00 21 00 Ω 0 0 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 76, 718 330 384 183 084 712, 595 30.00 31.00 03100 INTENSIVE CARE UNIT 13, 352 69, 343 0 59, 951 196, 109 31.00 03200 CORONARY CARE UNIT 0 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0 0 03400 SURGICAL INTENSIVE CARE UNIT 34.00 C 0 0 34 00 04000 SUBPROVIDER - IPF 40.00 0 0 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 0 04300 NURSERY 0 43 00 10, 305 76, 469 27, 712 43.00 04400 SKILLED NURSING FACILITY 0 44.00 44.00 0 04500 NURSING FACILITY 0 45.00 0 0 O 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 C 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 148. 727 0 81, 858 2, 316, 817 50.00 51.00 05100 RECOVERY ROOM 0 0 18, 728 17, 504 18, 200 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 148, 488 55, 214 0 52.00 53.00 05300 ANESTHESI OLOGY 0000000 0 0 53.00 53.01 05301 PAIN MANAGEMENT 0 53.01 05400 RADI OLOGY-DI AGNOSTI C 0 42,025 54.00 343, 378 233, 273 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 13, 643 1, 987 252,009 55.00 56, 00 05600 RADI OI SOTOPE 678, 593 56, 00 05601 CARDI AC CATH LAB 0 18, 033 56.01 34, 230 193, 672 56.01 05700 CT SCAN 0 195, 107 57 00 57 00 58.00 05800 MRI 0 92, 456 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0 0 0 59.00 0 06000 LABORATORY 0 60.00 81,065 538, 426 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 63 00 06300 BLOOD STORING PROCESSING & TRANS 000000000000 0 568, 076 63 00 C 0 0 64.00 06400 INTRAVENOUS THERAPY 3, 497 64.00 06500 RESPIRATORY THERAPY 37, 882 0 173, 880 65.00 65.00 06600 PHYSI CAL THERAPY 99, 557 0 0 10, 916 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 3, 815 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 876 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 0 0 7,896 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 n 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 795, 218 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 8, 666, 589 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 03950 NUTRITION THERAPY 13, 944 76.00 0 38 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 08800 RURAL HEALTH CLINIC 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 13, 916 90. 00 09000 CLINIC 0 10, 245 90.00

COST ALLOCATION - STA	1211CAL BASI 2		Provider C	CN: 15-0026	From 01/01/2018	worksneet B-1	
					To 12/31/2018	Date/Time Pre 5/28/2019 7:0	
Cost Cent	er Description	DI ETARY	CAFETERI A	MAINTENANCE (	OF NURSI NG	CENTRAL	
		(MEALS SERVED)	(MANHOURS)	PERSONNEL	ADMI NI STRATI ON	SERVICES &	
				(NUMBER	(DI DECT NECLAS	SUPPLY	
				HOUSED)	(DIRECT NRSING		
		10.00	11. 00	12.00	HRS) 13. 00	REQUIS.) 14.00	
90. 02   09002   WOUND   CLI	WI C	10.00	238		0 0	155, 479	90. 02
90. 02   09002   WOOND CLI			230		0	155, 479	1
91. 00 09100 EMERGENCY	INI C		124, 399		0 63, 875		
	ON BEDS (NON-DISTINCT PART		124, 377		03,073	477,007	92.00
	BLE COST CENTERS			1			72.00
99. 00 09900 CMHC		0	0		0 0	0	99. 00
101.00 10100 HOME HEAL	TH AGENCY	O	77, 441		0 0	•	101.00
SPECIAL PURPOSE	COST CENTERS			,	•		1
113. 00 11300   NTEREST	EXPENSE						113. 00
114. 00 11400 UTI LI ZATI	ON REVIEW-SNF						114. 00
115. 00 11500 AMBULATOR	Y SURGICAL CENTER (D.P.)	0	0	)	0 0	0	115. 00
116. 00 11600 HOSPI CE		0	30, 897	1	0 0	573, 878	116. 00
	(SUM OF LINES 1 through 117)	90, 070	1, 695, 426		0 571, 930	26, 144, 694	118. 00
NONREI MBURSABLE							
	WER COFFEE SHOP & CANTEEN	0	46, 029	1	0		190. 00
	CHP-GRANT I/COMMUNITY ED	0	5, 876	1	0 0		190. 01
	WER COFFEE SHOP & CANTEE	0	0	1	0 0	l	190. 02
190. 03 19003 LI FELI NE	DEL ATLONG	0	00.404	1	0		190. 03
190. 04 19004 COMMUNI TY		0	28, 121		0		190. 04
190. 05 19005 PRI VATE DI 190. 06 19006 PROFESSI O			0		0	<b>l</b>	190. 05 190. 06
190. 06 19000 PROFESSION	NAL DEVELOPMENT		2		0		190. 08
190. 08 19008 GOSHEN GA	CC CLINIC		11	1	0 0		190. 07
191. 00 19100 RESEARCH	SO CEINIO		13, 944	1	0 0		191. 00
192. 00 19200 PHYSI CI AN	S PRIVATE OFFICES		10, 711	,	0 0		192. 00
193. 00 19300 NONPALD W			0		0 0		193. 00
	t Adjustments					_	200.00
	Cost Centers						201.00
202.00 Cost to be	e allocated (per Wkst. B,	623, 665	871, 017		0 5, 020, 352	976, 235	202. 00
Part I) 203.00 Unit cost	multiplier (Wkst. B, Part I)	6, 924226	0. 486762	0. 0000	8. 777913	0. 037325	202 00
	e allocated (per Wkst. B,	13, 989	0. 486762 24, 970		0 429, 079		203. 00
Part II)	e arrocated (per wkst. b,	13, 909	24, 970	1	429,019	00, 990	204.00
1 1	multiplier (Wkst. B, Part	0. 155313	0. 013954	0.0000	0. 750230	0. 002332	205. 00
11)							
206.00 NAHE adju	stment amount to be allocated						206. 00
207.00 NAHE uni t	cost multiplier (Wkst. D,						207. 00
Parts III	and IV)						

In Lieu of Form CMS-2552-10 Health Financial Systems GOSHEN HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0026 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL (COSTED RECORDS & **ANESTHETI STS** REQUIS.) LI BRARY (TIME SPENT) (ASSI GNED (ASSI GNED (GROSS TIME) TIME) CHARGES) 19.00 20.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 00590 OTHER ADMIN & GENERAL 5.02 5.02 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 29, 268, 443 15.00 674, 981, 625 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 0 30, 353 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 20.00 02000 NURSING SCHOOL 20.00 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 Ω 21 00 21.00 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 48, 123, 008 23.482 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 12, 868, 886 2,562 0 0 31.00 03200 CORONARY CARE UNIT 0 32.00 0 0 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 C 0 34 00 04000 SUBPROVIDER - IPF 40.00 0 0 0 40.00 04100 SUBPROVIDER - IRF 41.00 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 0 04300 NURSERY 99 43 00 1, 910, 109 0 43 00 0 04400 SKILLED NURSING FACILITY 0 44.00 44.00 0 04500 NURSING FACILITY 0 o 45 00 0 O 45.00 04600 OTHER LONG TERM CARE 0 0 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 68, 412, 613 0 0 0 50.00 0 0 51.00 05100 RECOVERY ROOM 12, 070, 415 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 8, 903, 841 528 Λ 52.00 53.00 05300 ANESTHESI OLOGY 0000000 2, 721, 244 0 0 0 0 0 0 0 0 0 0 0 53.00 53.01 05301 PAIN MANAGEMENT 0 0 53.01 05400 RADI OLOGY-DI AGNOSTI C 38, 772, 386 54.00 0 0 54.00 |05500| RADI OLOGY-THERAPEUTI C 55.00 141, 485, 340 0 0 55.00 56, 00 05600 RADI OI SOTOPE 16, 116, 924 56.00 05601 CARDI AC CATH LAB 31, 888, 034 0 56.01 0 56.01 05700 CT SCAN 0 42, 427, 274 57 00 57 00 0 58.00 05800 MRI 8,043,002 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 59.00 06000 LABORATORY 0 60.00 41, 117, 489 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 0 0 0 0 0 0 0 0 0 62.00 63 00 06300 BLOOD STORING PROCESSING & TRANS. 0000000 1, 678, 086 0 63 00 0 06400 INTRAVENOUS THERAPY 0 64.00 5, 025, 696 0 64.00 06500 RESPIRATORY THERAPY 6, 545, 789 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 7, 258, 365 0 66.00 0 06700 OCCUPATIONAL THERAPY 2.571.531 0 67 00 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 1, 782, 132 0 68.00 06900 ELECTROCARDI OLOGY 8, 508, 458 69.00 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 30, 699, 489 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 24, 347, 930 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 56, 170, 710 0 73.00 29, 268, 443 73.00 0

127, 296

165, 299

1, 648, 167

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0 76.00

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0 89.00

ol 90.00

88.00

90. 00 09000 CLINIC

07400 RENAL DIALYSIS

03950 NUTRITION THERAPY

08800 RURAL HEALTH CLINIC

07500 ASC (NON-DISTINCT PART)

OUTPATIENT SERVICE COST CENTERS

08900 FEDERALLY QUALIFIED HEALTH CENTER

74.00

75.00

76.00

88 00

89. 00

Health Financial Systems	GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0026	Peri od: Worksheet B-1

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL (COSTED RECORDS & ANESTHETI STS (TIME SPENT) REQUIS.) LI BRARY (ASSI GNED (ASSI GNED TIME) (GROSS TIME) CHARGES) 15.00 19.00 20.00 16.00 17.00 90. 02 09002 WOUND CLINIC 90.02 4, 468, 608 09003 MOBILE CLINIC 0 0 90. 03 0 90.03 91.00 09100 EMERGENCY 0 41, 447, 422 3,682 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC 0 0 0 0 99.00 0 0 101. 00 101.00 10100 HOME HEALTH AGENCY <u>2, 534, 39</u>1 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 0 115.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 116. 00 11600 HOSPI CE 0 5, 141, 691 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 118.00 29, 268, 443 674, 981, 625 30, 353 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 0 0 190. 01 00000000 0 0 0 0 0 0 0 0 190. 02 19002 GIFT FLOWER COFFEE SHOP & CANTEE 0 0 190, 02 0 0 0 190. 03 190. 03 19003 LI FELI NE 0 190. 04 19004 COMMUNITY RELATIONS 0 0 0 190. 04 190. 05 19005 PRI VATE DUTY 0 0 190. 05 190. 06 19006 PROFESSI ONAL DEVELOPMENT 0 0 190, 06 0 190. 07 19007 FOUNDTI ON 0 0 0 190. 07 190. 08 19008 GOSHEN GACC CLINIC 0 190. 08 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192. 00 C 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 2, 700, 571 4, 789, 047 1, 684, 680 0 202. 00 Cost to be allocated (per Wkst. B, 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.092269 0.007095 55. 502916 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 101, 201 107, 200 29, 813 0 204. 00 Part II) 0.000000 205.00 205.00 0.003458 0.000159 0.982209 0.000000 Unit cost multiplier (Wkst. B, Part II)206.00 NAHE adjustment amount to be allocated 0 206. 00 (per Wkst. B-2) 0.000000 207.00 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)

					o 12/31/2018   Date/lime Pre	
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALAR				
		Y & FRINGES	PRGM COSTS	PRGM		
		APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSI GNED		
		TI ME)	TI ME)	TIME)		
		21. 00	22. 00	23. 00	1	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 01
5. 02	00590 OTHER ADMIN & GENERAL					5. 02
6.00	00600 MAINTENANCE & REPAIRS					6.00
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
12. 00	01200 MAI NTENANCE OF PERSONNEL					12.00
13.00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 00
						15. 00
						16.00
17. 00	01700 SOCIAL SERVICE					17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL					19. 00 20. 00
		0				21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0			22. 00
23. 00	02300 PARAMED ED PRGM		· ·	100		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	0	(		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0			31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	(	D	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	(		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(		34. 00
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0			40.00
41. 00 42. 00	04200 SUBPROVI DER	0	0			41. 00 42. 00
43. 00	04300 NURSERY	0	0			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0			44. 00
45.00	04500 NURSING FACILITY	0	0	(		45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	(		46. 00
	ANCI LLARY SERVI CE COST CENTERS			ı		
50.00	05000 OPERATI NG ROOM	0	0	•		50.00
51.00	l i	0	0	1		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0			52. 00 53. 00
53. 00	05301 PAIN MANAGEMENT	0	0			53. 00
54. 00	1	0	0			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	d		55. 00
56.00	05600 RADI 0I SOTOPE	0	0	(		56. 00
56. 01	05601 CARDI AC CATH LAB	0	0	(		56. 01
57. 00	05700 CT SCAN	0	0	(	D	57. 00
	05800 MRI	0	0	(		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(		59.00
60. 00 60. 01	06000 LABORATORY	0	0			60.00
61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U			60. 01 61. 00
62. 00		0	0			62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.	0	0			63. 00
	06400 I NTRAVENOUS THERAPY	0	0			64. 00
65. 00		0	0			65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(		67. 00
	1 1	0	0	(		68. 00
	06900 ELECTROCARDI OLOGY	0	0	(		69. 00
70.00	l i	0	0	9		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0			72. 00 73. 00
	07400 RENAL DIALYSIS		0			74.00
	07500 ASC (NON-DISTINCT PART)	0	0			75. 00
76. 00	03950 NUTRI TI ON THERAPY	0	0			76. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0	0		D	88. 00

				'	5/28/2019	
		INTERNS &	RESI DENTS	<u> </u>		
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
		APPRV	APPRV	(ASSI GNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TIME)	TIME)			
		21.00	22. 00	23. 00		
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		89. 00
90.00 09000	CLINIC	0	0	C		90. 00
90. 02 09002	WOUND CLINIC	0	0	C		90. 02
90. 03 09003	MOBILE CLINIC	0	0	C		90. 03
91.00 09100	EMERGENCY	0	0	100		91. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92. 00
OTHER	REIMBURSABLE COST CENTERS					
99.00 09900	CMHC	0	0	C		99. 00
101. 00 10100	HOME HEALTH AGENCY	0	0	C		101. 00
SPECI	AL PURPOSE COST CENTERS					
113. 00 11300	INTEREST EXPENSE					113. 00
114. 00 11400	UTILIZATION REVIEW-SNF					114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	o	C		115. 00
116.00 11600	HOSPI CE			C		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	o	100		118. 00
	IMBURSABLE COST CENTERS					
190. 00 19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C		190. 00
190. 01 19001	OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0	C		190. 01
190. 02 19002	GIFT FLOWER COFFEE SHOP & CANTEE	0	0	C		190. 02
190. 03 19003	LIFELINE	0	0	C		190. 03
190. 04 19004	COMMUNITY RELATIONS	0	0	C		190. 04
	PRI VATE DUTY	0	0	C		190. 05
190. 06 19006	PROFESSIONAL DEVELOPMENT	0	0	C		190. 06
190. 07 19007		0	0	C		190. 07
190. 08 19008	GOSHEN GACC CLINIC	0	0	C		190. 08
191. 00 19100	RESEARCH	0	0	C		191. 00
192. 00 19200	PHYSICIANS PRIVATE OFFICES	0	0	C		192. 00
193.00 19300	NONPALD WORKERS	0	0	C		193. 00
200. 00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	0	203, 104	1	202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	2, 031. 040000		203. 00
204.00	Cost to be allocated (per Wkst. B,	0	0	2, 207	7	204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	22.070000		205. 00
	[11]					
206. 00	NAHE adjustment amount to be allocated			C	)	206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,			0.000000	0	207. 00
	Parts III and IV)	1				

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm

				'	0 12/31/2010	5/28/2019 7:0	
			Title	xVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			
30. 00	03000 ADULTS & PEDIATRICS	20, 103, 104		20, 103, 104		20, 103, 104	
31. 00	03100 I NTENSI VE CARE UNI T	3, 923, 207		3, 923, 207		3, 949, 128	
32. 00	03200 CORONARY CARE UNIT	0				0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0				0	40.00
41. 00	04100 SUBPROVI DER - I RF	0				0	41.00
42.00	04200 SUBPROVI DER 04300 NURSERY	1 255 240		1 255 276	_	1 255 240	42.00
43. 00 44. 00	04400 SKI LLED NURSING FACILITY	1, 255, 269		1, 255, 269	0	1, 255, 269 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0			0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0				0	46.00
40.00	ANCI LLARY SERVI CE COST CENTERS				, O	U	40.00
50. 00	05000 OPERATING ROOM	15, 511, 552		15, 511, 552	2 0	15, 511, 552	50.00
51. 00	05100 RECOVERY ROOM	1, 468, 364		1, 468, 364		1, 468, 364	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 129, 906		3, 129, 906		3, 129, 906	
53. 00	05300 ANESTHESI OLOGY	32, 858		32, 858		32, 858	
53. 01	05301 PAIN MANAGEMENT	42, 510		42, 510		42, 510	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 514, 347		5, 514, 347			
55. 00	05500 RADI OLOGY-THERAPEUTI C	23, 957, 668		23, 957, 668		24, 053, 280	1
56. 00	05600 RADI OI SOTOPE	2,000,408		2, 000, 408		2, 000, 408	
56. 01	05601 CARDI AC CATH LAB	4, 035, 115		4, 035, 115		4, 035, 115	1
57. 00	05700 CT SCAN	1, 910, 201		1, 910, 201		1, 910, 201	57. 00
58. 00	05800 MRI	1, 186, 122		1, 186, 122		1, 186, 122	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		' ' '		0	59. 00
60.00	06000 LABORATORY	7, 926, 679		7, 926, 679	0	7, 926, 679	60.00
60. 01	06001 BLOOD LABORATORY	0				0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		1 0	0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62. 00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	688, 763		688, 763	0	688, 763	63.00
64.00	06400 I NTRAVENOUS THERAPY	359, 691		359, 691	0	359, 691	64. 00
65.00	06500 RESPI RATORY THERAPY	3, 103, 184	0	3, 103, 184	0	3, 103, 184	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 160, 117	0	4, 160, 117	0	4, 160, 117	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 144, 317	0	1, 144, 317	0	1, 144, 317	67. 00
68. 00	06800 SPEECH PATHOLOGY	629, 415	0	629, 415		629, 415	
69. 00	06900 ELECTROCARDI OLOGY	698, 561		698, 561		698, 561	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			_	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 697, 097		11, 697, 097		11, 697, 097	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 315, 348		10, 315, 348		10, 315, 348	
73.00	07300 DRUGS CHARGED TO PATIENTS	36, 130, 122		36, 130, 122		36, 130, 122	
74.00	07400 RENAL DIALYSIS	267, 792		267, 792		267, 792	
75. 00	07500 ASC (NON-DISTINCT PART)	421 007		421 00		421 007	
76.00	03950   NUTRITION THERAPY     OUTPATIENT SERVICE COST CENTERS	431, 097		431, 097	U	431, 097	76.00
88. 00	08800 RURAL HEALTH CLINIC	0				0	00 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	1
90.00	09000 CLINIC	992, 697		992, 697	-	992, 697	
90. 00	09002 WOUND CLINIC	2, 217, 593		2, 217, 593		2, 217, 593	
90. 02	09003 MOBILE CLINIC	2,217,575		2,217,393		2, 217, 343	1
91. 00	09100 EMERGENCY	7, 717, 999		7, 717, 999	_	7, 852, 038	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 624, 457		2, 624, 457		2, 624, 457	
72.00	OTHER REIMBURSABLE COST CENTERS	2,024,437	l .	2,024,407		2,024,437	72.00
99 00	09900 CMHC	0				0	99. 00
	10100 HOME HEALTH AGENCY	4, 651, 042		4, 651, 042		4, 651, 042	
	SPECIAL PURPOSE COST CENTERS	1,001,012		1,001,012		1,001,012	
113.00	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0				0	115. 00
	11600 H0SPI CE	2, 574, 886		2, 574, 886		2, 574, 886	116. 00
200.00		182, 401, 488				182, 794, 450	
201.00		2, 624, 457		2, 624, 457		2, 624, 457	201. 00
202.00		179, 777, 031					
		•	•	•			•

