Heal th Financia	al Systems	SCHNECK MEDI CAL	CENTER	In Lie	u of Form CMS-2552-
payments made	required by law (42 USC 1395g; since the beginning of the cost	t reporting period being	deemed overpaymen	ts (42 USC 1395g).	n FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPI TAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-0	065 Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared 5/23/2022 3:05 pm
PART I - COST	REPORT STATUS				
Provi der use only	 [X] Electronically prepared [Manually prepared cost [0] If this is an amended [F] Medicare Utilization. 	report	of times the provi " for low.	Date: 5/23/20 der resubmitted this o	
Contractor use only	5. [1]Cost Report Status 6 (1) As Submitted 7 (2) Settled without Audit 8	. Date Received: Contractor No	r this Provider CC	10.NPR Date: 11.Contractor's Vendo N12.[0]If line 5, co	or Code: 4
PART LL - CERT	IFICATION BY A CHIEF FINANCIAL	OFFLCER OR ADMINISTRATO	R OR PROVIDER(S)		
MI SREPRESENTAT ADMI NI STRATI VE PROVI DED OR PR	ION OR FALSIFICATION OF ANY INF ACTION, FINE AND/OR IMPRISONME OCURED THROUGH THE PAYMENT DIRE ACTION, FINES AND/OR IMPRISON	FORMATION CONTAINED IN T ENT UNDER FEDERAL LAW. ECTLY OR INDIRECTLY OF A	HIS COST REPORT MA FURTHERMORE, IF SE	RVICES IDENTIFIED IN 1	THIS REPORT WERE
CERTI F	ICATION BY CHIEF FINANCIAL OFF	ICER OR ADMINISTRATOR OF	PROVI DER(S)		
electr Staten beginr are tr applic regarc	BY CERTIFY that I have read the conically filed or manually sub- ment of Revenue and Expenses pro- ing 01/01/2021 and ending 12/3 rue, correct, complete and prepa- able instructions, except as no ling the provision of health cau- led in compliance with such laws	mitted cost report and separed by SCHNECK MEDICA 1/2021 and to the best of ared from the books and oted. I further certify re services, and that th	ubmitted cost repo L CENTER (15-0065 f my knowledge and records of the pro that I am familiar	ort and the Balance Sho) for the cost repor- l belief, this report a vider in accordance wi with the laws and reg	eet and ting period and statement th gulations
SI GNATUR	E OF CHIEF FINANCIAL OFFICER OR	ADMI NI STRATOR CHECKI	BOX	ELECTRONI C	
	1	2		SIGNATURE STATEMENT	
1			I have read and	d agree with the above	certi fi cati on

			-		
1	Deb	bie Mann	ř	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Debbi e Mann			2
3	Signatory Title	VICE PRESIDENT OF FINANCE			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 016, 125	181, 828	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-1	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	1, 016, 124	181, 827	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	er CCN:		Period: From 01/01/		Workshe Part I	et S-2	2
						To 12/31/	2021	Date/Ti 5/23/20	me Pre	epared
	1.00	2.00		3.00		2	1.00	0/20/20		
. 00	Hospital and Hospital Health Care Co Street: 411 WEST TIPTON STREET	PO Box:								1.0
. 00	City: SEYMOUR	State: IN	Zip Cod	e: 47274	- Count	y: JACKSON				2.0
		Component Name	CCN	CBSA	Provi der	Date		nt Syst		
			Number	Number	Туре	Certified	1, V	0, or XVIII		-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00		
00	Hospital and Hospital-Based Componer		1500/5	00015	1	07/1//10//	NI	P		
00 00	Hospi tal Subprovi der – IPF	SCHNECK MEDICAL CENTER	150065	99915	1	07/16/1966	N	P	0	3.0
00	Subprovider - IRF									5.0
00	Subprovider - (Other)		1510/5	00015		02/04/1000	NI	P		6.0
00 00	Swing Beds - SNF Swing Beds - NF	SCHNECK MEDICAL CENTER SCHNECK MEDICAL CENTER	15U065 15U065	99915 99915		03/04/1999		P	N O	8.0
00	Hospital -Based SNF			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						9.0
0. 00	Hospital-Based NF									10.0
. 00	Hospital-Based OLTC Hospital-Based HHA	JACKSON COUNTY HOME	157155	99915		07/01/1985	N	Р	0	11. (
. 00		HEALTH	107100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				'		12.0
3.00	Separately Certified ASC		151500	00015		10/00/1004				13.0
. 00	Hospi tal -Based Hospi ce	HOSPICE OF MEMORIAL HOSPITAL	151529	99915		12/09/1994				14.0
5. 00	Hospital-Based Health Clinic - RHC									15.0
. 00	Hospital - Based Health Clinic - FQHC									16.0
. 00 . 00	Hospital-Based (CMHC) I Renal Dialysis									17.