Provider CCN: 15-0026

				T			5/28/2019 7:03 pm	
					XVIII	Hospi tal	PPS	
		Cost Center Description	Inpati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
		cost center bescription	Tripati ent	outpatrent	+ col . 7)	Ratio	Inpatient	
					1 001. 7)	Nati o	Ratio	
			6. 00	7. 00	8.00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS	,					
30.00	1	ADULTS & PEDIATRICS	40, 462, 603		40, 462, 603			30. 00
31. 00		INTENSIVE CARE UNIT	12, 868, 886		12, 868, 886			31. 00
32. 00		CORONARY CARE UNIT	0		C			32. 00
33.00		BURN INTENSIVE CARE UNIT	0					33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 41. 00		SUBPROVIDER - IPF  SUBPROVIDER - IRF	0					40. 00 41. 00
42.00		SUBPROVI DER	0					42.00
43. 00	1	NURSERY	1, 910, 109		1, 910, 109			43. 00
44. 00		SKILLED NURSING FACILITY	0		1 .,,,,,,,,,			44. 00
45.00		NURSING FACILITY	o					45. 00
46.00		OTHER LONG TERM CARE	0		C			46. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	24, 711, 510	43, 701, 103			0. 000000	
51. 00		RECOVERY ROOM	3, 458, 093	8, 612, 322			0. 000000	
52. 00		DELIVERY ROOM & LABOR ROOM	7, 763, 234	1, 140, 607			0.000000	
53. 00 53. 01		ANESTHESI OLOGY PAIN MANAGEMENT	616, 645	2, 104, 599 0	1		0.000000	1
54. 00		RADI OLOGY-DI AGNOSTI C	8, 356, 904	30, 415, 482	1		0. 000000 0. 000000	
55. 00		RADI OLOGY-THERAPEUTI C	784, 906	140, 700, 434			0. 000000	
56. 00		RADI OI SOTOPE	1, 358, 754	14, 758, 170			0. 000000	
56. 01		CARDI AC CATH LAB	12, 294, 940	19, 593, 094			0. 000000	
57.00		CT SCAN	7, 409, 260	35, 018, 014			0.000000	
58.00	05800	MRI	902, 920	7, 140, 082	8, 043, 002	0. 147473	0. 000000	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	1	0. 000000	0.000000	
60.00	1	LABORATORY	14, 845, 324	26, 272, 165	41, 117, 489		0. 000000	1
60. 01		BLOOD LABORATORY	0	0	C	0. 000000	0. 000000	
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELL BLOOD STORING PROCESSING & TRANS.	1, 282, 353	395, 733	1, 678, 086	0. 000000 0. 410446	0. 000000 0. 000000	
64. 00		INTRAVENOUS THERAPY	86, 585	4, 939, 111			0. 000000	
65. 00		RESPI RATORY THERAPY	4, 199, 549	2, 346, 240			0. 000000	
66. 00		PHYSI CAL THERAPY	1, 433, 134	5, 825, 231			0. 000000	1
67.00		OCCUPATI ONAL THERAPY	1, 155, 504	1, 416, 027			0.000000	
68.00	06800	SPEECH PATHOLOGY	472, 963	1, 309, 169	1, 782, 132	0. 353181	0.000000	68. 00
69. 00		ELECTROCARDI OLOGY	4, 037, 935	4, 470, 523	8, 508, 458	0. 082102	0.000000	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	1	0. 000000	0. 000000	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	15, 030, 198	15, 669, 291			0.000000	
72.00		IMPL. DEV. CHARGED TO PATIENTS	16, 136, 375	8, 211, 555			0.000000	
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	12, 596, 262 98, 280	43, 574, 448 29, 016			0. 000000 0. 000000	1
75. 00		ASC (NON-DISTINCT PART)	90, 200 0	29,010	127, 290	0. 000000	0. 000000	
76.00		NUTRITION THERAPY	116, 345	48, 954	165, 299		0. 000000	1
		TIENT SERVICE COST CENTERS				=: -: -: -: -: -: -: -: -: -: -: -: -: -:		1
88. 00		RURAL HEALTH CLINIC	0	0	C			88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	o	0	-			89. 00
90.00	1	CLINIC	4, 000	1, 644, 167			0. 000000	1
90. 02		WOUND CLINIC	21, 983	4, 446, 625			0. 000000	
90. 03		MOBILE CLINIC	7 005 000	04.450.400	1	0.000000	0.000000	1
91. 00 92. 00		EMERGENCY	7, 295, 320	34, 152, 102			0.000000	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	812, 083	6, 848, 322	7, 660, 405	0. 342600	0. 000000	92. 00
99. 00	09900		O	0	C			99. 00
		HOME HEALTH AGENCY	o	2, 534, 391	1			101. 00
	SPECI.	AL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
	1	HOSPICE	0	5, 141, 691				116. 00
200. 00 201. 00	1	Subtotal (see instructions) Less Observation Beds	202, 522, 957	472, 458, 668	674, 981, 625			200. 00 201. 00
201.00	1	Total (see instructions)	202, 522, 957	472, 458, 668	674, 981, 625			201.00
202.00	1	Total (300 matructions)	202, 322, 737	712, 400, 000	U 074, 701, 020	1		1202.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0026

Provider CCN: 15-0026

Provider CCN: 15-0026

Provider CCN: 15-0026

Period:
From 01/01/2018
Part I
To 12/31/2018
Date/Time Prepared:

5/28/2019 7:03 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 43 00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44 00 44.00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 226735 50.00 51.00 05100 RECOVERY ROOM 0. 121650 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 351523 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.012075 53.00 05301 PAIN MANAGEMENT 0. 000000 53 01 53 01 05400 RADI OLOGY-DI AGNOSTI C 0. 145767 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0. 170005 55.00 05600 RADI 01 S0T0PF 56, 00 0. 124118 56,00 56.01 05601 CARDI AC CATH LAB 0. 126540 56.01 57.00 05700 CT SCAN 0.045023 57.00 05800 MRI 58.00 0. 147473 58.00 05900 CARDIAC CATHETERIZATION 59 00 0.000000 59 00 60.00 06000 LABORATORY 0.192781 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 63.00 06300 BLOOD STORING PROCESSING & TRANS. 0.410446 63.00 06400 I NTRAVENOUS THERAPY 0.071570 64.00 64.00 06500 RESPIRATORY THERAPY 65 00 0.474073 65 00 06600 PHYSI CAL THERAPY 66.00 0.573148 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 444994 67.00 68.00 06800 SPEECH PATHOLOGY 0. 353181 68.00 06900 ELECTROCARDI OLOGY 69.00 0.082102 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0. 381019 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72 00 0 423664 72 00 73.00 0.643220 73.00 74. 00 07400 RENAL DIALYSIS 2. 103695 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 03950 NUTRITION THERAPY 2.607983 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 0.602304 90.00 90.00 90.02 09002 WOUND CLINIC 0.496260 90.02 09003 MOBILE CLINIC 0.000000 90.03 90.03 09100 EMERGENCY 0. 189446 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 0.342600 92.00 OTHER REIMBURSABLE COST CENTERS 09900 CMHC 99.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115.00 116. 00 11600 HOSPI CE 116. 00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026

				'	0 12/31/2016	5/28/2019 7:0	
			Ti tI	e XIX	Hospi tal	Cost	<u> </u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	·				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	20, 103, 104		20, 103, 104	0	20, 103, 104	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 923, 207	1	3, 923, 207	25, 921	3, 949, 128	31.00
32.00	03200 CORONARY CARE UNIT	0	)		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	)		o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	)		o	0	34.00
40.00	04000 SUBPROVI DER - I PF	0			o	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0			o	0	41.00
42.00	04200 SUBPROVI DER	0			o	0	42.00
43.00	04300 NURSERY	1, 255, 269		1, 255, 269	o	1, 255, 269	43.00
44.00	04400 SKILLED NURSING FACILITY	0			o	0	44. 00
45.00	04500 NURSING FACILITY	0			o	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0			o	0	46. 00
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	15, 511, 552		15, 511, 552	0	15, 511, 552	50.00
51.00	05100 RECOVERY ROOM	1, 468, 364		1, 468, 364	0	1, 468, 364	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 129, 906	,	3, 129, 906	o	3, 129, 906	52.00
53.00	05300 ANESTHESI OLOGY	32, 858	8	32, 858	o o	32, 858	53. 00
53. 01	05301 PAIN MANAGEMENT	42, 510	)	42, 510	o	42, 510	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 514, 347	1	5, 514, 347	137, 390	5, 651, 737	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	23, 957, 668		23, 957, 668	95, 612	24, 053, 280	55. 00
56. 00	05600 RADI OI SOTOPE	2, 000, 408		2, 000, 408		2, 000, 408	
56. 01	05601 CARDI AC CATH LAB	4, 035, 115	1	4, 035, 115		4, 035, 115	1
57. 00	05700 CT SCAN	1, 910, 201	1	1, 910, 201		1, 910, 201	57. 00
58. 00	05800 MRI	1, 186, 122	1	1, 186, 122	1	1, 186, 122	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		(		0	59.00
60.00	06000 LABORATORY	7, 926, 679		7, 926, 679	o	7, 926, 679	60.00
60. 01	06001 BLOOD LABORATORY	0		1 (	1	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			ol	0	62.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	688, 763		688, 763	o	688, 763	63.00
64.00	06400 I NTRAVENOUS THERAPY	359, 691	ł	359, 691		359, 691	64.00
65. 00	06500 RESPI RATORY THERAPY	3, 103, 184	l l	1		3, 103, 184	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 160, 117	1	4, 160, 117		4, 160, 117	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 144, 317	1	1, 144, 317		1, 144, 317	67. 00
68. 00	06800 SPEECH PATHOLOGY	629, 415	1	629, 415		629, 415	ł
69. 00	06900 ELECTROCARDI OLOGY	698, 561	1	698, 561		698, 561	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			1	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 697, 097	· i	11, 697, 097	ol	11, 697, 097	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 315, 348		10, 315, 348		10, 315, 348	1
73.00	07300 DRUGS CHARGED TO PATIENTS	36, 130, 122		36, 130, 122	o	36, 130, 122	73. 00
74.00	07400 RENAL DIALYSIS	267, 792		267, 792		267, 792	1
75.00	07500 ASC (NON-DISTINCT PART)	0		. (		0	1
76.00	03950 NUTRI TI ON THERAPY	431, 097	1	431, 097	o o	431, 097	76. 00
	OUTPATIENT SERVICE COST CENTERS		•		·		
88. 00	08800 RURAL HEALTH CLINIC	0	)		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
90.00	09000 CLI NI C	992, 697	,	992, 697	o	992, 697	90.00
90. 02	09002 WOUND CLINIC	2, 217, 593		2, 217, 593		2, 217, 593	ı
90. 03	09003 MOBILE CLINIC	0		_,,,,	1	0	90. 03
91. 00	09100 EMERGENCY	7, 717, 999		7, 717, 999	134, 039	7, 852, 038	ı
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 624, 457		2, 624, 457		2, 624, 457	
	OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	'	,	'		
99. 00	09900 CMHC	0	)			0	99. 00
	10100 HOME HEALTH AGENCY	4, 651, 042		4, 651, 042		4, 651, 042	
	SPECIAL PURPOSE COST CENTERS		·		1		
113.00	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF		1				114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	)		)		115. 00
	11600 HOSPI CE	2, 574, 886	.]	2, 574, 886	1	2, 574, 886	
200.00		182, 401, 488				182, 794, 450	1
201.00		2, 624, 457		2, 624, 457		2, 624, 457	
202.00		179, 777, 031					
			'				

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026

					'	0 12/31/2016	5/28/2019 7:0	
			_	Ti tl	e XIX	Hospi tal	Cost	
				Charges		·		
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
			/ 00	7.00	0.00	0.00	Ratio	
	LNDAT	LENT DOUTING CEDVICE COCT CENTEDS	6. 00	7. 00	8. 00	9. 00	10. 00	
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	40 462 602		40 4/2 /02			20.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	40, 462, 603		40, 462, 603			30. 00 31. 00
31.00		CORONARY CARE UNIT	12, 868, 886		12, 868, 886			32.00
33. 00		BURN INTENSIVE CARE UNIT	0					33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT						34. 00
40. 00	1	SUBPROVI DER - I PF	0					40. 00
41. 00		SUBPROVI DER - I RF	o o					41. 00
42. 00		SUBPROVI DER	o		ĺ			42. 00
43.00		NURSERY	1, 910, 109		1, 910, 109			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44. 00
45.00	04500	NURSING FACILITY	o		0			45. 00
46.00	04600	OTHER LONG TERM CARE	0		0			46. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	24, 711, 510	43, 701, 103	68, 412, 613		0.000000	50.00
51. 00		RECOVERY ROOM	3, 458, 093	8, 612, 322			0. 000000	1
52. 00	1	DELIVERY ROOM & LABOR ROOM	7, 763, 234	1, 140, 607		0. 351523	0. 000000	1
53. 00		ANESTHESI OLOGY	616, 645	2, 104, 599			0. 000000	1
53. 01		PAIN MANAGEMENT	0	0		0.000000	0. 000000	1
54. 00		RADI OLOGY-DI AGNOSTI C	8, 356, 904	30, 415, 482			0.000000	1
55. 00		RADI OLOGY-THERAPEUTI C	784, 906	140, 700, 434			0.000000	1
56.00		RADI OI SOTOPE	1, 358, 754	14, 758, 170		0. 124118	0.000000	
56. 01		CARDIAC CATH LAB	12, 294, 940	19, 593, 094 35, 018, 014			0.000000	
57. 00 58. 00	05800	CT SCAN	7, 409, 260 902, 920	7, 140, 082			0. 000000 0. 000000	1
59.00		CARDI AC CATHETERI ZATI ON	902, 920	7, 140, 062	0, 043, 002	0. 147473	0. 000000	1
60.00		LABORATORY	14, 845, 324	26, 272, 165	41, 117, 489		0. 000000	1
60. 01	1	BLOOD LABORATORY	14, 043, 324	20, 272, 103	41, 117, 407	0. 000000	0. 000000	1
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0. 000000	0. 000000	1
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0. 000000	0. 000000	1
63. 00		BLOOD STORING PROCESSING & TRANS.	1, 282, 353	395, 733	1, 678, 086		0. 000000	1
64.00		INTRAVENOUS THERAPY	86, 585	4, 939, 111			0.000000	1
65. 00		RESPI RATORY THERAPY	4, 199, 549	2, 346, 240			0.000000	
66.00	06600	PHYSI CAL THERAPY	1, 433, 134	5, 825, 231	7, 258, 365	0. 573148	0.000000	66. 00
67.00	06700	OCCUPATI ONAL THERAPY	1, 155, 504	1, 416, 027	2, 571, 531	0. 444994	0.000000	67. 00
68. 00	06800	SPEECH PATHOLOGY	472, 963	1, 309, 169	1, 782, 132	0. 353181	0.000000	68. 00
69. 00		ELECTROCARDI OLOGY	4, 037, 935	4, 470, 523	8, 508, 458	0. 082102	0.000000	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	·	0. 000000	0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	15, 030, 198	15, 669, 291			0. 000000	1
72. 00		IMPL. DEV. CHARGED TO PATIENTS	16, 136, 375	8, 211, 555			0. 000000	
73.00		DRUGS CHARGED TO PATIENTS	12, 596, 262	43, 574, 448			0. 000000	
74.00		RENAL DIALYSIS	98, 280	29, 016	127, 296		0.000000	1
75. 00 76. 00		ASC (NON-DISTINCT PART) NUTRITION THERAPY	114 245	40 OE 4	145 200	0. 000000 2. 607983	0. 000000 0. 000000	
76.00		TIENT SERVICE COST CENTERS	116, 345	48, 954	165, 299	2.007903	0.000000	76.00
88. 00		RURAL HEALTH CLINIC	0	0	О	0. 000000	0. 000000	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0			0. 000000	
90.00		CLINIC	4,000	1, 644, 167	·		0. 000000	
90. 02	1	WOUND CLINIC	21, 983	4, 446, 625			0. 000000	
90. 03		MOBILE CLINIC	0	0			0. 000000	1
91.00		EMERGENCY	7, 295, 320	34, 152, 102	41, 447, 422		0.000000	
92.00		OBSERVATION BEDS (NON-DISTINCT PART	812, 083	6, 848, 322			0.000000	1
	OTHER	REIMBURSABLE COST CENTERS						1
99. 00	09900	CMHC	0	0	0			99. 00
101.00		HOME HEALTH AGENCY	0	2, 534, 391	2, 534, 391			101. 00
		AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE						113. 00
		UTI LI ZATI ON REVI EW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
		HOSPICE	0	5, 141, 691				116. 00
200.00	1	Subtotal (see instructions)	202, 522, 957	472, 458, 668	674, 981, 625			200. 00
201.00	1	Less Observation Beds Total (see instructions)	202 522 057	172 150 4/0	674 001 405			201. 00 202. 00
202.00	<b>4</b> 1	Tiotal (See Histinctions)	202, 522, 957	472, 458, 668	674, 981, 625	1		1202.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0026

Provider CCN: 15-0026

Provider CCN: 15-0026

Provider CCN: 15-0026

Period:
From 01/01/2018
Part I
To 12/31/2018
Date/Time Prepared:

5/28/2019 7:03 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 43 00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44 00 44.00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05301 PAIN MANAGEMENT 0.000000 53 01 53 01 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 55.00 05600 RADI 01 S0T0PF 0.000000 56,00 56,00 56.01 05601 CARDI AC CATH LAB 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 05800 MRI 58.00 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 59 00 59 00 60.00 06000 LABORATORY 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 63.00 06300 BLOOD STORING PROCESSING & TRANS. 0.000000 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 65 00 0.000000 65 00 06600 PHYSI CAL THERAPY 0.000000 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72 00 0.000000 72 00 73.00 0.000000 73.00 74. 00 07400 RENAL DIALYSIS 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 03950 NUTRITION THERAPY 0.000000 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 09000 CLI NI C 90.00 0.000000 90.00 90.02 09002 WOUND CLINIC 0.000000 90.02 09003 MOBILE CLINIC 90.03 0.000000 90.03 09100 EMERGENCY 91.00 91.00 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09900 CMHC 99.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115.00 116. 00 11600 HOSPI CE 116. 00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	GOSHEN HO	Provider Co		In Lie Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		T' ()	V0.01.1		5/28/2019 7:0	13 pm
C+ C+ D	Capi tal		Reduced	Hospi tal	PPS Per Diem (col.	
Cost Center Description	Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Capital Related Cost (col. 1 - col 2)	Days	3 / col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)  Cost Center Description	549, 755 166, 801 0 0 0 0 0 76, 306 0 792, 862 I npati ent Program days	O O O Inpatient Program Capital Cost (col. 5 x col. 6)	166, 80 76, 30	1 3, 208 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 31. 12	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 ADULTS & PEDIATRICS  31.00 INTENSIVE CARE UNIT  32.00 CORONARY CARE UNIT  33.00 BURN INTENSIVE CARE UNIT  34.00 SURGICAL INTENSIVE CARE UNIT  40.00 SUBPROVIDER - IPF  41.00 SUBPROVIDER - IRF  42.00 SUBPROVIDER - IRF  42.00 SUBPROVIDER  43.00 NURSERY  44.00 SKILLED NURSING FACILITY  NURSING FACILITY  200.00 Total (lines 30 through 199)	6, 796 1, 242 0 0 0 0 0 0 0 0 0 0 0	178, 939 64, 584 0 0 0 0 0 0 0 0 0 0 0 243, 523				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 7:0	pared: 3 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			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   OPERATING ROOM	1, 331, 195				149, 964	50.00
51. 00   05100   RECOVERY ROOM	50, 563	12, 070, 415			4, 060	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	101, 298	8, 903, 841	0. 01137	7 11, 670	133	52. 00
53. 00   05300   ANESTHESI OLOGY	596	2, 721, 244	0. 00021	9 284, 619	62	53.00
53. 01   05301   PAI N MANAGEMENT	341	0	0.00000	0 0	0	53. 01
54. 00   05400   RADI OLOGY-DI AGNOSTI C	700, 079	38, 772, 386	0. 01805	6 3, 730, 511	67, 358	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	543, 992	141, 485, 340	0. 00384	5 279, 203	1, 074	55. 00
56. 00   05600 RADI 0I SOTOPE	90, 308	16, 116, 924	0.00560	3 723, 692	4, 055	56. 00
56. 01   05601   CARDI AC   CATH   LAB	371, 174	31, 888, 034	0. 01164	0 4, 578, 222	53, 291	56. 01
57. 00   05700 CT SCAN	23, 104	42, 427, 274	0.00054	5 3, 219, 092	1, 754	57. 00
58. 00   05800 MRI	196, 384	8, 043, 002	0. 02441	7 334, 484	8, 167	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59. 00
60. 00   06000   LABORATORY	167, 615	41, 117, 489	0. 00407	6, 186, 534	25, 216	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	0 0	0	62.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	7, 913	1, 678, 086	0. 00471	5 458, 842	2, 163	63.00
64. 00 06400 I NTRAVENOUS THERAPY	4, 215	5, 025, 696	0. 00083	9 36, 074	30	64.00
65. 00 06500 RESPIRATORY THERAPY	105, 512	6, 545, 789	0. 01611	9 1, 798, 259	28, 986	65. 00
66. 00   06600 PHYSI CAL THERAPY	87, 384	7, 258, 365	0. 01203	9 719, 490	8, 662	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	16, 324	2, 571, 531	0.00634	8 602, 683	3, 826	67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 931	1, 782, 132	0. 00388	94, 284	367	68. 00
69. 00 06900 ELECTROCARDI OLOGY	28, 159	8, 508, 458	0. 00331	0 1, 963, 761	6, 500	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	O	0.00000	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 581	30, 699, 489	0. 00383	0 5, 689, 788	21, 792	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	103, 420	24, 347, 930	0.00424	8 6, 573, 972	27, 926	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	376, 537	56, 170, 710	0.00670	3 11, 617, 779	77, 874	73. 00
74. 00 07400 RENAL DIALYSIS	2, 166	127, 296	0. 01701	5 50, 544	860	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	O	0.00000	0	0	75. 00
76. 00 03950 NUTRI TI ON THERAPY	15, 023	165, 299	0. 09088	43, 965	3, 996	76. 00
OUTPATIENT SERVICE COST CENTERS	•		•			1
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o c	0.00000	0	0	89. 00
90. 00   09000   CLI NI C	30,000	1, 648, 167	0. 01820	1, 806	33	90.00
90. 02 09002 WOUND CLINIC	70, 130	4, 468, 608	0. 01569	4 5, 819	91	90. 02
90. 03   09003   MOBILE CLINIC	0	O	0.00000	ol	0	90. 03
91. 00 09100 EMERGENCY	236, 014	41, 447, 422	0. 00569	4 3, 095, 146	17, 624	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	71, 771	7, 660, 405	0.00936	9 327, 827	3, 071	92.00
200.00 Total (lines 50 through 199)	4, 855, 729	612, 063, 945	<u>;</u>	61, 104, 289	518, 935	200. 00

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2018	Part III	
				Γο 12/31/2018	Date/Time Pre 5/28/2019 7:0	parea: 3 nm
		Title	e XVIII	Hospi tal	PPS	э рііі
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
oost conten boscii pti on	Post-Stepdown	litar strig school	Post-Stepdown		Medi cal	
	Adjustments		Adjustments	0031	Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	l o		0		31. 00
32. 00 03200 CORONARY CARE UNIT	0			0	l	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	-	1			33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	1	1		l	34.00
40. 00   04000   SUBPROVI DER -   PF		1	1		l	40.00
41. 00   04100   SUBPROVI DER -   I RF	0	1		-	0	41.00
42. 00   04200   SUBPROVI DER				٥	0	
					0	43.00
		-		1	0	
44. 00 04400 SKILLED NURSING FACILITY	1	0				44. 00
45. 00 04500 NURSING FACILITY	0	0		0		45. 00
200.00   Total (lines 30 through 199)	0	0	(	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)	/ 00	7.00	0.00	
INDATI ENT. DOUTLINE CERVI OF COCT OFNITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					. 704	00.00
30. 00   03000   ADULTS & PEDI ATRI CS	0	1			6, 796	30.00
31. 00   03100   INTENSIVE CARE UNIT		0	-,		1	
32. 00   03200   CORONARY CARE UNIT		0	1		0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0	1	0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	1	0.00	0	34. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	1	1	0.00	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0	1	0.00	0	41. 00
42. 00   04200   SUBPROVI DER	0	0	(	0.00	0	42. 00
43. 00   04300   NURSERY		0	2, 452	0.00	0	43.00
44.00  04400 SKILLED NURSING FACILITY		0	(	0.00	0	44. 00
45.00  04500 NURSING FACILITY		0	(	0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	26, 54	1	8, 038	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000 ADULTS & PEDIATRICS	0					30.00
31.00   03100   INTENSIVE CARE UNIT	0					31.00
32. 00   03200   CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00   04000   SUBPROVI DER - 1 PF	0					40.00
41. 00   04100   SUBPROVI DER -   RF	0					41. 00
42. 00   04200   SUBPROVI DER	0					42. 00
43. 00   04300   NURSERY	0					43. 00
44. 00 04400 SKILLED NURSING FACILITY		l .				44. 00
45. 00   04500   NURSING FACILITY		l .				45. 00
200.00 Total (lines 30 through 199)						200. 00
200.00   10tal (11105 00 till ough 177)	1	I				1-00.00

Peri od: Worksheet D From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm THROUGH COSTS

								5/28/2019 7:0	3 pm
				Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nur	sing School	Nursing Sch	ool	Allied Health	Allied Health	
	·	Anesthetist	Pos	st-Stepdown			Post-Stepdown		
		Cost	Ac	djustments			Adjustments		
		1.00		2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATI NG ROOM	0		0		0	0	0	50. 00
51.00	05100 RECOVERY ROOM	0		0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0		0	0	l 0	52.00
53.00	05300 ANESTHESI OLOGY		)	0		0	0	0	53.00
53. 01	05301 PAI N MANAGEMENT	0		0		0	0	0	53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0		0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C			0		0	0	Ö	55. 00
56. 00	05600 RADI OI SOTOPE			0		0	0	Ö	56. 00
56. 01	05601 CARDI AC CATH LAB			0		0	0	0	56. 01
57. 00	05700 CT SCAN			0		0	0	Ö	57. 00
58. 00	05800 MRI			0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		()	0		0	0	0	59.00
60.00	06000 LABORATORY		()	0		0	0	0	60.00
	1 I		()	0		0	0	0	
60. 01	06001 BLOOD LABORATORY	0	1	U		U	Ü	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0		_	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		]	0		0	0	0	62.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	1	0		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	)	0		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	1	0		O	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	9	0		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	)	0		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	)	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0		0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0		0		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	)	0		0	0	0	75. 00
76.00	03950 NUTRITION THERAPY	0	)	0		0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	0	0	89. 00
90.00	09000 CLI NI C	0		0		0	0	l 0	90.00
90. 02	09002 WOUND CLINIC	0	)	0		0	0	0	90. 02
90. 03	09003 MOBILE CLINIC		)	n		0	0	Ö	90. 03
91. 00	09100 EMERGENCY		ا	0		0	0	203, 104	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			Ü		0	Ü	0	92. 00
200.00				0		0	0	-	
200.00	1.5ta. (11165 00 till oagii 177)	1	1	O	ı	J	O	200, 104	_50.00

THROUG	on CO313			-	Го 12/31/2018	Date/Time Pre 5/28/2019 7:0	
			Title	XVIII	Hospi tal	PPS	o piii
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0	0		68, 412, 613	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0	0	i	12, 070, 415	0. 000000	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	`	8, 903, 841	0. 000000	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	1	2, 721, 244	0. 000000	53. 00
53. 01	05301 PAIN MANAGEMENT	0	0	`	0	0. 000000	53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		38, 772, 386	0. 000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		141, 485, 340	0. 000000	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		16, 116, 924	0. 000000	56. 00
56. 01	05601 CARDI AC CATH LAB	0	0		31, 888, 034	0. 000000	56. 01
57. 00	05700 CT SCAN	0	0		42, 427, 274	0. 000000	57. 00
58. 00	05800 MRI	0	0		0,010,002	0. 000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0. 000000	59. 00
60.00	06000 LABORATORY	0	0		41, 117, 489	0. 000000	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0. 000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0. 000000	62. 00
63. 00	06300 BLOOD STORING PROCESSING & TRANS.	0	0	1	1, 678, 086	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0,020,070	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		6, 545, 789	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	1	7, 258, 365	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	2, 571, 531	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	(	1, 782, 132	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	8, 508, 458		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0. 000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	30, 699, 489	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	9	2 1/ 0 1 / / / 00		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	56, 170, 710	0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		127, 296	0.000000	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0.000000	75. 00
76. 00	03950 NUTRI TI ON THERAPY	0	0	(	165, 299	0. 000000	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS			1		0.000000	00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 1 (40 1(7	0.000000	89. 00
90.00	09000 CLINIC	0	0		1, 648, 167	0.000000	90.00
	09002 WOUND CLINIC		0	]	4, 468, 608		90. 02
90. 03	09003 MOBILE CLINIC		202 104	202.40	J 41 447 400	0.000000	90. 03
91.00	09100 EMERGENCY		203, 104	203, 104			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	202 104	202.40	7, 660, 405	0. 000000	
200.00	Total (lines 50 through 199)	0	203, 104	203, 104	612, 063, 945		200. 00

Health Financial Systems	GOSHEN HOSP	I TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0026	Peri od:	Worksheet D
TUDOUCU COSTS			From 01/01/2018	Part IV

THROUGH COSTS To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Title XVIII Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient I npati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col.  $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 7, 707, 076 8, 595, 870 50.00 0 0 05100 RECOVERY ROOM 51.00 0.000000 969, 147 1, 859, 580 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 11, 670 0 18, 574 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 590, 124 53.00 284, 619 0 05301 PALN MANAGEMENT 0.000000 0 53. 01 53.01 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 3, 730, 511 7, 032, 731 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 279, 203 10, 517, 127 0 55.00 723, 692 0 05600 RADI OI SOTOPE 0.000000 4, 322, 510 56.00 56 00 0 0 8, 262, 588 05601 CARDI AC CATH LAB 56.01 0.000000 4, 578, 222 0 56.01 57.00 05700 CT SCAN 0.000000 3, 219, 092 9, 176, 855 0 57.00 05800 MRI 0 58.00 0.000000 334, 484 1, 837, 461 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 59 00 0 0 4, 251, 055 60.00 06000 LABORATORY 0.000000 6, 186, 534 0 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 0 62.00 06300 BLOOD STORING PROCESSING & TRANS. 0.000000 458, 842 0 124, 761 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 36, 074 1, 204, 559 0 64.00 06500 RESPIRATORY THERAPY 1, 798, 259 0 65 00 0.000000 832, 156 Ω 65 00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 719, 490 67, 172 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 602, 683 58, 890 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 94, 284 0 5, 167 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 0.000000 1, 963, 761 69 00 1, 121, 829 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 5, 689, 788 0 3, 947, 147 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 573, 972 0 2, 511, 382 72.00 72.00 0.000000 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 42, 056, 483 0.000000 11, 617, 779 73.00 0 0 74.00 07400 RENAL DIALYSIS 0.000000 50, 544 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75 00 0.000000 0 03950 NUTRITION THERAPY 76.00 0.000000 43, 965 0 573 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 0 0 89.00 594, 926 09000 CLINIC 0.000000 90.00 90.00 1,806 0 0 09002 WOUND CLINIC 0 90.02 0.000000 5,819 729, 606 0 90.02 90.03 09003 MOBILE CLINIC 0.000000 0 90.03 91.00 09100 EMERGENCY 0.004900 3, 095, 146 5, 410, 428 91.00 15, 166 26.511 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 327, 827 1, 856, 629 92.00  $\cap$ Ω

61, 104, 289

15, 166

116, 986, 183

26, 511 200. 00

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0026 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 7:03 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 226735 8, 595, 870 1, 948, 985 50.00 51.00 05100 RECOVERY ROOM 0.121650 1, 859, 580 0 0 226, 218 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 6, 529 52 00 18, 574 0.351523 52 00 0 53.00 05300 ANESTHESI OLOGY 0.012075 590, 124 0 7, 126 53.00 53.01 05301 PAIN MANAGEMENT 0.000000 53.01 7, 032, 731 o 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.142224 0 1,000,223 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.169330 10, 517, 127 48 35 1, 780, 865 55.00 56.00 05600 RADI OI SOTOPE 0. 124118 4, 322, 510 0 0 536, 501 56.00 56.01 05601 CARDIAC CATH LAB 0.126540 8, 262, 588 14 0 1, 045, 548 56.01 05700 CT SCAN 413, 170 57 00 0.045023 9, 176, 855 0 57 00 58.00 05800 MRI 0.147473 1,837,461 0 270, 976 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 0 0 06000 LABORATORY 0. 192781 4, 251, 055 0 819, 523 60.00 60.00 0 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 62.00 62.00 06300 BLOOD STORING PROCESSING & TRANS. 0. 410446 124, 761 0 0 63.00 51, 208 63.00 06400 INTRAVENOUS THERAPY 0.071570 17 64.00 1, 204, 559 117 86, 210 64 00 65.00 06500 RESPIRATORY THERAPY 0.474073 832, 156 28 394, 503 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.573148 67, 172 0 38, 499 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.444994 58, 890 0 26, 206 67.00 06800 SPEECH PATHOLOGY O 0 68.00 0.353181 5, 167 1, 825 68 00 06900 ELECTROCARDI OLOGY 0.082102 1, 121, 829 0 0 92, 104 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0. 381019 0 1, 503, 938 71.00 3, 947, 147 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 423664 2, 511, 382 0 0 1, 063, 982 72.00 07300 DRUGS CHARGED TO PATIENTS 0.643220 42, 056, 483 27, 051, 571 73.00 367 65, 328 73.00 74.00 07400 RENAL DIALYSIS 2. 103695 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 Λ 75 00 03950 NUTRITION THERAPY 76.00 2.607983 573 0 1, 494 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 Λ 89.00 90.00 09000 CLI NI C 0.602304 594, 926 358, 326 90.00 09002 WOUND CLINIC 0.496260 729, 606 0 90.02 90.02 573 362,074 09003 MOBILE CLINIC 0.000000 0 90.03 90.03  $\cap$ Ω 91.00 09100 EMERGENCY 0. 186212 5, 410, 428 0 4 1,007,487 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.342600 1, 856, 629 636, 081 92.00 116, 986, 183 40, 731, 172 200. 00 200.00 65, 493 Subtotal (see instructions) 1.047 Less PBP Clinic Lab. Services-Program

116, 986, 183

1,047

65, 493

201.00

40, 731, 172 202. 00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part V | To 12/31/2018 | Date/Time Prepared: 5/28/2019 7:03 pm

							5/28/2019 7:0	03 pm
				Title	XVIII	Hospi tal	PPS	
			Cos	sts				
		Cost Center Description	Cost	Cost				
		·	Reimbursed	Rei mbursed				
			Servi ces	Services Not				
			Subject To	Subject To				
			,	Ded. & Coins.				
			(see inst.)	(see inst.)				
			6.00	7. 00				
	ANCI L	LARY SERVICE COST CENTERS	0.00	7.00	1			
50.00		OPERATING ROOM	O	2				50.00
51.00	1	RECOVERY ROOM	o	0				51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM		0				52. 00
53. 00	1	ANESTHESI OLOGY		0	1			53. 00
53. 00	1	PAIN MANAGEMENT		0				53. 01
54. 00	1	RADI OLOGY-DI AGNOSTI C		0				54. 00
	1							1
55. 00		RADI OLOGY-THERAPEUTI C	8	6	1			55. 00
56.00	1	RADI OI SOTOPE	0	0				56. 00
56. 01	4	CARDI AC CATH LAB	2	0				56. 01
57. 00	4	CT SCAN	0	0	1			57. 00
58. 00			0	0				58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	1			59. 00
60.00	06000	LABORATORY	0	0	)			60.00
60. 01		BLOOD LABORATORY	0	0	)			60. 01
61. 00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)			62.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	)			63.00
64.00	06400	I NTRAVENOUS THERAPY	1	8	1			64. 00
65. 00	06500	RESPI RATORY THERAPY	13	0	)			65. 00
66. 00	1	PHYSI CAL THERAPY	l ol	0	)			66.00
67.00	06700	OCCUPATIONAL THERAPY	l ol	0	)			67.00
68. 00	1	SPEECH PATHOLOGY	أم	0	1			68. 00
69. 00	1	ELECTROCARDI OLOGY		0	1			69. 00
70. 00		ELECTROENCEPHALOGRAPHY		0	1			70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT		0	1			71.00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS		0				72.00
73. 00		DRUGS CHARGED TO PATTENTS	236	42, 020				73. 00
74. 00	1	RENAL DIALYSIS	230	42, 020	1			74.00
	1		0	0				75.00
75. 00		ASC (NON-DISTINCT PART)	ı		1			
76. 00		NUTRI TI ON THERAPY	0	0	1			76. 00
00.66		TIENT SERVICE COST CENTERS						00.00
88. 00		RURAL HEALTH CLINIC	0	0				88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00		CLINIC	0	0	1			90.00
90. 02		WOUND CLINIC	284	0				90. 02
90. 03	4	MOBILE CLINIC	0	0	1			90. 03
91. 00	09100	EMERGENCY	0	1				91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	)			92. 00
200.0	0	Subtotal (see instructions)	544	42, 037	1			200. 00
201.0	o	Less PBP Clinic Lab. Services-Program	l ol					201. 00
		Only Charges						
202.0	0	Net Charges (line 200 - line 201)	544	42, 037	1			202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0026 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 7:03 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 226735 788, 858 178, 862 50.00 51.00 05100 RECOVERY ROOM 0.121650 147, 426 0 0 17, 934 51.00 05200 DELIVERY ROOM & LABOR ROOM 143, 199 0 52 00 50 338 52 00 0.351523 0 0 53.00 05300 ANESTHESI OLOGY 0.012075 43, 031 520 53.00 53.01 05301 PAIN MANAGEMENT 0.000000 0 0 53.01 122, 192 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.142224 859, 151 0 0 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.169330 383, 987 65, 021 55.00 56.00 05600 RADI OI SOTOPE 0. 124118 101, 304 12, 574 56.00 0 56.01 05601 CARDIAC CATH LAB 0.126540 77, 165 0 9, 764 56.01 0 05700 CT SCAN 0.045023 869 850 39, 163 57 00 57 00 58.00 05800 MRI 0.147473 119, 200 17, 579 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 0 59.00 06000 LABORATORY 0. 192781 0 60.00 1, 111, 908 214, 355 60.00 0 60.01 06001 BLOOD LABORATORY 0.000000 C 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 0 0 0 0 0 0 0 0 0 62.00 06300 BLOOD STORING PROCESSING & TRANS. 0. 410446 0 6, 019 63.00 14, 665 63.00 0 06400 INTRAVENOUS THERAPY 0.071570 127, 410 9, 119 64.00 64 00 0 65.00 06500 RESPIRATORY THERAPY 0.474073 34, 747 16, 473 65.00 06600 PHYSI CAL THERAPY 0.573148 320, 960 0 66.00 183, 958 66.00 06700 OCCUPATIONAL THERAPY 0 140, 773 67.00 0.444994 316, 349 67.00 0 06800 SPEECH PATHOLOGY 185, 957 68.00 0.353181 526, 521 68 00 06900 ELECTROCARDI OLOGY 0.082102 98, 198 0 69.00 69.00 8,062 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 381019 0 92.903 71.00 243, 827 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 423664 66, 685 28, 252 72.00 554, 914 07300 DRUGS CHARGED TO PATIENTS 0.643220 0 0 73.00 862, 713 73.00 0 0 74.00 07400 RENAL DIALYSIS 2. 103695 O 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 Λ 75 00 03950 NUTRITION THERAPY 0 76.00 2.607983 4,624 12, 059 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 90.00 09000 CLI NI C 0.602304 29, 172 0 17, 570 90.00 90.02 09002 WOUND CLINIC 0.496260 27, 084 0 0 0 0 0 0 90.02 13, 441 90.03 09003 MOBILE CLINIC 0.000000 0 90.03 Ω 91.00 09100 EMERGENCY 0.186212 2, 914, 588 0 542, 731 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.342600 179, 513 0 61, 501 92.00 0 2, 602, 034 200. 00 200.00 10, 412, 135 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program

0

0

10, 412, 135

201.00

2, 602, 034 202. 00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Peri od: Worksheet D From 01/01/2018 Part V To 12/31/2018 Date/Ti me Prepared: 5/38/2019 7:03 pm