. 00	Other									19.
						From: 1.00		To 2. (-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
. 00	Type of Control (see instructions)					8				21.
				-	1.00	2.00		3. ()()	-
	Inpatient PPS Information				1.00	2.00		0.0		
. 00	Does this facility qualify and is it				Y	N				22.0
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			ĸ						
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle am								
0.01	hospital?) In column 2, enter "Y" fo		to for th		Y	Y				22.0
. 01	Did this hospital receive interim un cost reporting period? Enter in colu				Ŷ	Y				22.1
	the portion of the cost reporting pe	riod occurring prior to	October	1.						
	Enter in column 2, "Y" for yes or "N			cost						
. 02	reporting period occurring on or aft Is this a newly merged hospital that			re	Ν	N				22.
	payments to be determined at cost re	port settlement? (see i	nstructio	ns)						
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob									
	or "N" for no, for the portion of th									
	October 1.									
2.03	Did this hospital receive a geograph rural as a result of the OMB standar				Ν	N		N		22.0
	adopted by CMS in FY2015? Enter in c	olumn 1, "Y" for yes or	"N" for	no						
	for the portion of the cost reportin	g period prior to Octob	er 1. Ent	er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" f	or						
. 04	yes or "N" for no. Did this hospital receive a geograph	ic reclassification from	m urban t	o	Ν	N		Ν		22.
	rural as a result of the revised OME	delineations for stati	stical ar	eas						
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			=1						
	reporting period occurring on or aft	er October 1. (see inst	ructions)							
	Does this hospital contain at least counted in accordance with 42 CFR 41									
	yes or "N" for no.		ii J, T							
2 00	Which method is used to determine Me					3 N				23.0
. 00	below? In column 1, enter 1 if date	or admission, 2 if censi	us days,	or 3						
5. 00				cost						
. 00	if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of identifying the days method used in the prior	in this r cost	cost						

	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	N: 15-0065		ri od:			sheet	S-2
					To	om 01/0 12/3	1/2021		e/Time	Prepare 3:05 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	S Mec eli	ut-of tate di cai d gi bl e npai d	Medica HMO da		Other Medi ca days	i d
		1.00	2.00	3.00		1.00	5.00		6.00	
i r Me ou 4, 25.00 I f Me Me Ou Me	f this provider is an IPPS hospital, enter the n-state Medicaid paid days in column 1, in-state edicaid eligible unpaid days in column 2, ut-of-state Medicaid paid days in column 3, ut-of-state Medicaid eligible unpaid days in column , Medicaid HMO paid and eligible but unpaid days in olumn 5, and other Medicaid days in column 6. f this provider is an IRF, enter the in-state edicaid paid days in column 1, the in-state edicaid eligible unpaid days in column 2, ut-of-state Medicaid days in column 2, ut-of-state Medicaid days in column 3, out-of-state edicaid eligible unpaid days in column 4, Medicaid MO paid end eligible unpaid days in column 4, Medicaid	0	0			8 0	1,	0		94 24. 25.
	MO paid and eligible but unpaid days in column 5.					Urban/R	ural S	Date	of Ge	ogr
(00 F				al and the C		1. (00		2.00	
7.00 Er re	nter your standard geographic classification (not w ost reporting period. Enter "1" for urban or "2" fo nter your standard geographic classification (not w eporting period. Enter in column 1, "1" for urban o	nrrural. mage) status mr "2" for r	at the en rural. If a	d of the co			2			26. 27.
5.00 If	nter the effective date of the geographic reclassif f this is a sole community hospital (SCH), enter th ffect in the cost reporting period.			CH status i	n		0			35.
					-	Begi nr 1. (E	ndi ng:	
6.00 Er	nter applicable beginning and ending dates of SCH s	tatus. Subs	script line	36 for num	ber	1. (0		2.00	36.
7.00 If	f periods in excess of one and enter subsequent dat f this is a Medicare dependent hospital (MDH), enter		er of perio	ds MDH stat	us		0			37.