					5/28/2019 7:0	)3 pm
		Ti tl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
53. 01 05301 PAIN MANAGEMENT	0	0				53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	l o				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00   05600 RADI OI SOTOPE	0	0				56.00
56. 01   05601 CARDI AC CATH LAB		0				56. 01
57. 00   05700 CT SCAN		0				57.00
58. 00   05800   MRI						58.00
	0	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	· ·				59.00
60. 00   06000   LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00  06500   RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00  07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00   07400   RENAL DIALYSIS	0	0				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76.00 03950 NUTRITION THERAPY	0	0				76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	0	0				90.00
90. 02   09002   WOUND CLINIC	0	0				90. 02
90. 03 09003 MOBILE CLINIC	1 0	0				90. 03
91. 00 09100 EMERGENCY	1	0				91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
200.00 Subtotal (see instructions)		0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	0	0				202. 00
202. 30	1	1	ı			1-02.00

Health Financial Systems	GOSHEN HOSPITAL	In Lie	Lieu of Form CMS-25			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0026	Peri od: From 01/01/2018	Worksheet D-1			
		To 12/31/2018	Date/Time Pre 5/28/2019 7:0			
	Title XVIII	Hospi tal	PPS			
Cost Center Description	Cost Center Description					
			1. 00			

		Title XVIII	Hospi tal	572872019 7:0 PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			20, 881 20, 881	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days.	20, 881	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		- 21 -6	18, 155	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	21 -6	0	7 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			, 70,	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	6, 796	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruct			0	11 00
11. 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) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
10.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00					19. 00
20. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost				20. 00
	reporting period			0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe	•	ng period (line	20, 103, 104	21. 00 22. 00
22.00	5 x line 17)	or or the cost reporti	ng perrou (rrne	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0.4 00	x line 20)	, ,	'		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		0 20, 103, 104	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			20, 103, 104	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	1
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	ı
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nna private room cost dit	rerential (line	20, 103, 104	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			962. 75	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		6, 542, 849 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		6, 542, 849	
		,	'		

Heal th	Financial Systems	GOSHEN HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0026	Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Prep 5/28/2019 7:03	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		, 0. 1	50  0		72.00
43. 00	INTENSIVE CARE UNIT	3, 949, 128	3, 208				
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	C			0	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	C			0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)			1			47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			19, 788, 220	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ons)		27, 859, 996	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	atient routine s	services (from	n Wkst. D. sur	n of Parts I and	243, 523	50. 00
			•				
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	534, 101	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				777, 624	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	27, 082, 372	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00						0	54. 00
55.00	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tar	rget amount (1	ine 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	· ·			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ending 1996, ι	updated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	narket basket		0.00	60. 00
61. 00						0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00	Relief payment (see instructions)	·				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00				
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of the	e cost reporti	ng period (See	0	64. 00
4F 00	instructions) (title XVIII only)	to often Decembe	on 21 of the s	ant manamtin	namind (Can	0	/F 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts at ter beceilibe	er si or the c	ost reportini	g perrou (see		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	eportina period	0	67. 00
	(line 12 x line 19)	· ·				_	
68.00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				<u> </u>		70. 00
71. 00	Adjusted general inpatient routine service of						71.00
72.00	Program routine service cost (line 9 x line			05)			72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
74 00	26, line 45)	20 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li    Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess				nus line 70)		79. 00 80. 00
81. 00	· · · · · · · · · · · · · · · · · · ·						81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00			cough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					2, 726	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			962. 75	88. 00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				2, 624, 457	89.00

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	OPERATI NG COST Provi der CCN: 15-0026			Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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 O	COST					
90.00 Capital -related cost	549, 755	20, 103, 104	0. 02734	7 2, 624, 457	71, 771	90.00
91.00 Nursing School cost	0	20, 103, 104	0.00000	0 2, 624, 457	0	91.00
92.00 Allied health cost	0	20, 103, 104	0.00000	0 2, 624, 457	0	92.00
93.00 All other Medical Education	0	20, 103, 104	0. 00000	0 2, 624, 457	0	93. 00

Health Financial Systems GOSHEN HOSF	I TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0026	Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Data/Tima Dra	paradi
			To 12/31/2018	Date/Time Pre 5/28/2019 7:0	
	Ti tl e	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description		Ratio of Cos		Inpatient	
·		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	
30. 00   03000   ADULTS & PEDI ATRI CS			15, 574, 351		30.00
31. 00   03100   I NTENSI VE CARE UNI T			4, 903, 099		31.00
32. 00   03200   CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00   03400  SURGI CAL I NTENSI VE CARE UNIT			0		34.00
40. 00   04000   SUBPROVI DER -   1 PF 41. 00   04100   SUBPROVI DER -   1 RF			0		40.00
42. 00   04100   SUBPROVI DER - 1 RF			0		42.00
43. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00   05000   0PERATI NG   ROOM		0. 22673	35 7, 707, 076	1, 747, 464	50.00
51. 00   05100   RECOVERY ROOM		0. 1216			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 35152	· ·	1	1
53. 00   05300   ANESTHESI OLOGY		0. 0120			1
53. 01   05301   PALN   MANAGEMENT		0. 00000	· ·	0	1
54. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 14576		543, 785	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 17000			1
56. 00   05600   RADI OI SOTOPE		0. 1241			1
56. 01   05601   CARDI AC   CATH   LAB		0. 12654	4, 578, 222	579, 328	56. 01
57.00   05700   CT   SCAN		0. 04502	3, 219, 092	144, 933	57. 00
58. 00   05800   MRI		0. 1474	73 334, 484	49, 327	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 00000	00	0	59. 00
60. 00   06000   LABORATORY		0. 19278	6, 186, 534	1, 192, 646	60.00
60. 01  06001 BL00D LABORATORY		0.00000	00	0	60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	
62.00  06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
63.00 O6300 BLOOD STORING PROCESSING & TRANS.		0. 4104			1
64. 00   06400   I NTRAVENOUS THERAPY		0. 0715			1
65. 00   06500   RESPI RATORY THERAPY		0. 4740			1
66. 00 06600 PHYSI CAL THERAPY		0. 57314			1
67. 00 06700 OCCUPATIONAL THERAPY		0. 44499			1
68. 00   06800   SPEECH PATHOLOGY		0. 35318			1
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 08210		161, 229 0	1
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3810			
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 42366			1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 64322			1
74. 00   07400   RENAL DI ALYSI S		2. 10369			1
75. 00   07500   ASC (NON-DISTINCT PART)		0. 00000	· ·	0	1
76. 00 03950 NUTRI TI ON THERAPY		2. 60798			
OUTPATIENT SERVICE COST CENTERS		2.0077	107 700	111,000	70.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
90. 00   09000   CLI NI C		0. 60230	1, 806	1, 088	
90. 02   09002   WOUND CLI NI C		0. 49620	5, 819	2, 888	90. 02
90. 03   09003   MOBI LE CLINI C		0.00000	00	0	90. 03
91. 00   09100   EMERGENCY		0. 1894	3, 095, 146	586, 363	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34260		112, 314	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			61, 104, 289	19, 788, 220	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		I	61, 104, 289	l	202. 00

Health Financial Systems GOSHEN HOSF	I TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0026	Peri od:	Worksheet D-3	
			From 01/01/2018		
			To 12/31/2018		
	T: +1	a VIV	Hooni tol	5/28/2019 7:0	13 pm
Cook Cooking December 1	11 (1	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INDATI ENT. DOUTINE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 500 071		20.00
30. 00   03000   ADULTS & PEDI ATRI CS			1, 533, 071	1	30.00
31. 00   03100   INTENSI VE CARE UNI T			178, 488		31.00
32. 00   03200   CORONARY CARE UNIT			0	1	32. 00
33. 00   03300   BURN   INTENSIVE CARE UNIT			0	1	33.00
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT			0	1	34.00
40. 00   04000   SUBPROVI DER -   PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0	!	41.00
42. 00   04200   SUBPROVI DER			0	1	42. 00
43. 00   04300   NURSERY			0	)	43. 00
ANCI LLARY SERVI CE COST CENTERS					l
50.00   05000   OPERATING ROOM		0. 2267:		1	
51.00   05100   RECOVERY ROOM		0. 1216!		1	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 35152		1	
53. 00   05300   ANESTHESI OLOGY		0. 0120		1	1
53. 01   05301   PAI N   MANAGEMENT		0.0000	00	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1422	24 98, 725	14, 041	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 1693	30 0	0	55. 00
56. 00   05600   RADI OI SOTOPE		0. 1241	18 11, 730	1, 456	56. 00
56. 01   05601   CARDI AC CATH LAB		0. 1265	40 144, 781	18, 321	56. 01
57. 00  05700   CT   SCAN		0. 04502	23 119, 200	5, 367	57. 00
58. 00   05800   MRI		0. 1474	73 6, 200	914	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000	00	0	59.00
60. 00   06000   LABORATORY		0. 19278	302, 315	58, 281	60.00
60. 01 06001 BL00D LABORATORY		0.0000	00	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	00	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000	00	0	62.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.		0. 4104	46 22, 356	9, 176	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 0715			
65. 00 06500 RESPIRATORY THERAPY		0. 4740			1
66. 00   06600   PHYSI CAL THERAPY		0. 57314			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4449			
68. 00 06800 SPEECH PATHOLOGY		0. 35318			
69. 00 06900 ELECTROCARDI OLOGY		0. 08210		1	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3810		1	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4236			1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 6432		1	
74. 00   07400   RENAL DI ALYSI S		2. 1036			
75. 00 07500 ASC (NON-DISTINCT PART)		0.0000		0	1
76. 00 03950 NUTRI TI ON THERAPY		2. 60798			1
OUTPATIENT SERVICE COST CENTERS		2.0077	1,000	2,030	70.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		1	1
90. 00   09000   CLI NI C		0. 60230			
90. 02   09002   WOUND CLINIC		0. 4962			
90. 03   09003   MOBI LE CLI NI C		0.00000			1
91. 00   09100   EMERGENCY		0. 1862			
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0. 1862		1	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 3420			
201.00 Less PBP Clinic Laboratory Services-Program only charges	(lino 61)		4, 936, 452	1,030,732	201.00
202.00   Net charges (line 200 minus line 201)	(11116 01)		4 024 452	,	201.00
202.00   Net charges (Title 200 IIII hus Title 201)		I	4, 936, 452	1	1202.00

	Title XVIII Hospital	5/28/2019 7: 0 PPS	3 pm
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0 11, 789, 995	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3, 968, 245	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octobe 1 (see instructions)	r 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	1, 516, 666 0	2. 00 2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructions) Managed Care Simulated Payments	0	2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	114. 53	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or before 12/31/1996. (see instructions)		5. 00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7. 00 7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cos report straddles July 1, 2011, see instructions.	t 0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		9. 00
12. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		11. 00 12. 00
13. 00 14. 00	Total allowable FTE count for the prior year.  Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997 otherwise enter zero.	, 0. 00 0. 00	
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program	0. 00 0. 00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	0. 00 0. 00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	
20.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)	0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)	0.00000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(C).	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)	0. 000000 0. 000000	
	IME add-on adjustment amount (see instructions)	0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0 0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.86	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	18. 98	
32.00	Sum of lines 30 and 31	21. 84	
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	7. 23 284, 830	
57.00	propriopor tronate ordine dujustilient (see Tristi detrolis)	1 204, 030	34.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0026	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/28/2019 7:0	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompanyated Care Adjustment		1. 00	2. 00	
. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 766 695 164	8, 272, 872, 447	35.
. 01	Factor 3 (see instructions)		0. 000205381	0. 000206000	
. 02	,	enter zero on this line) (se		2, 193, 418	
. 03	Total uncompensated care (sum of columns 1 and 2 on line	35. 03)	1, 039, 457 1, 592, 319	552, 862	35. 36.
. 00	Additional payment for high percentage of ESRD beneficia Total Medicare discharges on Worksheet S-3, Part I exclu		ugh 46) 0		40.
. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 6 instructions)	82, 683, 684 an 685. (see	0		41.
. 01	Total ESRD Medicare covered and paid discharges excludin an 685. (see instructions)	g MS-DRGs 652, 682, 683, 68	4 O		41.
. 00	Divide line 41 by line 40 (if less than 10%, you do not Total Medicare ESRD inpatient days excluding MS-DRGs 65 instructions)	, , ,	0.00 e 0		42. 43.
. 00	Ratio of average length of stay to one week (line 43 div days)	ided by line 41 divided by 7	0. 000000		44.
. 00	Average weekly cost for dialysis treatments (see instruc		0.00		45.
. 00	Total additional payment (line 45 times line 44 times li	ne 41.01)	0		46.
. 00	Subtotal (see instructions)	DIII b	19, 152, 055		47.
. 00	Hospital specific payments (to be completed by SCH and M only. (see instructions)	DH, small rural hospitals	0		48.
	John y. (See Tristructrons)			Amount	
				1. 00	
. 00	Total payment for inpatient operating costs (see instruc	tions)		19, 152, 055	49.
. 00	Payment for inpatient program capital (from Wkst. L, Pt.		)	1, 355, 998	
. 00	Exception payment for inpatient program capital (Wkst. L			0	51.
. 00	Direct graduate medical education payment (from Wkst. E-	4, line 49 see instructions)		0	52.
. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			30, 861 0	53. 54.
. 01	Islet isolation add-on payment			0	1
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, I	ine 69)		0	55
. 00	Cost of physicians' services in a teaching hospital (see	•		0	56
. 00	Routine service other pass through costs (from Wkst. D,	Pt. III, column 9, lines 30	through 35).	0	57
. 00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		15, 166	58
. 00	Total (sum of amounts on lines 49 through 58)			20, 554, 080	
00				32, 837	
. 00	Total amount payable for program beneficiaries (line 59	minus iine 60)		20, 521, 243	
. 00	Deductibles billed to program beneficiaries			1, 764, 300 23, 450	
. 00	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			23, 450 33, 318	
. 00				21, 657	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		11, 115	1
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	· · · · · ·		18, 755, 150	
. 00	Credits received from manufacturers for replaced devices	for applicable to MS-DRGs (	see instructions)	0	68
. 00	Outlier payments reconciliation (sum of lines 93, 95 and	96).(For SCH see instruction	ns)	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
. 50	Rural Community Hospital Demonstration Project (§410A De	· · · · · · · · · · · · · · · · · · ·	ınstructions)	0	70
. 87 . 88	Demonstration payment adjustment amount before sequestra			0	70 70
. 89	SCH or MDH volume decrease adjustment (contractor use on Pioneer ACO demonstration payment adjustment amount (see	3.		U	70
. 90	HSP bonus payment HVBP adjustment amount (see instruction	· ·		0	
. 91	HSP bonus payment HRR adjustment amount (see instruction			0	
	Bundled Model 1 discount amount (see instructions)	,		0	
. 92	bullul ed woder   di scoulit amount (see l'isti de l'ons)				
	HVBP payment adjustment amount (see instructions)			19, 674	70

70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70. 97
70. 98	Low Volume Payment-3		0	70. 98
70. 70	HAC adjustment amount (see instructions)		204, 766	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18, 518, 918	
71. 00	Sequestration adjustment (see instructions)		370, 378	
71. 01	Demonstration payment adjustment amount after sequestration		0	1
72.00	Interim payments		18, 121, 226	
73. 00	Tentative settlement (for contractor use only)		10, 121, 220	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		27 314	74.00
7 1. 00	73)		27,011	7 1. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with		511, 695	75. 00
	CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			-
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
70.00	plus 2.04 (see instructions)		U	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	,
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
94. 00	The rate used to calculate the time value of money (see instructions)		_	94. 00
95. 00	Time value of money for operating expenses (see instructions)		0.00	1
96. 00			0	
70.00	Time varies of money for eaptral fertited expenses (see first detroits)	Prior to 10/1		70.00
		1.00	2. 00	
	HSP Bonus Payment Amount	1.00	2.00	
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.000000000	0.0000000000	101.00
	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment	1		1
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment	·		1
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00	Medicare discharges (see instructions)			202. 00
203.00	Case-mix adjustment factor (see instructions)			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod)	urrent 5-year demonst	ration	
204.00	Medicare target amount			204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00	Reserved for future use			210. 00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
	Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
	Low-volume adjustment (see instructions)			213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursemen	t)		218. 00
	(line 212 minus line 213) (see instructions)			

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2018 | Part A Exhibit 4 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026

						0 12/31/2010	5/28/2019 7:0	3 pm
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		5.00	1.00
1.00	payments	1.00		J			J	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	11, 789, 995	0	11, 789, 995	5	11, 789, 995	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	3, 968, 245	0		3, 968, 245	3, 968, 245	1. 02
1. 03	occurring on or after October  1 DRG for Federal specific	1. 03	0	0	C		0	1. 03
	operating payment for Model 4 BPCI occurring prior to October 1							
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. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	1, 516, 666	0	1, 134, 383	382, 283	1, 516, 666	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	0	(	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	C	0	0	4. 00
5. 00	Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
5.00	A, line 21 (see instructions)	21.00	0.000000	0. 000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	C	0	0	6. 01
	instructions)							l
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	C	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	0	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10.00	Allowable disproportionate	33. 00	0. 0723	0. 0723	0. 0723	0. 0723		10.00
	share percentage (see instructions)							
11. 00	Di sproporti onate share adjustment (see instructions)	34. 00	284, 830	0	213, 104	71, 726	284, 830	
11. 01	Uncompensated care payments	36.00	1, 592, 319	0	1, 039, 457	552, 862	1, 592, 319	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	n beneficiary	di scharges 0	C	0	0	12. 00
55	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	19, 152, 055 0	0	14, 176, 939 (	4, 975, 116 0	19, 152, 055 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	19, 152, 055	0	14, 176, 939	4, 975, 116	19, 152, 055	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 355, 998	0	C	1, 355, 998	1, 355, 998	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	0	0	C	o	0	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from	68. 00	0	0	C	0	0	17. 01 17. 02
	manufacturers for replaced devices for applicable MS-DRGs							

					1	o 12/31/2018	Date/Time Prep 5/28/2019 7:03	
				Title	XVIII	Hospi tal	PPS	o piii
	·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation	93. 00	0	0	C	0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0	14, 176, 939	6, 331, 114	20, 508, 053	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	1, 272, 862	0	C	1, 272, 862	1, 272, 862	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
04 00	than outlier	0.00	05 (00			05 (00	05 (00	04 00
21.00	Capital DRG outlier payments	2.00	25, 603	0		25, 603	25, 603	1
21. 01	Model 4 BPCI Capital DRG	2. 01	O O	0	(		Ü	21. 01
22. 00	outlier payments Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
22.00	percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23. 00	Indirect medical education	6. 00		0	(		0	23. 00
23.00	adjustment (see instructions)	0.00	٩	Ü		,	U	23.00
24. 00	Allowable disproportionate	10.00	0. 0452	0. 0452	0. 0452	0. 0452		24. 00
24.00	share percentage (see	10.00	0.0432	0.0432	0.0432	0.0432		24.00
	i nstructi ons)							
25. 00	Di sproporti onate share	11. 00	57, 533	0		57, 533	57, 533	25. 00
20.00	adjustment (see instructions)	11.00	07,000	O		07,000	07,000	20.00
26. 00	Total prospective capital	12. 00	1, 355, 998	0	l	1, 355, 998	1, 355, 998	26, 00
	payments (see instructions)		.,,,,,,,,			1, 222, 112	.,,	
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0.000000		27. 00
28. 00	Low volume adjustment	70. 96			C		0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.				l	[		l

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E | From 01/01/2018 | Part A Exhibit 5 | To 12/31/2018 | Date/Time Prepared: | From 2012 | Prepared: | Prepar 
 Heal th Financial
 Systems
 GOSHEN HODE

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN: 15-0026

				10	) 12/31/2018	5/28/2019 7:03	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1.00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	11, 789, 995	11, 789, 995		11, 789, 995	1. 01
1 00	discharges occurring prior to October 1	1 00	2 0/0 245		2 0/0 245	2 0/0 245	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 968, 245		3, 968, 245	3, 968, 245	1. 02
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
1.03	for Model 4 BPCI occurring prior to October	1.03	0	U		U	1.03
	1						
1.04	DRG for Federal specific operating payment	1. 04	o		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	1, 516, 666	1, 006, 267	510, 399	1, 516, 666	2. 00
	instructions)						
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2 00	BPCI	2 01		0	0	0	2 00
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0	0	3. 00 4. 00
4.00	Indirect Medical Education Adjustment	3.00	U U	U	U	U	4.00
5.00	Amount from Worksheet E, Part A, Line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
0.00	(see instructions)	21.00	0.00000	0.00000	0.00000		0.00
6.00	IME payment adjustment (see instructions)	22. 00	o	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	o	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t				
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)		_	_	_	_	
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	Ü	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	29. 01	0	0	0	0	9. 01
7. 01	lines 6.01 and 8.01)	29.01		O	O	O	7. 01
	Disproporti onate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0723	0. 0723	0. 0723		10.00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	284, 830	213, 104	71, 726	284, 830	11.00
	instructions)						
11. 01	Uncompensated care payments	36.00	1, 592, 319	1, 039, 457	552, 862	1, 592, 319	11. 01
40.00	Additional payment for high percentage of ESF				0	0	10.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	19, 152, 055	14, 048, 823	5, 103, 232	19, 152, 055	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00	19, 152, 055	14, 040, 623	5, 103, 232 N	19, 152, 055	14. 00
14.00	and MDH, small rural hospitals only.) (see	40.00		O	O	J	14.00
	instructions)						
15.00	Total payment for inpatient operating costs	49.00	19, 152, 055	14, 048, 823	5, 103, 232	19, 152, 055	15. 00
	(see instructions)						
16.00	Payment for inpatient program capital (from	50.00	1, 355, 998	1, 015, 773	340, 225	1, 355, 998	16. 00
	Wkst. L, Pt. I, if applicable)						
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	
17. 01	Net organ acquisition cost	40.00		=1	_	_	17. 01
17. 02	Credits received from manufacturers for	68. 00	0	0	0	0	17. 02
18. 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
10.00	amount (see instructions)	73.00		U	U	ا	10.00
19. 00	SUBTOTAL			15, 064, 596	5, 443, 457	20, 508, 053	19, 00
		1	'		-,, ,	,,,	

			Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	1, 272, 862	952, 723	320, 139	1, 272, 862	20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
	Capital DRG outlier payments	2. 00	25, 603	19, 987	5, 616	25, 603	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	0.0000	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. 0452	0. 0452	0. 0452		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	57, 533	43, 063	14, 470	57, 533	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 355, 998	1, 015, 773	340, 225	1, 355, 998	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2. 00	3. 00	4. 00	
27. 00							27. 00
	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	19, 674	7, 898	11, 776		
	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
	HRR adjustment (see instructions)	70. 94	-51, 140	-45, 981	-5, 159	-51, 140	
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
	HAC Reduction Program adjustment (see instructions)	70. 99		150, 265	54, 501		
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems	GOSHEN HOSPI TAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0026	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 7:03 pm		

			10 12/01/2010	5/28/2019 7:0	3 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			42, 581	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		40, 704, 661	2.00
3.00	OPPS payments			21, 499, 590	3. 00
4.00	Outlier payment (see instructions)			445, 667	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		26, 511	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			42, 581	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			66, 540	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			66, 540	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(6	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00	Total customary charges (see instructions)			66, 540	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lin	ne 11) (see	23, 959	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
04 00	instructions)			40 504	04 00
21. 00	Lesser of cost or charges (see instructions)			42, 581	
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			21, 971, 768	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	- \		12/	25 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		136	
26. 00	Deductibles and Coinsurance amounts relating to amount on line			3, 864, 903	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	orus the sum of lines 22	and 23] (See	18, 149, 310	27. 00
20 00	instructions)  Direct graduate medical education payments (from Wkst. E. 4. Li	no EO)		0	28. 00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			18, 149, 310	
31. 00	Primary payer payments			2, 390	
32.00	Subtotal (line 30 minus line 31)			18, 146, 920	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	`FS)		10, 140, 720	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
34. 00	Allowable bad debts (see instructions)			290, 116	
35. 00	Adjusted reimbursable bad debts (see instructions)			188, 575	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		235, 536	
37. 00	Subtotal (see instructions)	4011 0113)		18, 335, 495	
38. 00	MSP-LCC reconciliation amount from PS&R			44	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	-,		0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	ő	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	sed devices (see institue	11 0113)	Ö	39. 99
40. 00	Subtotal (see instructions)			18, 335, 451	
40. 01	Sequestration adjustment (see instructions)			366, 709	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41. 00	Interim payments			17, 889, 412	
42. 00	Tentative settlement (for contractors use only)	0			
43. 00	Balance due provider/program (see instructions)	79, 330			
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2	chapter 1.	385, 903	
00	§115. 2		· · ·		50
	TO BE COMPLETED BY CONTRACTOR				
90.00				0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)				94. 00
			!	-	•

Provider CCN: 15-0026

Interim payments payable on Individual bils, 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.    3.01						5/28/2019 7:03	3 pm
mm/dd/yyyy			Title	XVIII		PPS	
1.00   10tal Interim payments paid to provider   1.00   2.00   3.00   4.00   1.7,889,412   1.00			I npati en	t Part A	Part B		
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either   Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero   List separately each retracactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   O			1.00	2.00	3. 00	4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00	Total interim payments paid to provider		18, 121, 226		17, 889, 412	1. 00
Write "NONE" or enter a zero   3.00   List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2. 00	submitted or to be submitted to the contractor for		0		0	2. 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		write "NONE" or enter a zero					
payment. If none, write "NONE" or enter a zero. (1)	3. 00	amount based on subsequent revision of the interim rate					3. 00
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02   0							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR  5.01 TENTATIVE TO PROGRAM  TO TOTAL Medicare program liability (see instructions)  TO SETTLEMENT TO PROGRAM  TO TOTAL Medicare program liability (see instructions)  TO SETTLEMENT TO PROGRAM  TO TOTAL Medicare program liability (see instructions)  TENTATIVE TO PROGRAM  TO SETTLEMENT TO PROGRAM  TO TOTAL Medicare program liability (see instructions)  TO SETTLEMENT TO PROGRAM  TO TOTAL MEDICARY (Mo/Day/Yr)  TO TOTAL Medicare program liability (see instructions)		ADJUSTMENTS TO PROVIDER		1			3. 01
3.04   0   0   0   3.5     3.05				· -		1	3. 02
3.55   Provider to Program						-	
Provider to Program							
3.50   ADJUSTMENTS TO PROGRAM	3.05	Dravi dan ta Dragnam		0		0	3.05
3.51   0	2 50						2 50
3.52   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50   0   0   3.5     3.53   3.50   0   0   0   3.5     3.50   3.50-3.98   0   0   0   3.5     4.00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR		ADJUSTIMENTS TO PROGRAM					
3.53   3.54   0   0   0   3.5   3.54   3.54   0   0   0   3.5   3.54   3.59   3.50-3.98   3.50-3.99						"	3. 51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   18,121,226   17,889,412   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							3. 53
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							3. 54
3. 50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 O1-3 49 minus sum of lines					3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)					
TO BE COMPLÉTED BY CONTRACTOR	4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		10, 121, 220		17, 007, 412	4.00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00	list senarately each tentative settlement navment after					5. 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						3.00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider					
Solidar to Program   Solidar	5. 01			0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM   0	5.03			0		0	5. 03
5.51   0							
5.52   0 0 0 5.50     5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0 0 0 5.50     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TENTATI VE TO PROGRAM		0		0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 27, 314 79, 330 6. 00 7. 00 Total Medicare program liability (see instructions) 18, 148, 540 17, 968, 742 7. 00  Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00						"	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  27,314 79,330 6.00 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00				1		-	5. 52
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  27,314 79,330 6.0 0 6.0 17,968,742 7.0 Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 00	· · · · · · · · · · · · · · · · · · ·					6. 00
7.00 Total Medicare program liability (see instructions)  18,148,540  17,968,742  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01			27, 314		79, 330	6. 01
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00	6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program liability (see instructions)		18, 148, 540			7. 00
0 1.00 2.00							
8.00  Name of Contractor   8.0	0.00		(	)	1. 00	2.00	0.5-
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems GOSHEN HOSF	PI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0026 Period:					
			From 01/01/2018 To 12/31/2018		pared:	
				5/28/2019 7:0	)3 pm	
		Title XVIII	Hospi tal	PPS		
				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.	S-3, Pt. I col. 15 line	14		1.00	
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			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	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	0 Sequestration adjustment amount (see instructions)					
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30. 00	
31. 00	Other Adjustment (specify)				31.00	
22 00	00 Polance due provider (line 0 (or line 10) minus line 20 and line 21) (assingtructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

		OSPI TAL		In Lieu of Form CMS-2552		
BALANCE SHEET (If you are nonproprietary and do not maintain		Provider CCN: 15-0026		Peri od:	Worksheet G	
fund-t only)	ype accounting records, complete the General Fund column			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
——————————————————————————————————————	,				5/28/2019 7:0	3 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 056, 720		0	0	1.00
2.00	Temporary investments	0		0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	105, 709, 703		0	0	4. 00
5. 00	Other recei vable	103, 707, 703		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-62, 442, 644		0	0	6. 00
7.00	Inventory	5, 395, 670		0 0	0	7. 00
8.00	Prepai d expenses	5, 328, 279	(	0	0	8. 00
9.00	Other current assets	0	(	0	0	
10.00	Due from other funds	U FF 047 720		0 0	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	55, 047, 728		J 0	0	11. 00
12. 00	Land	4, 027, 467		0 0	0	12. 00
13. 00	Land improvements	2, 736, 366		0	0	13. 00
14.00	Accumulated depreciation	-1, 751, 510		0 0	0	14. 00
15.00	Bui I di ngs	113, 518, 308		0 0	0	15. 00
16. 00	Accumul ated depreciation	-42, 181, 693		0	0	16. 00
17. 00	Leasehold improvements	36, 948		0	0	17. 00
18.00	Accumulated depreciation	-36, 948		0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	18, 768, 387 -7, 891, 317		0 0	0	19. 00 20. 00
21. 00	Automobiles and trucks	-7,091,317	•	0	0	21.00
22. 00	Accumulated depreciation	0		0	0	22. 00
23. 00	Major movable equipment	112, 448, 891		0	0	23. 00
24. 00	Accumulated depreciation	-73, 408, 973		0 0	0	24. 00
25. 00	Mi nor equipment depreciable	0	(	0 0	0	25. 00
26. 00	Accumul ated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0		0 0	0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	126, 265, 926		0	0	30.00
00.00	OTHER ASSETS	120/200/720		<u></u>		00.00
31.00	Investments	0	(	0 0	0	31. 00
32. 00	Deposits on Leases	0		0	0	1
33. 00	Due from owners/officers	0		0	0	33. 00
34.00	Other assets	203, 532, 704		0	0	34. 00
35. 00 36. 00	Total other assets (sum of lines 31-34)	203, 532, 704		0 0	0	35. 00 36. 00
30.00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	384, 846, 358		J <sub>1</sub> U	U	30.00
37. 00	Accounts payable	15, 964, 018		0 0	0	37. 00
38. 00	Salaries, wages, and fees payable	10, 094, 098		0	0	38. 00
39. 00	Payroll taxes payable	378, 575		0 0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 648, 151		0 0	0	40. 00
41. 00	Deferred income	0	(	0	0	1
42.00	Accel erated payments	0			0	42. 00
43. 00 44. 00	Due to other funds Other current liabilities	2, 625, 642		0 0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	30, 710, 484		0	0	
10.00	LONG TERM LIABILITIES	00,710,101		<u>J</u>	<u> </u>	10.00
46. 00	Mortgage payable	0	(	0 0	0	46. 00
47. 00	Notes payable	30, 465, 212		0 0	0	
48. 00	Unsecured Loans	0	(	0	0	
49. 00	Other long term liabilities	376, 166		0	0	1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	30, 841, 378		0 0	0	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	61, 551, 862	'	J <sub>1</sub> U	0	31.00
52. 00	General fund balance	323, 294, 496				52. 00
53. 00	Specific purpose fund			O		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	323, 294, 496			0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	384, 846, 358			0	
	59)				_	

Provider CCN: 15-0026

					10 12/31/2018	5/28/2019 7:03	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
				'	'		
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		321, 563, 193	l .	(		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 728, 854	l .			2.00
3.00	Total (sum of line 1 and line 2)		324, 292, 047		(		3. 00
4.00	TEMPORARILY RESTRICTED ASSETS	528, 153			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		528, 153		(		10.00
11. 00	Subtotal (line 3 plus line 10)		324, 820, 200		(	1	11. 00
12.00	EQUITY TRANSFER	1, 525, 704			0	0	
13.00		0			0	0	
14. 00		0			0	0	
15. 00		0			0	0	
16. 00		0			0	0	16. 00
17. 00		0			0	0	
18. 00	,		1, 525, 704	1	(		18. 00
19. 00			323, 294, 496		(	)	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Endownent Fund	PLAIIL	Tuliu			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	TEMPORARILY RESTRICTED ASSETS	1	0				4. 00
5. 00			0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11. 00	Subtotal (line 3 plus line 10)	o			0		11. 00
12. 00	EQUITY TRANSFER		0				12.00
13. 00			0				13.00
14. 00			0				14.00
15.00			o				15.00
16.00			o				16.00
17. 00		1	0				17. 00
18. 00	Total deductions (sum of lines 12-17)	o			0		18. 00
	,	0			0		
18. 00	,	-					18. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0026

			-	To 12/31/2018	Date/Time Prep 5/28/2019 7:03	
	Cost Center Description		Inpatient	Outpati ent	Total	J pili
	5557 55117511 555511 511511		1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES	I	11.00	2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		42, 372, 71		42, 372, 712	1. 00
2.00	SUBPROVIDER - I PF		,,		0	2. 00
3.00	SUBPROVI DER - I RF				0	3. 00
4. 00	SUBPROVI DER				0	4. 00
5. 00	Swing bed - SNF				0	5. 00
6. 00	Swing bed - NF				0	6. 00
7. 00	SKILLED NURSING FACILITY		·		0	7. 00
8. 00	NURSING FACILITY				0	8. 00
9. 00	OTHER LONG TERM CARE		·		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		42, 372, 71		42, 372, 712	
10.00	Intensive Care Type Inpatient Hospital Services		12, 072, 71.	-	12, 072, 712	10.00
11. 00	INTENSIVE CARE UNIT		12, 868, 88		12, 868, 886	11 00
12. 00	CORONARY CARE UNIT		12, 000, 00		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		·	ó	0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		·		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)		· ·		O	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	12, 868, 88		12, 868, 886	
10.00	11-15)	111103	12, 000, 00		12, 000, 000	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	,	55, 241, 59	3	55, 241, 598	17. 00
18. 00	Ancillary services	·	157, 147, 97		556, 839, 345	
19. 00	Outpatient services		8, 133, 38		55, 224, 603	
20. 00	RURAL HEALTH CLINIC			0	00, 22 1, 000	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER				Ö	21. 00
22. 00	HOME HEALTH AGENCY		· ·	2, 534, 391	2, 534, 391	
23. 00	AMBULANCE SERVICES			2, 334, 371	2, 334, 371	23. 00
24. 00	CMHC			0	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		(		Ö	25. 00
26. 00	HOSPI CE		·	5, 141, 691	5, 141, 691	
27. 00	PROFESSI ONAL REVENUE		1, 411, 65		19, 399, 211	
27. 01	NON REIMBURSABLE		1, 411, 03	816, 495	816, 495	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	221, 934, 60		695, 197, 334	
20.00	G-3, line 1)	to wkst.	221, 734, 00	473, 202, 723	075, 177, 554	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			251, 217, 751		29. 00
30.00	ADD (SPECIFY)		(	201, 217, 701		30.00
31. 00	(or correspond					31. 00
32. 00			·			32. 00
33. 00			·			33. 00
34. 00			·			34. 00
35. 00			·	á		35. 00
36. 00	Total additions (sum of lines 30-35)		· ·	0		36. 00
37. 00	DEDUCT (SPECIFY)		(	)		37. 00
38. 00	DEBOOT (SEESTED)		·			38. 00
39. 00			·			39. 00
40. 00						40. 00
41. 00			ì	5		41. 00
42. 00	Total deductions (sum of lines 37-41)		`	<u></u>		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	(transfer		251, 217, 751		43. 00
	to Wkst. G-3, line 4)	., (:. a51 61		23.,217,731		
	1			1		1

llool +b	Financial Cystems COSUEN I	IOCDI TAI	la li o	u of Form CMS-2	DEE2 10	
	Health Financial Systems GOSHEN HOSPITAL In Lieu STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0026 Period:					
	From 01/01/2018 To 12/31/2018					
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 20)		1. 00 695, 197, 334	1. 00	
2.00	Less contractual allowances and discounts on patients' acc	,		439, 170, 238	2. 00	
3. 00	Net patient revenues (line 1 minus line 2)	Journey		256, 027, 096	3. 00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		251, 217, 751	4. 00	
5. 00	Net income from service to patients (line 3 minus line 4)	110		4, 809, 345	5. 00	
0.00	OTHER I NCOME			1,007,010	0.00	
6.00	Contributions, donations, bequests, etc			4, 069, 470	6. 00	
7.00	Income from investments			-12, 278, 668	7. 00	
8.00	Revenues from telephone and other miscellaneous communicat		0	8. 00		
9.00	Revenue from television and radio service	0	9. 00			
10.00	Purchase di scounts	83, 208	10.00			
11. 00	Rebates and refunds of expenses			1, 330, 722	11. 00	
12.00				0	12.00	
13. 00	1 · · · · · · · · · · · · · · · · · · ·			0	13.00	
14. 00	1			337, 528		
15. 00	3 1			0	15.00	
16. 00			0	16. 00		
17. 00	Revenue from sale of drugs to other than patients			0	17. 00	
18. 00	Revenue from sale of medical records and abstracts			0	18. 00	
19. 00				0	19. 00	
20. 00	3			0	20. 00	
21. 00	1			0	21. 00	
	Rental of hospital space			1, 447, 137		
23. 00	The state of the s			0	23. 00	
	MI SC OTHER OPER/NON OPER REVENUE			2, 930, 112		
	Total other income (sum of lines 6-24)			-2, 080, 491	25. 00	
	Total (line 5 plus line 25)			2, 728, 854		
	OTHER EXPENSES (SPECIFY) Total other expenses (sum of line 27 and subscripts)			0	27. 00 28. 00	
	Net income (or loss) for the period (line 26 minus line 28	2)		2, 728, 854		
27.00	The tricome (or 1055) for the period (trie 20 millus fille 20	,,	ļ	2, 120, 004	∠7.00	

Heal th	Financial Systems		GOSHEN HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der Co	CN: 15-0026	Peri od:	Worksheet H-1	
				HHA CCN:	15-7174	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	pared:
						Home Health	5/28/2019 7:0 PPS	3 pm
						Agency I	FF3	
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on	Subtotal	
		for Cost	Fixtures	Equi pment	Operation 8	i	(cols. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col . 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3. 00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable			0			0	2. 00
2.00	Equipment			0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	0	
4. 00 5. 00	Transportation Administrative and General	1, 359, 346	0	0	•	0 0	1, 359, 346	4. 00 5. 00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	887, 296 384, 765	0	0		0 0	887, 296 384, 765	
8. 00	Occupational Therapy	158, 085	ő	0		0 0	158, 085	
9.00	Speech Pathology	52, 697	0	0		0 0	52, 697	
10. 00 11. 00	Medical Social Services Home Health Aide	98, 595 68, 608	0	0		0 0	98, 595 68, 608	
12. 00	Supplies (see instructions)	21, 048	Ö	0		0 0	21, 048	1
13.00	Drugs	0	O	0	•	0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0	•	0 0	0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0	1	0 0	0	
18. 00	Clinic		Ö	0	•	0 0	0	1
19.00	Health Promotion Activities	0	0	0	•	0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0	0	•	0 0	0	
22. 00	Homemaker Service	O	Ö	0	•	0 0	0	22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0		0 0	0	23. 00 23. 50
	Total (sum of lines 1-23)	3, 030, 440	0	0	•	0 0	3, 030, 440	1
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2. 00
2 00	Equi pment							2 00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5.00	Administrative and General	1, 359, 346						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	721, 768	1, 609, 064					6. 00
7.00	Physi cal Therapy	312, 986	697, 751					7. 00
8.00	Occupational Therapy Speech Pathology	128, 594	286, 679					8.00
9. 00 10. 00	Medical Social Services	42, 866 80, 202	95, 563 178, 797					9. 00 10. 00
11. 00	Home Health Aide	55, 809	124, 417					11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	17, 121	38, 169 0					12. 00 13. 00
14. 00	DME		0					14. 00
45.00	HHA NONREI MBURSABLE SERVI CES	1 al						1
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	Ö					17. 00
18.00	Clinic	0	O					18.00
19. 00 20. 00	Health Promotion Activities Day Care Program		0					19. 00 20. 00
21. 00	Home Delivered Meals Program		O					21. 00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0					22. 00 23. 00
23. 50	Tel emedi ci ne		o					23. 50
24. 00	Total (sum of lines 1-23)		3, 030, 440					24. 00