7.01 Is ac	s in effect in the cost reporting period. s this hospital a former MDH that is eligible for t ccordance with FY 2016 OPPS final rule? Enter "Y" f			ayment in						37.
	nstructions)	5								
8.00 If gr		s of MDH st	atus. If I	ine 37 is						38.
8.00 If gr	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number o	s of MDH st	atus. If I	ine 37 is		Y/			Y/N	
8.00 I f gr er 9.00 Dc 1 ac or	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number on nter subsequent dates. oes this facility qualify for the inpatient hospita ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions)	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter	atus. If I n excess o djustment (iii)? En e requireme in column	for low vol for low vol ter in colu nts in 2 "Y" for y	ımn ves	Y/ 1. (Y	00		Y/N 2.00 Y	
8.00 f gr er 9.00 Dc hc 1 ac or 0.00 Is	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospita ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente	atus. If I n excess o adjustment (iii)? En e requireme in column at? Enter " er "Y" for	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	imn ves or	1. (00		2.00	38.
8.00 1 gr er 9.00 Dc hc 1 ac or 0.00 Is "N nc	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospita ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octo o in column 2, for discharges on or after October 1	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente	atus. If I n excess o adjustment (iii)? En e requireme in column at? Enter " er "Y" for	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	imn ves or	1. (Y	00	XVI 2.	2.00 Y N	38.
8. 00 1 gr er 9. 00 Dc hc 1 ac or 0. 00 Is "N nc	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number on nter subsequent dates. oes this facility qualify for the inpatient hospita ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octo o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital	s of MDH st f periods i), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst	atus. If I n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for cructions)	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	ımn ves or for	1. (Y	20 V 1.00) 2.	2.00 Y N <u>11 X</u> 00 3.	38. 39. 40.
8. 00 1 gr er 9. 00 Dc hc 1 ac or 0. 00 s 5. 00 Pr 0c bc 6. 00 s	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospital ospitals in accordance with 42 CFR §412. 101(b)(2)(i "/" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412. 101(b)(2)(i), (ii), or (i " "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octoo o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payment ith 42 CFR Section §412. 320? (see instructions) s this facility eligible for additional payment exc	s of MDH st if periods i l payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Ente . (see inst . (see inst . eption for	atus. If I n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for cructions) proportiona extraordin	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	imn ves or for a acc	1. (Y N cordance	20 V 1.00		2.00 Y N 11 X 00 3.	38. 39. 40.
3. 00 1 gr er 9. 00 Do hc 1 ac or 0. 00 1 1 s "N nc 5. 00 Dc wi 5. 00 1 1 s "N bc bc y 1 s "N bc y 1 s "N bc y s "N bc y s s s s s s s s s s s s s s s s s s	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospital ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octo o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payme ith 42 CFR Section §412.320? (see instructions) s this facility eligible for additional payment exc ursuant to 42 CFR §412.348(f)? If yes, complete Wks t. III.	s of MDH st f periods i (i payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Ente . (see inst . (see inst . (see inst . t for disp . t, Pt. I	atus. If I n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for cructions) proportiona extraordin II and Wks	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt.	imn ves or for acc stanc I t	1.(Y N cordance ces chrough	200 	D 2.	2.00 Y N <u>11 X</u> 00 3. V I	38. 39. 40. 1X 00 N 45.
3. 00 I f gr gr gr er 9. 00 Dc hc 1 1 ac or 0 5. 00 Fr 5. 00 I s pu Pr 7. 00 I s 3. 00 I s Te Te	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospita ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octor o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payment ith 42 CFR Section §412.320? (see instructions) s this facility eligible for additional payment excursuant to 42 CFR §412.348(f)? If yes, complete Wks t. III. s this a new hospital under 42 CFR §412.300(b) PPS s the facility electing full federal capital payment eaching Hospitals	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Enter . (see inst . (see inst . (see inst . t. L. Pt. I capital? E t? Enter "	atus. If I n excess o djustment (iii)? En e requireme in column et? Enter " er "Y" for ructions) proportiona extraordin II and Wks Enter "Y fo Y" for yes	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for	imn ves for a acc stanc l t l" fo	1.(Y N cordance ces chrough or no.	200 1.00 2 N N N N N) 2. N	2.00 Y N <u>111 X1</u> 00 3. J 1 J 1	38. 39. 40. 1X 00 N 45. N 45. N 46. N 46.
3. 00 f 1 gr er 2. 00 Dc hc 1 ac or 0. 00 S "N nc 5. 00 S 5. 00 S PL 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number of nter subsequent dates. oes this facility qualify for the inpatient hospital ospitals in accordance with 42 CFR §412. 101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet ccordance with 42 CFR 412. 101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octor o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payment ith 42 CFR Section §412. 320? (see instructions) s this facility eligible for additional payment excursuant to 42 CFR §412. 348(f)? If yes, complete Wks t. III. s this a new hospital under 42 CFR §412. 300(b) PPS s the facility electing full federal capital payment	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Enter n adjustmer ber 1. Enter . (see inst . (see inst . (see inst . (see inst . (see inst . (see inst . (se	atus. If I n excess o djustment (iii)? En e requireme in column nt? Enter " er "Y" for cructions) oroportiona extraordin II and Wks Enter "Y fo Y" for yes ME program o 1 is "Y", the prior	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	Imn ves or for for tance tanco	1.(Y N cordance ces chrough or no. or yes c spital mate	200 V 1.00 P N N N N N N N N N N	D 2.	2.00 Y N <u>111 X1</u> 00 3. J 1 J 1	38. 39. 40. 1 <u>X</u> 00 N 45. N 45. N 45. N 45.
3. 00 1 gr er 9. 00 Dc hc 1 ac or 0. 00 5 5. 00 Dc Wi 5. 00 Dc Wi 5. 00 Dc S. 00 C S. 00 S. 00 S S. 00 S S	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number on nter subsequent dates. oes this facility qualify for the inpatient hospital ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet cordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octo o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payme ith 42 CFR Section §412.320? (see instructions) s this facility eligible for additional payment exc ursuant to 42 CFR §412.348(f)? If yes, complete Wks t. III. s this a new hospital under 42 CFR §412.300(b) PPS s the facility electing full federal capital paymen eaching Hospitals s this a hospital involved in training residents in N" for no in column 1. For column 2, if the respons as involved in training residents in approved GME p ear, and are you are impacted by CR 11642 (or appli nter "Y" for yes; otherwise, enter "N" for no in co f line 56 is yes, is this the first cost reporting ME programs trained at this facility? Enter "Y" for s "Y" did residents start training in the first mo or yes or "N" for no in column 2. If column 2 is "	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmer ber 1. Enter n adjustmer ber 1. Enter . (see inst . (see inst). (see inst . (see inst . (se	atus. If I n excess o djustment (iii)? En e requireme in column nt? Enter " er "Y" for rructions) oroportiona extraordin II and Wks Enter "Y fo Y" for yes GME program n 1 is "Y", the prior MA direct ng which r " for no i cost repor	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	mn // ves or for for //	1.(Y Y N cordance ces through or no. or yes c spital mate duction? oroved column Enter "Y	DO V 1. OC N N N N N N N N N 1	D 2.	2.00 Y N <u>111 X1</u> 00 3. J 1 J 1	38. 39. 40. 1X 00 N 45. N 45. N 46. N 46.