111 41-	Figure 1 Contains		COCHENILIA	OCDI TAI		1-11-		2552 40
	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS	110	GOSHEN HO	Provider C	CN: 1E 0024	Period:	u of Form CMS-2 Worksheet H-1	
COST A	LECCATION - MMA STATISTICAL BAS	51 3		HHA CCN:	15-7174	From 01/01/2018 To 12/31/2018	Part II	pared:
						Home Health Agency I	PPS	<u> 5 piii                                </u>
		Capital Rel	ated Costs			Agency		
		oup tur nor	4104 00313					
		Bl dgs &	Movabl e	Plant		onReconciliation		
		Fixtures	Equipment (DOLLAR VALUE)	Operation & Maintenance	(MI LEAGE)		& General (ACCUM. COST)	
		(SQUARE FEET)	(DULLAR VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS			2.25				
1.00	Capital Related - Bldg. &	0				0		1.00
	Fi xtures							
2.00	Capital Related - Movable		0			0		2. 00
3. 00	Equipment   Plant Operation & Maintenance		0	0		0		3. 00
4.00	Transportation (see		0	0		0		4. 00
4.00	instructions)				1			4.00
5.00	Administrative and General	0	0	O		0 -1, 359, 346	1, 671, 094	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0		C	1	0 0	887, 296	
7.00	Physi cal Therapy	0	_	0	1	0	384, 765	1
8. 00	Occupational Therapy	0	0	0		0 0	158, 085	
9.00	Speech Pathology	0	0	0	1	0 0	52, 697	1
10. 00 11. 00	Medical Social Services Home Health Aide	0	0	0		0 0	98, 595	10. 00 11. 00
12. 00	Supplies (see instructions)		0	0		0 0		12.00
13. 00	Drugs		_	0	1	0	21,040	•
14. 00	DME	0		Ö		0 0	0	•
	HHA NONREIMBURSABLE SERVICES					•		
15. 00	Home Dialysis Aide Services	0	0	O	1	0 0	0	15. 00
16. 00	Respiratory Therapy	0	_	0	1	0 0	0	
17. 00	Private Duty Nursing	0	0	0		0 0	0	1
18.00	Clinic	0	0	0	1	0	0	
19. 00 20. 00	Health Promotion Activities	0	0	0	l .	0	0	
21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0	0	1
22. 00	Homemaker Service		0	0			0	1
23. 00	All Others (specify)	0	0	Ö		0 0	0	1
23. 50	Tel emedi ci ne	Ö	0	O	,	0 0	0	
24.00	Total (sum of lines 1-23)	0	0	O		0 -1, 359, 346	1, 671, 094	•
25. 00	Cost To Be Allocated (per	0	0	0		0	1, 359, 346	25. 00
27.00	Worksheet H-1, Part I)	0.000000	0.000000	0.000000		00	0.040	2/ 22
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	UU	0. 813447	26.00

						Agency I	PPS	
			CAPITAL REL	ATED COSTS		rigerie y 1		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	
		0	1.00	2. 00	4. 00	5. 01	5A. 01	
1.00	Administrative and General	0	10, 410	22, 178	340, 785	11, 278	384, 651	1. 00
2.00	Skilled Nursing Care	1, 609, 064	0	0	321, 233	0	1, 930, 297	2. 00
3.00	Physical Therapy	697, 751	0	0	139, 299		837, 050	
4.00	Occupati onal Therapy	286, 679	0	0	57, 232		343, 911	4. 00
5.00	Speech Pathology	95, 563	0	0	19, 078		114, 641	5. 00
6.00	Medical Social Services	178, 797	0	0	35, 695		214, 492	
7. 00 8. 00	Home Health Aide Supplies (see instructions)	124, 417 38, 169	0	0	24, 839	0	149, 256 38, 169	
9. 00	Drugs	30, 109	0	0		0	36, 109	
10. 00	DME	0	0	0	Ö	0	0	
11. 00	Home Dialysis Aide Services	Ö	o o	o	ď	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	C	0	0	12. 00
13.00	Private Duty Nursing	0	0	0	C	0	0	13. 00
14. 00	Clinic	0	0	0	C	0	0	14. 00
15.00	Health Promotion Activities	0	0	0	C	0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0		0	0	16. 00 17. 00
18. 00	Homemaker Service	0	0	0		0	0	ı
19. 00	All Others (specify)	0	0	ő	ď	0	0	19. 00
19. 50		0	0	0	C	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	3, 030, 440	10, 410	22, 178	938, 161	11, 278	4, 012, 467	20. 00
21. 00	Unit Cost Multiplier: column						0. 000000	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description		MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		GENERAL 5. 02	REPAI RS 6.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
1.00	Administrative and General	45, 772	0	72, 479	C		0	1. 00
2.00	Skilled Nursing Care	229, 697	0	0	C	-	0	1
3.00	Physical Therapy	99, 606	0	0	C	0	0	
4.00	Occupational Therapy	40, 924	0	0	0	0	0	1
5. 00 6. 00	Speech Pathology Medical Social Services	13, 642 25, 524	0	0		0	0	
7. 00	Home Heal th Ai de	17, 761	0	0		0	0	
8. 00	Supplies (see instructions)	4, 542	0	0		0	0	
9.00	Drugs	0	0	0	C	0	0	1
10.00	DME	0	0	0	C	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0		0	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0	1 0	0	0	1
16. 00		0	0	Ö	ď	0	0	
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17. 00
18.00	Homemaker Service	0	0	0	C	0	0	18. 00
19. 00	All Others (specify)	0	0	0	С	١	0	
19. 50	1	0	0	0	O		0	
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	477, 468	0	72, 479	C	31, 521	0	20.00
21. 00	26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	/ dealmal places	I .	İ		i	1		
	6 decimal places.							

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

5/28/2019 7:03 pm

Home Health PPS Agency I MAINTENANCE OF PHARMACY Cost Center Description CAFETERI A NURSI NG CENTRAL MEDI CAL SERVICES & RECORDS & PERSONNEL ADMI NI STRATI ON LI BRARY SUPPLY 12.00 13.00 15.00 11.00 14.00 16.00 Administrative and General 16, 749 1, 430 17, 982 1.00 2.00 Skilled Nursing Care 11, 298 0000000000000000000 C 0 2.00 Physical Therapy 0 3.00 3,689 0 3.00 0 4.00 Occupational Therapy 2, 244 0 4.00 Speech Pathology 0 5.00 532 0 0 0 0 0 0 0 0 0 5.00 Medical Social Services 0 6.00 1, 282 6.00 1, 901 0 7.00 0 Home Health Aide 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 Drugs 0 9.00 0 0 0 10 00 DMF 10 00 Home Dialysis Aide Services 0 0 11.00 0 11.00 12.00 Respiratory Therapy 12.00 13.00 Private Duty Nursing 0 0 13.00 Ω 0 14 00 Clinic 14 00 15.00 Health Promotion Activities 0 0 15.00 0 0 16.00 Day Care Program 0 16.00 0 0 17 00 Home Delivered Meals Program Ω 17 00 18.00 Homemaker Service 0 0 0 18.00 19.00 All Others (specify) 0 0 0 19.00 0 19.50 Tel emedi ci ne 19.50 0 0 Total (sum of lines 1-19) (2) 17, 982 37, 695 1, 430 20 00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places INTERNS & RESIDENTS Cost Center Description SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED **ANESTHETI STS** Y & FRINGES PRGM COSTS **PRGM APPRV APPRV** 17. 00 19. 00 20.00 21. 00 22.00 23. 00 1.00 Administrative and General 1.00 0000000000000000000000 2.00 Skilled Nursing Care 0 0 0 0 2.00 0 0 3.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3.00 0 0 0 4 00 Occupational Therapy O 4 00 5.00 Speech Pathology 0 0 5.00 Medical Social Services 6.00 6.00 0 7.00 Home Health Aide 0 0 0 7.00 0 0 8.00 Supplies (see instructions) 0 8.00 9.00 Drugs 0 0 9.00 0 0 0 10.00 10.00 Home Dialysis Aide Services 0 0 0 11.00 11.00 0 0 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 14.00 Health Promotion Activities 0 0 0 15.00 15.00 0 0 0 16.00 Day Care Program 16.00 Home Delivered Meals Program 17.00 17.00 Homemaker Service All Others (specify) 0 18.00 0 0 18.00 0 19.00 19.00 0 0 0 0 19.50 Tel emedi ci ne 19.50 20.00 20.00 Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column 0, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-0026 Peri od: Worksheet H-2 From 01/01/2018 Part I HHA CCN: 15-7174 12/31/2018 Date/Time Prepared: To 5/28/2019 7:03 pm Home Health PPS Agency I Total HHA Cost Center Description Subtotal Intern & Subtotal Allocated HHA Residents Cost Costs A&G (see Part & Post II) Stepdown Adjustments 24. 00 25. 00 26.00 27. 00 28. 00 1.00 Administrative and General 570, 584 570, 584 1.00 0 2, 171, 292 303, 621 2, 474, 913 2 00 2 00 Skilled Nursing Care 2, 171, 292 3.00 Physical Therapy 940, 345 0 940, 345 131, 491 1, 071, 836 3.00 4.00 Occupational Therapy 387, 079 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 387, 079 54, 126 441, 205 4.00 Speech Pathology 128, 815 18, 013 5 00 128, 815 146, 828 5 00 6.00 Medical Social Services 241, 298 241, 298 33, 741 275, 039 6.00 7.00 Home Health Aide 168, 918 168, 918 23, 620 192, 538 7.00 8.00 Supplies (see instructions) 42,711 42, 711 5, 972 48, 683 8.00 9.00 0 9 00 Drugs 0 0 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 0 0 11.00 11.00 0 Respiratory Therapy 0 12.00 12.00 0 0 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 15.00 15.00 0 Day Care Program 0 0 0 0 16.00 16, 00 0 17.00 Home Delivered Meals Program 0 17.00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 19.50 0 Total (sum of lines 1-19) (2) 4, 651, 042 4, 651, 042 570, 584 20.00 4, 651, 042 20.00 Unit Cost Multiplier: column 0.139833 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	GOSHEN HOSP	I TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA BASIS	COST CENTERS STATISTICAL	Provi der CCN: 15-0026 HHA CCN: 15-7174	Peri od: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part II Date/Time Prepared: 5/28/2019 7:03 pm
			Home Health	PPS

						Home Health Agency I	PPS	
		CAPITAL REI	ATED COSTS			Agency		
		DI DO A FLYT	10/01 5 50/11 0	5454 0455			OTUES 4544 4	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	OUNTS	Reconciliation	OTHER ADMIN &     GENERAL	
		(SQUARE TELT)	(DOLLAR VALUE)	DEPARTMENT	RECEI VABLE		(ACCUM. COST)	
				(GROSS	(GROSS		(**************************************	
				SALARI ES)	CHARGES)			
1.00	Administrative and General	1. 00 5, 125	2. 00 31, 583	4. 00 941, 300	5. 01 2, 534, 391	5A. 02	5. 02 384, 651	1. 00
2.00	Skilled Nursing Care	5, 125	31, 303	887, 296		_	1, 930, 297	
3.00	Physical Therapy	0	ő	384, 765		_	837, 050	
4.00	Occupational Therapy	0	0	158, 085	l .	0	343, 911	4. 00
5.00	Speech Pathology	0	0	52, 697	l .	1	114, 641	5. 00
6.00	Medical Social Services	0	0	98, 595		_	214, 492	
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	68, 608	0	-	149, 256 38, 169	7. 00 8. 00
9. 00	Drugs	0	0	0		1	0	9. 00
10.00	DME	0	0	0	C	0	o	10.00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13. 00 14. 00	, ,	0	0	0		0	0	13. 00 14. 00
15. 00		0	0	0			0	15. 00
16. 00	1	0	Ö	0	o c	Ö	Ö	16. 00
17. 00	9	0	0	0	C	0	0	17. 00
18. 00	1	0	0	0	C	0	0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	0	0	0		0	0	19. 00 19. 50
	Total (sum of lines 1-19)	5, 125	31, 583	2, 591, 346	2, 534, 391	0	4, 012, 467	
	Total cost to be allocated	10, 410		938, 161			477, 468	21. 00
22. 00		2. 031220		0. 362036			0. 118996	22. 00
	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE TEET)	(WEALS SERVED)	(MANTOONS)	
			· ·	LAUNDRY)				
1 00	Administrative and General	6.00	7. 00 5, 125	8. 00	9. 00 5, 125	10.00	11.00	1 00
1. 00 2. 00	Skilled Nursing Care	0	5, 125	0	· ·		34, 411 23, 211	1. 00 2. 00
3. 00	Physical Therapy	0	o	0	i c	Ö	7, 578	
4.00	Occupational Therapy	0	0	0	C	0	4, 611	4. 00
5.00	Speech Pathology	0	0	0	C	0	1, 092	5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	0		0	2, 633 3, 905	
8. 00	Supplies (see instructions)	0	0	0	1		3, 403	8. 00
9. 00	Drugs	0	0	0	o c	0	o	9. 00
10. 00	DME	0	0	0	C	0	0	10. 00
11.00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0	0	12. 00 13. 00
14. 00	, ,	0	0	0		0	0	14. 00
	Health Promotion Activities	0	o	Ō	d	Ö	Ö	
16. 00	Day Care Program	0	0	0	C	0	0	
17. 00		0	0	0		0	0	17. 00
18. 00 19. 00	1	0		0		0		18. 00 19. 00
19. 50	1 Others (specify)	1	ı	U	1	]	١	19. 50
	Tel emedi ci ne	0	Ol	0	) C	)  U	l OI	19.00
20. 00	Total (sum of lines 1-19)	0 0	0 5, 125	0	5, 125		77, 441	20. 00
20. 00 21. 00 22. 00	Total (sum of lines 1-19) Total cost to be allocated	0 0 0 0.000000	72, 479	0 0 0 0.000000	31, 521	0	37, 695	20. 00 21. 00

Heal th	Financial Systems		GOSHEN HOS	SDI TAI		In lie	u of Form CMS-2	2552_10
	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN			CN: 15-0026	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	15-7174	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/28/2019 7:0	pared:
						Home Health	PPS	<u>o p</u>
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	Agency I MEDICAL	SOCIAL SERVICE	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	(TIME ODENT)	
		(NUMBER HOUSED)	(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(TIME SPENT)	
			HRS)	REQUIS.)	45.00	CHARGES)	47.00	
1. 00	Administrative and General	12.00	13.00	14. 00 38, 300	15. 00	16. 00 0 2, 534, 391	17. 00 0	1.00
2.00	Skilled Nursing Care	0	o	0		0 0	0	•
3.00	Physical Therapy	0	0	0		0 0	0	•
4. 00 5. 00	Occupational Therapy Speech Pathology			0		0 0	0	4. 00 5. 00
6. 00	Medical Social Services		o	0		0 0	0	6. 00
7.00	Home Heal th Ai de	0	0	0		0 0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs			0		0 0	0	
10.00	DME		o	0		0 0	0	10. 00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing			0		0 0	0	12. 00 13. 00
14. 00	Clinic		o	0		0 0	0	14. 00
15. 00	Health Promotion Activities	0	0	0		0 0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program			0		0 0	0	16. 00 17. 00
18. 00	Homemaker Service		o	0		0 0	0	18. 00
19.00	All Others (specify)	0	0	0		0 0	0	
19. 50 20. 00	Telemedicine Total (sum of lines 1-19)			0 38, 300		0 0 2, 534, 391	0	19. 50 20. 00
21. 00	Total cost to be allocated	0	0	1, 430		0 17, 982	0	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 037337 I NTERNS &		0. 007095	0. 000000	22. 00
	Cost Center Description	NONPHYSICI AN ANESTHETI STS	NURSING SCHOOLS	ERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	ER PARAMED ED PRGM		
		(ASSI GNED	(ASSI GNED	APPRV	APPRV	(ASSI GNED		
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	TIME)		
		19. 00	20.00	TI ME) 21. 00	TI ME) 22. 00	23. 00		
1.00	Administrative and General	0	0	0		0 0		1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy			0		0 0		2. 00 3. 00
4. 00	Occupati onal Therapy		Ö	0		0 0		4. 00
5.00	Speech Pathology	0	0	0		0 0		5. 00
6. 00 7. 00	Medical Social Services Home Health Aide		0	0		0 0		6. 00 7. 00
8. 00	Supplies (see instructions)		1 1	0		0 0		8. 00
9.00	Drugs	0	- I	0		0 0		9.00
10. 00 11. 00	DME Home Dialysis Aide Services		0	0		0 0		10. 00 11. 00
12. 00	Respiratory Therapy		Ö	Ö		0 0		12. 00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14. 00 15. 00	Clinic Health Promotion Activities		0	0		0 0		14. 00 15. 00
16. 00	Day Care Program		o	0		0 0		16. 00
17. 00	Home Delivered Meals Program	0	0	0		0 0		17. 00
18. 00 19. 00	Homemaker Service All Others (specify)			0		0 0		18. 00 19. 00
	Tel emedi ci ne		o o	0		0 0		19. 50
20.00	Total (sum of lines 1-19)	0	0	0		0 0		20.00
21. 00 22. 00	Total cost to be allocated Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 00000	0 00 0.000000		21. 00 22. 00
			,				•	

	Financial Systems		GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	<u> 2552</u> -10
	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-0026	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2018 To 12/31/2018		
				Titl€	× XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
	•	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II)	2.00	4.00	4) 5. 00	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00	4.00		
	BENEFICIARY COST LIMITATION	OI AGGREGATE I	ROGRAW COST, A	OUNEONTE OF TE	IL TROOKAW ETW	TATION COST, OF	`	
	Cost Per Visit Computation	1			1			
1.00	Skilled Nursing Care	2. 00			2, 474, 91	·	312. 45	
2. 00	Physi cal Therapy	3. 00	1 ' ' 1	C	., ,		359. 56	
. 00	Occupational Therapy	4.00		C	1, 20		335. 26	
. 00	Speech Pathology Medical Social Services	5. 00 6. 00	1	C	146, 82		734. 14 552. 29	
. 00	Home Health Aide	7. 00	· · · · · · · · · · · · · · · · · · ·		275, 03 192, 53		105. 96	
. 00	Total (sum of lines 1-6)	7.00	4, 602, 359	C	i .		103. 70	7. 00
	110141 (94111 91 111199 1 9)		17 0027 007		Program Visit			71.00
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
					Deductibles 8	Deductibles		
		0	1.00	2. 00	Coi nsurance 3.00	4. 00	5. 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
3. 00	Skilled Nursing Care		21140	C	2, 88	0		8.00
3. 01	Skilled Nursing Care		23060	C	1	0		8. 01
. 02	Skilled Nursing Care		99915	C	84			8. 02
. 00	Physi cal Therapy		21140	C	1, 24			9.00
. 01	Physical Therapy		23060	C	1			9. 01
. 02	Physical Therapy		99915	C	27			9. 02
0. 00	Occupational Therapy Occupational Therapy		21140 23060		51	6		10. 00 10. 01
0. 01	Occupational Therapy		99915		14			10.01
1. 00	Speech Pathology		21140		7			11.00
1. 01	Speech Pathology		23060	C		6		11. 01
1. 02	Speech Pathology		99915	C		2		11. 02
2. 00	Medical Social Services		21140	C	16	2		12.00
2. 01	Medical Social Services		23060	C	)	2		12. 01
2. 02	Medical Social Services		99915	C	8			12. 02
3. 00	Home Heal th Ai de		21140	C	68			13.00
3. 01	Home Heal th Ai de		23060	C		0		13. 01
3. 02	Home Health Aide Total (sum of lines 8-13)	•	99915	C	23 7, 19			13. 02 14. 00
4.00	Cost Center Description	From Wkst H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col 3	14.00
	oost conten bescriptron	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	ŕ	
				Part II)				
	Constitution and Dr. Co. Co. Co.	0	1.00	2. 00	3. 00	4. 00	5. 00	
5. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	8. 00	48, 683	C	48, 68	3 0	0. 000000	15.00
6. 00		9. 00		C		0 0	0. 000000	
0. 00	10031 OF Drugs	7.00	Program Visits		Cost of	0	0. 000000	10.00
			g		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		4 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	0F AGGREGATE F	7.00 PROGRAM COST A	8.00 GGREGATE OF TH	9.00 F PROGRAM LIM	10.00	11. 00	
	BENEFICIARY COST LIMITATION	OI AGGREGATE I	ROOM COST, A	GGREGATE OF TI	IL TROOKAW LIW	TATION COST, OF	`	
	Cost Per Visit Computation							1
00	Skilled Nursing Care	0	-1			0 1, 166, 376		1.00
. 00	Physi cal Therapy	0	1, 534			0 551, 565		2.00
. 00	Occupational Therapy	1 0	669			0 224, 289		3.00
3. 00		•	1					
. 00	Speech Pathology	0	82			0 60, 199		
3. 00 4. 00 5. 00	Speech Pathology Medical Social Services	0	250			0 138, 073		5. 00
3.00 4.00 5.00 6.00	Speech Pathology	0 0 0	250 925					4. 00 5. 00 6. 00 7. 00