8. 00 1 1 gr er 9. 00 Dc hc 1 ac or 0. 00 s "N 5. 00 Dc Wi 6. 00 s 8. 00 s 8. 00 s 7. 00 s 8. 00 s 8. 00 s 8. 00 s 8. 00 s 5. 00 s 7. 00 s 6. 00 s 7. 00 s 8. 00 1 s 7. 00	nstructions) f line 37 is 1, enter the beginning and ending date reater than 1, subscript this line for the number on inter subsequent dates. oes this facility qualify for the inpatient hospital ospitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet cordance with 42 CFR 412.101(b)(2)(i), (ii), or (i r "N" for no. (see instructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octo o in column 2, for discharges on or after October 1 rospective Payment System (PPS)-Capital oes this facility qualify and receive Capital payment ith 42 CFR Section §412.320? (see instructions) s this facility eligible for additional payment excurs ursuant to 42 CFR §412.348(f)? If yes, complete Wks t. III. s this a new hospital under 42 CFR §412.300(b) PPS s the facility electing full federal capital payment eaching Hospitals s this a hospital involved in training residents in N" for no in column 1. For column 2, if the respons as involved in training residents in approved GME p ear, and are you are impacted by CR 11642 (or appli nter "Y" for yes; otherwise, enter "N" for no in co f line 56 is yes, is this the first cost reporting ME programs trained at this facility? Enter "Y" for s "Y" did residents start training in the first mon	s of MDH st if periods i), (ii), or the mileage ii)? Enter n adjustmer ber 1. Enter . (see inst . (see inst . (see inst . (see inst . (see inst . Enter . (see inst . (see inst . Enter . (see inst . (see inst . (see inst . (see inst . (see inst . (see inst . (see inst .	atus. If I n excess o djustment (iii)? En e requireme in column et? Enter " er "Y" for rructions) oroportiona extraordin II and Wks Enter "Y fo Y" for yes ME program n 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable. for physici	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for ye yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	Imn res or for for for stance or for stance of the stance	1.(Y Y N cordance ces through or no. or yes c spital mate duction? proved column Enter "Y in 2 is	DO V 1. OC N N N N N N N N N 1	D 2.	2.00 Y N <u>111 X1</u> 00 3. J 1 J 1	38. 39. 40. 1X 00 N 45. N 45. N 46. N 46. N 46. S6.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/23/2022 3:0	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	1
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (s 1 umn 1. CR) NAHE	see lf column 1	N			60.00
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 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) 1.01 Enter the average number of unweighted primary care 				0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports 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,						61. 0
 and primary care FTEs added under section 5503 of 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 						61. 03
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line (1.02) (are instructions).						61.0
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 care or general surgery. (see instructions)						61.0
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61.1
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	0. 00	61.2
The direct own in anwergined count.			I	I	1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				iod for which		62.00
your hospital received HRSA PCRE funding (see instru 2.01 Enter the number of FTE residents that rotated from	ictions) a Teachi	ng Health Cer	nter (THC) into			62. 0 [°]
during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid			ons)			

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPL		CK MEDICAL CENTER ATA Provider CO		eri od:	u of Form CMS- Worksheet S-2	
				om 01/01/2021	Part I	epared:
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			-This base year	is your cost	reporti ng	
period that begins on or after Ju 4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to roi settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2)	yes, or your facili per of unweighted no ations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Site	nospi tai		
	1.00	2.00	3.00	4.00	5.00	1
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00		0 65.00
Section 5504 of the ACA Current `		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
beginning on or after July 1, 20		ry caro rocidont	0.00	0.00	0.00000	66 00
5.00 Enter in column 1 the number of u FTEs attributable to rotations or Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp inweighted non-prima il. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	, 00. UL
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col.	
			FTËs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Site			
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0.00	0. 000000	η 67.0C

	Financial Systems SCHNECK MEDICAL CENTER		In Lieu	of Forr	n CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0065	From 01/0	1/2021 1/2021	Workshe Part I Date/Ti	me Pre	pared:
				5/23/20	22 3:0	5 pm
			1.00	2.00	3.00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprovi der	? N			70.00
	Enter "Y" for yes or "N" for no.	·				
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N"				0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new	teachi ng				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" Column 3: If column 2 is Y, indicate which program year began during this cost repo		.			
	(see instructions)		·			
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	IDE	N	1 1		75.00
	subprovider? Enter "Y" for yes and "N" for no.					75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program recent cost reporting period ending on or before November 15, 2004? Enter "Y" for v				0	76.00
	no. Column 2: Did this facility train residents in a new teaching program in accord					
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instructi					
	indicate which program year began during this cost reporting period. (see instruct)	ons)				
				1.0	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost report	ting period?	Enter	N		81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for		or no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Se §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ection				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under sec	i on		Ν		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V		XI>	v	
		1. (2.0		-
00.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" 1	îor N		Y		90.00
90.00	yes or "N" for no in the applicable column.			ř		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either i	n N		Ν		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.					