	Financial Systems TIONMENT OF PATIENT SERVICE COST	-S	GOSHEN H	OSPITAL Provider CO	CN: 15-0026	In Lie	u of Form CMS- Worksheet H-3	
				HHA CCN:	15-7174	From 01/01/2018 To 12/31/2018		epared:
				Title	: XVIII	Home Health	PPS	о рііі
	Cost Center Description					Agency I		
	·	6.00	7.00	8. 00	9. 00	10. 00	11. 00	
0.00	Limitation Cost Computation	I	I		ı			1 0 00
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care							8. 00 8. 01
8. 02	Skilled Nursing Care							8. 02
9.00	Physi cal Therapy							9.00
9. 01	Physi cal Therapy							9. 01
9. 02 10. 00	Physical Therapy Occupational Therapy							9. 02
10. 00	Occupational Therapy							10.00
10. 02	Occupational Therapy							10. 02
11. 00	Speech Pathology							11.00
11. 01	Speech Pathology							11. 01
11. 02 12. 00	Speech Pathology Medical Social Services							11. 02 12. 00
12. 01	Medical Social Services							12. 01
12. 02	Medical Social Services							12. 02
13.00	Home Health Aide							13.00
13. 01 13. 02	Home Health Aide Home Health Aide	•						13. 01 13. 02
	Total (sum of lines 8-13)							14. 00
		Prog	ram Covered Cha	arges	Cost of			
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
		6. 00	Coi nsurance 7.00	Coi nsurance 8.00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Comput		11.5					
15.00	Cost of Medical Supplies	0	,	ł		0 0	0	
16.00	Cost of Drugs Cost Center Description	Total Program	0	0		] 0	0	16. 00
	occi contor beser pri en	Cost (sum of						
		col s. 9-10)	-					-
	PART I - COMPUTATION OF LESSER	0F AGGREGATE F	PROGRAM COST A	GGREGATE OF TH	F PROGRAM II	MITATION COST OF	)	
	BENEFICIARY COST LIMITATION	OI AGGILLATE I	ROGIVANI COST, P	IOOKEONTE OF TH	L TROOKAW ET	WITTATTON COST, OF	•	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1, 166, 376						1.00
2.00	Physical Therapy Occupational Therapy	551, 565 224, 289						2. 00 3. 00
4. 00	Speech Pathology	60, 199						4.00
5.00	Medical Social Services	138, 073						5.00
6.00	Home Heal th Ai de	98, 013						6.00
7.00	Total (sum of lines 1-6)  Cost Center Description	2, 238, 515						7. 00
	oost conten bescriptron	12.00						1
	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	Physi cal Therapy							9. 01
9. 02	Physical Therapy							9. 02
10. 00 10. 01	Occupational Therapy Occupational Therapy							10. 00 10. 01
10. 01	Occupational Therapy							10. 01
11.00	Speech Pathology							11.00
	Speech Pathology							11. 01
11. 01	Speech Pathology							11. 02 12. 00
11. 01 11. 02	Modical Social Social Convices							12. 00
11. 01 11. 02 12. 00	Medical Social Services Medical Social Services							
11. 01 11. 02	Medical Social Services Medical Social Services Medical Social Services							12. 02
11. 01 11. 02 12. 00 12. 01 12. 02 13. 00	Medical Social Services Medical Social Services Home Health Aide							12. 02 13. 00
11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	Medical Social Services Medical Social Services Home Health Aide Home Health Aide							12. 02 13. 00 13. 01
11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Medical Social Services Medical Social Services Home Health Aide							12. 02 13. 00

Heal th Financ	Health Financial Systems GOS							In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT	T OF PATIENT SERVICE COST	rs .		Provi d	der CC		Peri od:	04 (0040	Worksheet H-3	
				нна сс	CN:	15-7174	From 01/ To 12/	31/2018	Part II Date/Time Prep 5/28/2019 7:03	
						XVIII	Home H	eal th	PPS	<u> Бііі</u>
							Ageno	cy I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total H	IHA	HHA Shared	Transt	fer to		
		Part I, col.	Ratio	Charge (1	from	Ancillary	Part	I as		
		9, line		provi de	er	Costs (col.	1 Indi	cated		
				records	s)	x col. 2)				
		0	1. 00	2. 00		3.00	4.	00		
PART I	I - APPORTIONMENT OF COS	T OF HHA SERVIO	ES FURNI SHED B	Y SHARED I	HOSPI	TAL DEPARTMEN	ITS			
1.00 Physic	cal Therapy	66. 00	0. 573148		0		0 col . 2,	line 2.	00	1.00
2. 00 Occupa	ational Therapy	67. 00	0. 444994		0		0 col . 2,	line 3.	00	2.00
3.00 Speech	n Pathol ogy	68. 00	0. 353181		0		0 col . 2,	line 4.	00	3. 00
4.00 Cost c	of Medical Supplies	71. 00	0. 381019		0		0 col . 2,	line 15	5. 00	4.00
5.00 Cost o	of Drugs	73. 00	0. 643220		0		0 col . 2,	line 16	5. 00	5. 00

	Financial Systems GOSHEN HOSP ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0026	Peri od:	u of Form CMS-2 Worksheet H-4	
LCOL	ATTON OF THE RETWINDORSEMENT SETTEEMENT	HHA CCN:	15-7174	From 01/01/2018 To 12/31/2018	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health Agency I	5/28/2019 7: 0 PPS	з рііі
				Par	t B	
			Part A	Not Subject to Deductibles &	Deductibles &	
			1.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	OMADY CHARGES	1.00	2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services	OWART CHARGES	,			1
	Reasonable cost of services (see instructions)			0 0	0	1.
	Total charges			0 0	0	2.
	Customary Charges  Amount actually collected from patients liable for payment fo	r corvi coc		0 0	0	3.
00	on a charge basis (from your records)	i services			U	3.
00	Amount that would have been realized from patients liable for	payment		0 0	0	4.
	for services on a charge basis had such payment been made in	accordance				
	with 42 CFR §413.13(b)		0.0000	0.00000	0.000000	_
	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000	0.000000	0. 000000 0	1
	Excess of total customary charges over total reasonable cost	(complete		o o	0	
	only if line 6 exceeds line 1)					
00	Excess of reasonable cost over customary charges (complete on	lyifline		0 0	0	8
00	1 exceeds line 6) Primary payer amounts	1		o	0	9
00 1	rilliary payer amounts			Part A	Part B	
				Servi ces	Servi ces	
	DADT 11 COMPUTATION OF THE PERMIT			1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10
	Total PPS Reimbursement - Full Episodes without Outliers			o	961, 039	
	Total PPS Reimbursement - Full Episodes with Outliers			0	120, 936	12
	Total PPS Reimbursement - LUPA Episodes			0	22, 927	
1. 00	Total PPS Reimbursement - PEP Episodes			0	7, 345	
1	Total PPS Outlier Reimbursement - Full Episodes with Outliers			U	25, 629 767	
. 00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			Ö	767 0	1
	DME Payments			ŏl	0	
1	Oxygen Payments			o	0	
. 00	Prosthetic and Orthotic Payments			0	0	20
	Part B deductibles billed to Medicare patients (exclude coins	urance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)			0	1, 138, 643	
1	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	1, 138, 643	23
	Coinsurance billed to program patients (from your records)			O O	1, 130, 043	1
	Net cost (line 24 minus line 25)			0	1, 138, 643	
	Reimbursable bad debts (from your records)				.,	27
3. 00	Reimbursable bad debts for dual eligible beneficiaries (see i					28
	Total costs - current cost reporting period (line 26 plus line	e 27)		0	1, 138, 643	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. = \		0	0	
1	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	S)		0	0	
1	Subtotal (see instructions)			0	1, 138, 643	
	Sequestration adjustment (see instructions)			o	22, 773	
	Demonstration payment adjustment amount after sequestration			0	0	1 .
	Interim payments (see instructions)			0	1, 115, 870	
	Tentative settlement (for contractor use only)			0	0	
	Balance due provider/program (line 31 minus lines 31.01, 32, Protested amounts (nonallowable cost report items) in accorda		Dub 1F 2	0	0	
5. 00						

GOSHEN HOSPI TAL

Health Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES In Lieu of Form CMS-2552-10
Worksheet H-5 Provider CCN: 15-0026 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm HHA CCN: 15-7174

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	1, 115, 870 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0 0	3. 03
3. 04 3. 05				0		3. 04 3. 05
3.03	Provider to Program			υ <sub> </sub>	0	3. 03
3. 50	Trovider to rrogidin			0	0	3. 50
3.51				o	0	3. 51
3.52				o	0	3. 52
3.53				0	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	1, 115, 870	4. 00
	line 32)					
5. 00	TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.03	Provider to Program			U <u> </u>	U	3. 03
5. 50	Trovider to Trogram			ol	0	5. 50
5. 51				O	0	5. 51
5.52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	1 115 970	6. 02 7. 00
7. 00	Total Medicare program liability (see instructions)			Contractor Number	1,115,870 NPR Date (Mo/Day/Yr)	7.00
		(	)	1. 00	2. 00	
8. 00	Name of Contractor				2.00	8. 00
	,			•	. '	

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Hospi ce CCN: 15-1527

						3/20/2019 7.0	o piii
				1	Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FLXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		591	591	0	591	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	293, 823	0	293, 823	o	293, 823	3.00
4.00	ADMINISTRATIVE & GENERAL*	o	90, 044	90, 044	o	90, 044	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	o	0	5. 00
6. 00	LAUNDRY & LINEN SERVICE*	أم	0	أ	ol	0	6.00
7. 00	HOUSEKEEPI NG*		0		٥	0	7. 00
8. 00	DI ETARY*		640	640	0	640	8.00
9. 00	NURSING ADMINISTRATION*		040	040	0	040	9. 00
			001 510	221 512	01 404		ł
10.00	ROUTINE MEDICAL SUPPLIES*	0	221, 512	221, 512	-81, 406	140, 106	10.00
11. 00	MEDI CAL RECORDS*	0	0	0	O	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	16, 861	16, 861	0	16, 861	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13. 00
14.00	PHARMACY*	0	247, 756	247, 756	-247, 756	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	0	226, 315	226, 315	0	226, 315	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**		0		ol	0	26. 00
27. 00	NURSE PRACTITIONER**		0		0	0	27.00
28. 00	REGI STERED NURSE**	418, 895	/16 O11	835, 806	ol Ol	835, 806	28.00
29. 00	LPN/LVN**	410, 073	416, 911	033, 000	ol ol		
	1	0	0		U o	0	29. 00
30.00	PHYSI CAL THERAPY**	0	0	0	U	0	30.00
31. 00	OCCUPATI ONAL THERAPY**	0	0	9	0	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	l o	O	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0	0	0	O	0	33. 00
34. 00	SPIRITUAL COUNSELING**	0	0	이	이	0	34. 00
35. 00	DI ETARY COUNSELI NG**	0	0	0	0	0	35. 00
36. 00	COUNSELING - OTHER**	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	257, 063	0	257, 063	0	257, 063	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	562	562	o	562	38. 00
39.00	PATI ENT TRANSPORTATION**	o	0	o	o	0	39. 00
40.00	I MAGI NG SERVI CES**	o	0	o	o	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	ol ol	ol	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**		0		٥	0	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**		0		0	0	42. 50
43. 00	OUTPATIENT SERVICES**		0		0	0	43.00
	1	0	0		o o		•
44. 00	PALLIATIVE RADIATION THERAPY**	0	0		U	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	0	O	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS	1		1			
60. 00	BEREAVEMENT PROGRAM *	0	0	0	이	0	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*	ol	0	o	o	0	65.00
66. 00	RESI DENTI AL CARE*	l	0	o	ol	0	66.00
67. 00	ADVERTI SI NG*	0	0	o	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	ا	n	l o	n n	0	68. 00
69. 00	THRIFT STORE*		0	١	δ	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD*		0		٥	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*		0		S S	0	71.00
	` ′	969, 781	1 221 122	2 100 073	220 1/2		
100.00	TOTAL	909, 781	1, 221, 192	2, 190, 973	-329, 162	1, 861, 811	100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

					Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5			
		4.00	± col. 6)	-		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1.00	CAP REL COSTS-BLDG & FLXT*	ol	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	ا	591	1		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	l o	293, 823			3. 00
4. 00	ADMINISTRATIVE & GENERAL*		90, 044	•		4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	l o	70, 011	1		5. 00
6. 00	LAUNDRY & LINEN SERVICE*	o	0			6. 00
7. 00	HOUSEKEEPI NG*	ol	0			7. 00
8.00	DI ETARY*	ol	640			8.00
9. 00	NURSING ADMINISTRATION*	o	0			9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	o	140, 106			10.00
11. 00	MEDICAL RECORDS*	o	0			11. 00
12. 00	STAFF TRANSPORTATION*	o	16, 861			12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	o	0			13. 00
14.00	PHARMACY*	О	0			14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	o	O			15. 00
16.00	OTHER GENERAL SERVICE*	o	226, 315	;		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	0	0			25. 00
26.00	PHYSI CI AN SERVI CES**	0	0			26. 00
27.00	NURSE PRACTITIONER**	0	0			27. 00
28.00	REGI STERED NURSE**	0	835, 806	<b>,</b>		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	1		33. 00
34. 00	SPIRITUAL COUNSELING**	0	0	•		34. 00
35. 00	DI ETARY COUNSELI NG**	0	0	1		35. 00
36. 00	COUNSELING - OTHER**	0	0			36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	257, 063	1		37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	562	1		38. 00
39. 00	PATIENT TRANSPORTATION**	0	0			39. 00
40.00	I MAGI NG SERVI CES**	0	0	1		40.00
41.00	LABS & DI AGNOSTI CS**	0	0	1		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	1		42.00
42. 50	DRUGS CHARGED TO PATIENTS** OUTPATIENT SERVICES**	0	0	1		42. 50
43. 00 44. 00	PALLIATIVE RADIATION THERAPY**		0	1		43. 00 44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**		0	1		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**		0	•		46. 00
40.00	NONREI MBURSABLE COST CENTERS	l d		′		46.00
60. 00	BEREAVEMENT PROGRAM *	ol	0			60.00
61.00	VOLUNTEER PROGRAM *		0	1		61.00
62. 00	FUNDRAI SI NG*		0	1		62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	ا	0	1		63.00
64. 00	PALLIATIVE CARE PROGRAM*	l ol	0	1		64. 00
65. 00	OTHER PHYSICIAN SERVICES*	l ol	0	1		65. 00
66. 00	RESIDENTI AL CARE*	o	Ö	•		66. 00
67. 00	ADVERTI SI NG*	o	0	•		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	o	0	o		68. 00
69. 00	THRIFT STORE*	Ö	0			69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	Ö	0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	O	O			71.00
100.00		o	1, 861, 811			100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

CARE

Peri od: Worksheet 0-2

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Hospi ce CCN: 15-1527

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED						25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	414, 139	412, 178	826, 317	0	826, 317	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	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	o	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	o	0	34.00
35.00	DI ETARY COUNSELI NG	O	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	O	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	254, 144	0	254, 144	o	254, 144	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	O	562	562	o	562	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42. 00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	o	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	0	ol	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	ol	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	ol	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)		0	0	o	0	46. 00
	TOTAL *	668, 283	412, 740	1, 081, 023	o	1, 081, 023	100.00
	ofor the amount in column 7 to Wkst O.E. colu	-			-		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Transfer the amount fir corumn 7 to wast. 0-5, co			
	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
	6. 00	7. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00   I NPATI ENT CARE-CONTRACTED			25. 00
26. 00 PHYSI CI AN SERVI CES	C	0	26. 00
27. 00 NURSE PRACTITIONER		0	27. 00
28. 00 REGI STERED NURSE	C	826, 317	28.00
29. 00   LPN/LVN	C	0	29. 00
30. 00 PHYSI CAL THERAPY		0	30.00
31. 00 OCCUPATI ONAL THERAPY	C	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32.00
33.00 MEDICAL SOCIAL SERVICES	C	0	33.00
34. 00   SPIRITUAL COUNSELING	C	0	34.00
35. 00 DI ETARY COUNSELING	C	0	35. 00
36. 00 COUNSELING - OTHER	C	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	254, 144	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	562	38.00
39. 00 PATI ENT TRANSPORTATI ON	C	0	39.00
40.00 I MAGI NG SERVI CES	C	0	40.00
41.00 LABS & DIAGNOSTICS	C	0	41.00
42. 00   MEDI CAL SUPPLI ES-NON-ROUTI NE	C	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	C	0	42. 50
43.00 OUTPATIENT SERVICES	C	0	43.00
44.00 PALLIATIVE RADIATION THERAPY		o	44.00
45.00 PALLIATIVE CHEMOTHERAPY		o	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		o	46.00
100.00 TOTAL *	c	1, 081, 023	100.00
* Transfer the amount in column 7 to Wket O.E. o.	-l 1		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

RESPITE CARE

Hospi ce CCN: 15-1527

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm

						3/20/2017 7.0	J PIII
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATIENT CARE-CONTRACTED		0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	1, 028	1, 023	2, 051	0	2, 051	28. 00
29. 00		0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34. 00
35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	631	0	631	0	631	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	1, 659	1, 023	2, 682	0	2, 682	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 52.					