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent "Y" for yes or "N" for no in the applicable column.	er N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		Ν		94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.0	00	0.0	00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N		Ν		96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0.0	00	0.0	0	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and residents pos	st Y		Y		98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	1				
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on V			Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.	for				
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation			Y		98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.	1				
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital ((Ν		98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colu for title V, and in column 2 for title XIX.	imn 1				
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N		Ν		98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, in column 2 for title XIX.	and				
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance	on Y		Y		98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, an column 2 for title XIX.	id in				
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Y		Y		98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in					
	column 2 for title XIX. Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			_	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of pay for outpatient services? (see instructions)	ment				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&					107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an					
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S- Part I Date/Time Pr 5/23/2022 3:	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
			104	1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	-
111.00 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 lumn 1 is Y, ticipating ir	period? Enter enter the column 2.	Ν		111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? "Y", enter e	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3" percent i ncl udes s) based on				11/ 00
116.00 Is this facility classified as a referral center? Enter "Y" " "N" for no.	tor yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur- "Y" for yes or "N" for no.	ance? Enter	N			117.00
118.00 is the maipractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr	5	1			118.00
In the porrey is cranin-induc. Enter 2 in the porrey is occurr	ence.	Premi ums	Losses	Insurance	
119 Ollist amounts of malarastics promiums and paid losses		1.00 1,501,117	2.00	3.00	0118.01
118.01 List amounts of malpractice premiums and paid losses:		1, 501, 117	0		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA \$3121 and applicable amendmen	column 1, "N alifies for 1	f" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	ntable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def		-	Y	5.00	122.00
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. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N'	'for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en		fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent		fication date			127.00
in column 1 and termination date, if applicable, in column 2					
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2					128.00
129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.	r the certifi	cation date in			129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE		IEDI CAL CENTER Provi der CC	N: 15-0065	Fro Fro To	riod: om 01/0 12/3	01/2021 31/2021	u of Form CM Worksheet S Part I Date/Time P 5/23/2022 3	-2 repared
0.00 f this is a Medicare certified pa	anoroac trancol ant cont	tor optor the cort	ti fi coti or		1.	00	2.00	130.0
date in column 1 and termination of				'				130.0
1.00 If this is a Medicare certified in			erti fi cati	on				131.0
date in column 1 and termination of 2.001f this is a Medicare certified is			cation da	ate				132.0
in column 1 and termination date,								
3.00Removed and reserved 4.00If this is an organ procurement o	rappization (OPO) onto	or the OPO number i	n column	1				133.0
and termination date, if applicable				1				134.
All Providers 0.00Are there any related organization	n or home office costs	as defined in CMS	Dub 15	1		N		140.
chapter 10? Enter "Y" for yes or					I	IN .		140.
are claimed, enter in column 2 the	e home office chain nur		tions)			2.00		
<u> </u>	in organization, enter	2.00 on lines 141 thro	ugh 143 t	he nam	e and	3.00 address	of the home	
office and enter the home office	contractor name and co	ntractor number.						
1.00Name: 2.00Street:	Contractor's Name PO Box:	9:	Contra	actor'	s Numb	er:		141.0
3. 00 Ci ty:	State:		Zip Co	ode:				143.
							1.00	_
4.00 Are provider based physicians' cos	sts included in Workshe	eet A?					1.00 Y	144.
· · · · · ·				_				
5.00 f costs for renal services are cl	laimed on Wkst A line	e 74 are the costs	s for		1.	00	2.00	145.
inpatient services only? Enter "Y				s				145.
no, does the dialysis facility ind period? Enter "Y" for yes or "N"		tion for this cost	reportino	9				
6.00 Has the cost allocation methodolog		eviously filed cost	t report?		1	N		146.
Enter "Y" for yes or "N" for no in		ub. 15-2, chapter 4	40, §4020)) f				
		ub. 15-2, chapter 4	40, §4020)) f				_
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Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi 0.00 Was there a change to the simplifi 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	dd/yyyy) in column 2. ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each cor ampus hospital that has Name 0 T) incentive in the Amer r under \$1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc- not a meaningful user,	for yes or "N" for "for yes or "N" for d? Enter "Y" for yes Part A 1.00 r an exemption fro mponent for Part A N N N N N N N N N N N N N	no. pr no. es or "N" Part 2.00 m the app and Part N N N N N Uses in di State 2.00 d Reinves 'N" for no e 167 is ' c qualify	for no B licati B. (S fferen Zip C 3.0	Tit 3. on of ee 42 nt CBS ode 0 0 Act enter	00 the I ow CFR §41 N N N N N As? CBSA 4.00 the	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.

Health Financial Systems	SCHNECK MEDICA	L CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0065	Period:	Worksheet S-2	2
			From 01/01/2021	Part I	norod.