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	2, 051	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	631	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	l ol	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	l ol	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	l ol	42. 50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	l o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	l o	46.00
100.00	TOTAL *	0	2, 682	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

INPATIENT CARE

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 7:03 pm Hospi ce CCN: 15-1527

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	3, 728	3, 710	7, 438	0	7, 438	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	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2, 288	0	2, 288	0	2, 288	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	O	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	O	0	0	0	0	39. 00
40.00	I MAGING SERVICES	o	0	0	O	0	40.00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	o	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	0	o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	o	0	46. 00
100.00	TOTAL *	6, 016	3, 710	9, 726	o	<u>9,</u> 726	100. 00
* T		1 1: 52					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		ADSOSTMENTS	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	7, 438	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	o	34.00
35.00	DI ETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 288	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	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	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	O	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	O	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	9, 726	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Hool th	Financial Systems	GOSHEN HOSPITAL		In Lie	u of Form CMS	2552 10
	Financial Systems LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPIC		CN: 15-0026 F	Period:	u of Form CMS-2 Worksheet 0-5	
	ES FOR ALLOCATION	Hospi ce CC	F	From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
				Hospi ce I	5/28/2019 7:0	3 pm
	Descriptions		HOSPICE DIRECT		TOTAL EXPENSES	
	beset i per ons		EXPENSES (see		(sum of cols.	
			instructions)		1 + 2)	
				WKST B PART I	/	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT		(	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		591	1 0	591	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT		293, 823	351, 194	645, 017	3. 00
4.00	ADMINISTRATIVE & GENERAL		90, 044	303, 981	394, 025	4. 00
5.00	PLANT OPERATION & MAINTENANCE			0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE		(	0	0	6. 00
7.00	HOUSEKEEPING			0	0	7. 00
8.00	DI ETARY		640	0	640	8. 00
9.00	NURSI NG ADMI NI STRATI ON			0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		140, 106	21, 420		
11. 00	MEDI CAL RECORDS			36, 480		
12.00	STAFF TRANSPORTATION		16, 86	1	16, 861	12. 00
13.00	VOLUNTEER SERVICE COORDINATION				0	13. 00
	PHARMACY			0	0	14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES				0	15. 00
16. 00	OTHER GENERAL SERVICE		226, 315	5 0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE			T		
50. 00	HOSPI CE CONTI NUOUS HOME CARE		(	1	0	50.00
51. 00	HOSPI CE ROUTI NE HOME CARE		1, 081, 023		1, 081, 023	
	HOSPICE INPATIENT RESPITE CARE		2, 682		2, 682	1
53. 00	HOSPICE GENERAL INPATIENT CARE		9, 726		9, 726	53. 00
(0.00	NONREI MBURSABLE COST CENTERS			\[ \]	_	(0.00
60.00	BEREAVEMENT PROGRAM		1		0	60.00
61. 00	VOLUNTEER PROGRAM		,		0	61.00
62.00	FUNDRALSING			ור	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	63.00

713, 075

1, 861, 811

64.00

65.00

0 66.00

69. 00 70. 00

0 71.00

99. 00

0 67.00

0 68.00

0

2, 574, 886 100. 00

64. 00 PALLIATIVE CARE PROGRAM

65. 00 OTHER PHYSICIAN SERVICES

68. 00 | TELEHEALTH/TELEMONI TORI NG

99.00 NEGATIVE COST CENTER

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

66. 00 RESIDENTIAL CARE

67. 00 ADVERTISING

100. 00 TOTAL

Heal th FinancialSystemsGOSHENCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS 

			nospi ce coi	1. 10 1027	12/01/2010	5/28/2019 7: 0	3 pm
					Hospi ce I		
	Descriptions	TOTAL EXPENSES CA	P REL BLDG &	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
	·		FLX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	591		591			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	645, 017	0	0	645, 017		3. 00
4.00	ADMINISTRATIVE & GENERAL	394, 025	0	591	645, 017	1, 039, 633	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	o	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	o	0	6. 00
7.00	HOUSEKEEPI NG	0	0	0	o	0	7. 00
8.00	DI ETARY	640	0	0	o	640	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	o	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	161, 526	0	l o	o	161, 526	10.00
11. 00	MEDI CAL RECORDS	36, 480	0	l o	o	36, 480	11. 00
12. 00	STAFF TRANSPORTATION	16, 861	0	0	o	16, 861	
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	o	0	13. 00
14. 00	PHARMACY	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	226, 315	0	0	0	226, 315	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	٦	0	17. 00
	LEVEL OF CARE	1	-	-1	·	-	
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	1, 081, 023			o	1, 081, 023	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	2, 682	0	o	o	2, 682	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	9, 726	0	0	o	9, 726	
	NONREI MBURSABLE COST CENTERS	, ,	-		-,	,	
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	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 PHYSI CI AN SERVI CES	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	_	_	٦	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0	n	o	0	71.00
99. 00	NEGATIVE COST CENTER		0	ا	ol		99. 00
	TOTAL	2, 574, 886	0	591	645, 017	2, 574, 886	
			٥	,	2 . 2 , 9 . 7	_, _, ., 000	, , , , , ,

Heal th FinancialSystemsGOSHENCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Peri od: Worksheet 0-6
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 7:03 pm Provider CCN: 15-0026 Hospi ce CCN: 15-1527

						5/28/2019 /: 0	3 PIII
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL	1, 039, 633					4.00
5. 00	PLANT OPERATION & MAINTENANCE	0	0				5. 00
6. 00	LAUNDRY & LINEN SERVICE		0				6. 00
7. 00	HOUSEKEEPI NG		0	`	ا ا		7. 00
8.00	DI ETARY	433	0		0	1, 073	8.00
9. 00	NURSING ADMINISTRATION	433	0		0	1,073	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	109, 381	0		0		10.00
			0		0		11.00
11. 00	MEDICAL RECORDS	24, 703	U		0		
12.00	STAFF TRANSPORTATION	11, 418	Ü		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	Ü		0		13.00
14. 00	PHARMACY	0	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00	OTHER GENERAL SERVI CE	153, 255	0		0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0					50. 00
51. 00	HOSPICE ROUTINE HOME CARE	732, 041					51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 816	0			220	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	6, 586	0	(	0	853	53. 00
	NONREI MBURSABLE COST CENTERS	,			,		
60.00	BEREAVEMENT PROGRAM	0	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 PHYSICIAN SERVICES	o	0		0		65. 00
66.00	RESI DENTI AL CARE	o	0	(	ol ol	0	66. 00
67.00	ADVERTI SI NG	o	0		0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	0		o		68. 00
69. 00	THRI FT STORE	l	0		o		69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		ol ol	0	
	NEGATIVE COST CENTER		n			0	1
	TOTAL	1, 039, 633	Ö			_	100.00
	1 -	., ., , ,	· ·	1	٦	., 0, 0	

Hear th	Financiai Systems	GUSHEN HUS	PLIAL		in Lie	U OT FORM CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der Co	CN: 15-0026	Peri od:	Worksheet 0-6	
			Heeni ee CCI	N. 1E 1E07	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	narad.
			Hospi ce CCI	N: 15-1527	To 12/31/2018	5/28/2019 7:0	
					Hospi ce I	072072017 7.0	o piii
	Descriptions Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	·	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						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	0					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	270, 907				10. 00
11.00	MEDI CAL RECORDS	0		61, 18	33		11.00
12.00	STAFF TRANSPORTATION	0			28, 279		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			o	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			o	0	15. 00
16.00	OTHER GENERAL SERVICE	0			o	0	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	0	266, 703	60, 2	34 28, 279	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	864	19	95 0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	3, 340	7!	54 0	0	53. 00
	NONREI MBURSABLE COST CENTERS	•	•	,			
60.00	BEREAVEMENT PROGRAM	0			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				o	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66, 00	RESI DENTI AL CARE	0			0	0	66.00
67. 00	ADVERTI SI NG				0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE				0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			[		Ü	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			[	n	0	•
99. 00	NEGATIVE COST CENTER		Ω	,	o o	0	99. 00
	TOTAL		270. 907	61, 18	28, 279		100.00
	1	١	2.3,707	1 51,11		Ü	1.30.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0026 Peri od: Worksheet 0-6 From 01/01/2018 Part I Hospi ce CCN: 15-1527 12/31/2018 Date/Time Prepared: To 5/28/2019 7:03 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 379, 570 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 0 HOSPICE ROUTINE HOME CARE 51.00 2, 168, 280 51.00 C 0 HOSPICE INPATIENT RESPITE CARE 385, 347 52.00 C 379, 570 0 52.00 0 53.00 HOSPICE GENERAL INPATIENT CARE 21, 259 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n 60.00 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0 61.00 0 61.00 0 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 0 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 68.00

0 0

0

0

0

0

379, 570

0

0

0 70.00

Ω

0 99.00

2, 574, 886 100. 00

69.00

71.00

69.00

70.00

71 00

100.00 TOTAL

THRIFT STORE

99.00 NEGATIVE COST CENTER

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

Health Financial Systems	GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS Provider CCN: 1 Hospi ce CCN:	From 01/01/2018 Part II

			Hospi ce cci	1: 15-1527   1	0 12/31/2018	5/28/2019 7:0	
					Hospi ce I	0, 20, 201, 110	<u> </u>
	Cost Center Descriptions	CAP REL BLDG & C	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	<b>'</b>	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (I	DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
		1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		2, 044				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	_,	544, 975			3. 00
4. 00	ADMINISTRATIVE & GENERAL	0	2, 044	544, 975		1, 535, 253	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		2,011	011, 770	1, 007, 000	0	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0	Č	0	0	6. 00
7. 00	HOUSEKEEPI NG		0	0	0	0	7. 00
8. 00	DI ETARY		0	0	0	640	8. 00
9. 00	NURSING ADMINISTRATION		0		0	040	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		0	0	0	161, 526	10.00
11. 00			0		0	36, 480	11. 00
			0	0	0		
12.00		0	0	0	0	16, 861	12.00
13.00			0	U	U	0	13.00
14.00		0	0	Ü	0	0	14.00
15. 00		0	0	Ü	0	0	15. 00
16. 00		0	0	C	0	226, 315	16. 00
17. 00		0	0		0	0	17. 00
	LEVEL OF CARE					_	
50.00				C	0	0	50.00
51. 00	l .			C	0	1, 081, 023	51. 00
52.00		0	0	C	0	2, 682	52. 00
53. 00		0	0	C	0	9, 726	53. 00
	NONREI MBURSABLE COST CENTERS	T			1		
60. 00		0	0	C	-	0	60.00
61. 00		0	0	C	0	0	61. 00
62. 00		0	0	C	0	0	62. 00
63. 00		0	0	C	0	0	63. 00
64. 00		0	0	C	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0	C	0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0	C	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	C	0	0	68. 00
69.00	THRIFT STORE	0	0	C	0	0	69. 00
70.00					0		70. 00
71.00		0	o	C	0	0	71. 00
99. 00							99. 00
100.00	O COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	591	645, 017		1, 039, 633	100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 289139	1. 183572		0. 677174	101. 00

Health Financial Systems	GOSHEN H	OSPI TAL			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi d	er CC	N: 15-0026	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S					From 01/01/2018		
		Hospi d	e CCN	: 15-1527	To 12/31/2018	Date/Time Pre	
						5/28/2019 7:0	3 pm
					Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY	&	HOUSEKEEPI NO	DI ETARY	NURSI NG	
	OPERATION &	LINEN SER	VICE	(SQUARE FEET)	) (IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACII	_I TY		DAYS)		
	(SQUARE FEET)	DAYS)				(DIRECT NURS.	
						HRS. )	
	E 00	4 00		7 00	9 00	0.00	

	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	•	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DIRECT NURS.	
						HRS. )	
	I	5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	T	Г	T			
1. 00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPI NG	0		0			7.00
8.00	DI ETARY	0		0	292		8.00
9.00	NURSING ADMINISTRATION	0		0		198, 103	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14. 00	PHARMACY	0		1 0		ol	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16. 00	OTHER GENERAL SERVICE	0		0		o o	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	l	0		_	17. 00
	LEVEL OF CARE	_		_			
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	0	60	· ·	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0					53. 00
00.00	NONREI MBURSABLE COST CENTERS			<u> </u>	202	, and the second	00.00
60. 00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		l ő		l ol	61. 00
62. 00	FUNDRAI SI NG	0		l ő		0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		١		l ol	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0				l ö	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES	0				l ől	65. 00
66. 00	RESI DENTI AL CARE	0	0	١	0	0	66. 00
67. 00	ADVERTI SI NG	0	٥	1	O	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG						68. 00
69. 00	THRIFT STORE						69. 00
70.00	NURSING FACILITY ROOM & BOARD					ا	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	_	_		^	0	70.00
99.00	NEGATIVE COST CENTER		١	1	U	ا	99.00
					1 070		
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0 000000	0 000000	0 000000	1, 073		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.000000	3. 674658	0. 000000	101.00

Health Financial Systems	GOSHEN HOSP	I TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI	CE GENERAL SERVICE COSTS	Provider CCN: 1			Worksheet 0-6
STATISTICAL BASIS				From 01/01/2018	
		Hospica CCN.	15_1527	To 12/21/2019	Data/Tima Dranarad

STATISTICAL BASIS			Hospi ce CCI		rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/28/2019 7:0	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS	_					
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	18, 818					10. 00
11. 00	MEDI CAL RECORDS		18, 818	3			11. 00
12.00	STAFF TRANSPORTATION			20, 883	3		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			( C	0		13. 00
14.00	PHARMACY			( C	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			C	0	0	15. 00
16. 00	OTHER GENERAL SERVICE			( C	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						4
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	) C	-	0	
51. 00	HOSPICE ROUTINE HOME CARE	18, 526	18, 526			0	
52.00	HOSPICE INPATIENT RESPITE CARE	60			,	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	232	232	2  C	0	0	53. 00
	NONREI MBURSABLE COST CENTERS	1	1	_		_	4
60. 00	BEREAVEMENT PROGRAM			C	-		
61. 00	VOLUNTEER PROGRAM			C			
62. 00	FUNDRAI SI NG			C	_	1	1
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			C	_	· ·	
64. 00	PALLIATIVE CARE PROGRAM			C	-	1	1
65. 00	OTHER PHYSI CI AN SERVI CES			C	0	1	
66. 00	RESI DENTI AL CARE				0	0	
67. 00	ADVERTI SI NG			C	0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	1
69. 00	THRI FT STORE			C	0	0	
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			C	0	0	1
99. 00							99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	· ·					100.00
101.00	UNIT COST MULTIPLIER	14. 396163	3. 251302	1. 354164	0.000000	0.000000	1101.00

Health Financial Systems	GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENE STATISTICAL BASIS		CN: 15-0026

						5/28/2019 7:03	3 pm
,					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 SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
			ŕ	DAYS)			
		15. 00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS	·		•	*		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE	•					5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDICAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION					ŀ	13. 00
14.00	PHARMACY						14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	405 505				15. 00
16.00	OTHER GENERAL SERVICE		405, 595				16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			C	)		17. 00
F0 00	LEVEL OF CARE						F0 00
	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
	HOSPICE ROUTINE HOME CARE	0	0	1			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	405, 595				52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	<u> </u> C	)		53. 00
	NONREI MBURSABLE COST CENTERS		_	1			
60.00	BEREAVEMENT PROGRAM		0	1			60.00
61. 00	VOLUNTEER PROGRAM		0	1			61. 00
62. 00	FUNDRAI SI NG		0	1			62. 00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63. 00
64. 00	PALLIATIVE CARE PROGRAM		0				64. 00
	OTHER PHYSICIAN SERVICES		0	)			65. 00
66. 00	RESI DENTI AL CARE	0	0	C			66. 00
67. 00	ADVERTI SI NG		0	1			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	)			68. 00
69.00	THRI FT STORE		0				69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	C			71. 00
99.00	NEGATIVE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part	1)	379, 570	) c			100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 935835	0.000000	)		101. 00
		•	•	•			•

Heal th	Financial Systems	GOSHEN HOS	PI TAL		In Lie	u of Form CMS-:	2552-10
APPORT	TONMENT OF HOSPITAL-BASED HOSPICE SHARED SEI		Provi der CC	CN: 15-0026	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	N: 15-1527	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 7:0	pared: 3 pm
					Hospi ce I		
				Charges by	/LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co Part I, Col. 9 Iine	Ratio	НСНС	HRHC	HI RC	
		0	1.00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						1
1. 00 2. 00 3. 00	PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 573148 0. 444994 0. 353181		0 0 0 0 0 0	0 0 0	2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	73. 00 96. 00 60. 00	0. 643220 0. 192781		0 0	0	5. 00
6. 01 7. 00 8. 00	BLOOD LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER	60. 01 71. 00 93. 00	0. 000000 0. 381019		0 0	0	
9. 00 10. 00 11. 00	RADIOLOGY-THERAPEUTIC NUTRITION THERAPY Totals (sum of lines 1-11)	55. 00 76. 00	0. 169330 2. 607983		0 0	0	
		Charges by LOC (from Provider Records)			ce Costs by LOC		
	Cost Center Descriptions	HGI P HG	CHC (col. 1 x col. 2) 6.00	HRHC (col. 1 col. 3) 7.00	xHIRC (col. 1 x col. 4) 8.00	HGIP (col. 1 x <u>col. 5)</u> 9.00	
	ANCILLARY SERVICE COST CENTERS	0.00	0.00	7.00	0.00	71.00	
1. 00 2. 00 3. 00 4. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY DRUGS CHARGED TO PATI ENTS	0 0 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 6. 01 7. 00	DURABLE MEDICAL EQUIP-RENTED LABORATORY BLOOD LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENT	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	6. 01 7. 00
8. 00 9. 00 10. 00 11. 00	OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC NUTRITION THERAPY Totals (sum of lines 1-11)	0	0 0 0		0 0 0 0 0 0	0 0 0	10.00

Health Financial Systems	GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Peri od: Worksheet 0-8 From 01/01/2018
		To 12/31/2018 Date/Time Prepared:

5/28/2019 7:03 pm Hospi ce I TITLE XVIII TITLE XIX TOTAL MEDI CARE MEDI CAI D 3. 00 1 00 2 00 HOSPICE CONTINUOUS HOME CARE 1.00 Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, 0 1.00 line 11) Total unduplicated days (Wkst. S-9, col. 4, line 10)
Total average cost per diem (line 1 divided by line 2) 2.00 2.00 0 0.00 3.00 3.00 4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 4.00 Program cost (line 3 times line 4) 5.00 0 5.00 HOSPICE ROUTINE HOME CARE 6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, 2, 168, 280 6.00 line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 18, 526 7.00 8.00 Total average cost per diem (line 6 divided by line 7) 117.04 8.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9.00 16, 414 0 9.00 10.00 Program cost (line 8 times line 9) 1, 921, 095 10.00 HOSPICE INPATIENT RESPITE CARE Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, 385, 347 11 00 11 00 line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 60 12.00 13.00 Total average cost per diem (line 11 divided by line 12) 6, 422. 45 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 14.00 55 0 14.00 Program cost (line 13 times line 14) 353, 235 15.00 0 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, 21, 259 16.00 line 11) 17 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 232 17 00 Total average cost per diem (line 16 divided by line 17) 18.00 91.63 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 158 19.00 Program cost (line 18 times line 19)
TOTAL HOSPICE CARE 20.00 14, 478 0 20.00 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 2, 574, 886 21.00

18, 818

136. 83 23. 00

22.00

Total unduplicated days (Wkst. S-9, col. 4, line 14)

23.00 Average cost per diem (line 21 divided by line 22)

22.00

Heal th	Financial Systems G	OSHEN HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0026	Peri od: From 01/01/2018 To 12/31/2018		
	. <u> </u>	Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			1 272 0/2	1.00
1.00	Model 4 BPCI Capital DRG other than outlier			1, 272, 862 0	1.00
2.00	Capital DRG outlier payments			25, 603	
2. 01	Model 4 BPCI Capital DRG outlier payments			20,000	
3.00	Total inpatient days divided by number of days in the	ne cost reporting period (see ins	tructions)	59. 29	
4.00	Number of interns & residents (see instructions)	3 1 1 (11	,	0.00	4. 00
5.00	Indirect medical education percentage (see instructi	ons)		0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 1.01) (see instructions)	e 5 by the sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare 30) (see instructions)	,	E, part A line	2. 86	
8.00	Percentage of Medicaid patient days to total days (s	see instructions)		18. 98	
9.00	Sum of lines 7 and 8			21. 84	
10.00	Allowable disproportionate share percentage (see ins				10.00
11. 00 12. 00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions			57, 533 1, 355, 998	
12.00	Total prospective capital payments (see mistructions	<u> </u>		1, 333, 440	12.00
				1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST				4 00
1. 00 2. 00	Program inpatient routine capital cost (see instruc-			0	
3.00	Program inpatient ancillary capital cost (see instru Total inpatient program capital cost (line 1 plus li	,		0	
4. 00	Capital cost payment factor (see instructions)	THE 2)		0	
5.00	Total inpatient program capital cost (line 3 x line	4)		0	
0.00	Trocal Impactions program capital cook (Impactor)			Ţ.	0.00
	DADT III COMPUTATION OF EVERDTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary ci	rcumstances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus li			0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x li	ne 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstance	es (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extr	raordinary circumstances (line 2	x line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)	,	•	0	8. 00
9.00	Current year capital payments (from Part I, line 12,	as applicable)		0	9. 00
10.00	Current year comparison of capital minimum payment I	1 1 3 1	,	0	
11. 00	Carryover of accumulated capital minimum payment lev Worksheet L, Part III, line 14)	vel over capital payment (from pr	ior year	0	11. 00
12.00	Net comparison of capital minimum payment level to o			0	
13.00	Current year exception payment (if line 12 is positi			0	
14. 00	Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this li	ne)	following period	0	
	Current year allowable energing and conital neumoni	t (coo instructions)		0	15. 00
15. 00	Current year allowable operating and capital payment				
16. 00		uctions)		0	16. 00