			To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provid	er have any days for indi	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans rep	orted 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, e	enter the number of secti	on		
1876 Medicare days in column 2. (see	instructions)				

^{5/23/2022 3:05} pm

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0065	Period: From 01/01/2021	u of Form CMS Worksheet S- Part II	
				To 12/31/2021		
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	N for all NO r	esponses. En	ter all dates in	the	
	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.
	reporting period? If yes, enter the date of the change in o	column 2. (see		· ·		_
			Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in the Medicare I	Program? If	N N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary. Is the provider involved in business transactions, includi		N			3.
	contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	offices, drug der or its of the board				
	relationships? (see instructions)		V /N	Turno	Doto	
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/29/2021	4.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rea		N			5.
				Y/N 1.00	Legal Oper. 2.00	_
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i	s the provide	er N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during tl	ne N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatio	N N		9.
0. 00	Was an approved Intern and Resident GME program initiated (cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N	Y/N	11.
					1.00	_
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	Y N	12. 13.
. 00		ents waived? I	fyes, see in	nstructions.	N	14.
. 00	Did total beds available change from the prior cost report	<u> </u>	yes, see ins t A		N T B	15.
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
. 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	N		N		16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/14/2022	Y	04/14/2022	17.
. 00	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	N		Ν		18.
. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		19.
19.00	Cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		

HOSPI TAL AND HOSI	I TAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCM	√: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time F 5/23/2022 3	Prepared:
		Descrip	otion	Y/N	Y/N	<u>. 05 pm</u>
		0		1.00	3.00	
	or 17 is yes, were adjustments made to PS&R a for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
1 00 Was the co	st report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
	f yes, see instructions.	N		N		21.00
					1.00	
	BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS HO)SPI TALS)			
Capital Re		<u> </u>				
	s been relifed for Medicare purposes? If yes, se					22.0
	es occurred in the Medicare depreciation expense	e due to appraisa	als made du	ring the cost		23.0
	period? If yes, see instructions. eases and/or amendments to existing leases enter	ed into durina t	this cost r	eporting period?		24.00
	e instructions	cu into during i		cporting period:		24.00
5.00 Have there	been new capitalized leases entered into during	g the cost report	ting period	?lfyes, see		25.00
instructio				-		
	s subject to Sec.2314 of DEFRA acquired during t	the cost reportin	ng period?	lf yes, see		26.00
instructio 7.00 Has the pr	ns. ovider's capitalization policy changed during th	na cost ranortino	n period? I	f vos submit		27.00
copy.	Swider is capital reaction porrey changed during th		j per lou: l	i yes, subili t		27.00
Interest E	(pense					
8.00 Were new I	oans, mortgage agreements or letters of credit e	entered into duri	ng the cos	t reporting		28.00
	yes, see instructions.					
	ovider have a funded depreciation account and/or		ot Service	Reserve Fund)		29.0
	a funded depreciation account? If yes, see inst ng debt been replaced prior to its scheduled mat		deht? If ve	AA2 2		30.00
i nstructi c	o	unity with new t	Jent: II ye	5, 500		30.00
	een recalled before scheduled maturity without i	ssuance of new of	debt? If ye	s, see		31.00
instructio						
Purchased			1 11			
	es or new agreements occurred in patient care se ts with suppliers of services? If yes, see instr		i through c	ontractual		32.00
	is yes, were the requirements of Sec. 2135.2 ap		1 to compet	itive biddina? If	-	33.00
	structions.	· · · · · · · · · · · · · · · · · · ·	,			
Provi der-B	ased Physi ci ans					
	es furnished at the provider facility under an a	arrangement with	provi der-b	ased physi ci ans?		34.0
	e instructions.			www.state.e.bee.ed		25.00
	is yes, were there new agreements or amended ex during the cost reporting period? If yes, see i		is with the	provi der-based		35.00
physicians	during the cost reporting periods in yes, see i			Y/N	Date	
				1.00	2.00	
Home Offic						
	office costs claimed on the cost report?			-		36.00
	is yes, has a home office cost statement been p	prepared by the h	nome office	?		37.00
	e instructions. is yes , was the fiscal year end of the home of	fice different f	from that o	f		38.00
	er? If yes, enter in column 2 the fiscal year en					00.00
39.00 f ine 36	is yes, did the provider render services to oth			s,		39.00
see instru			-			
	is yes, did the provider render services to the	e home office? I	f yes, see			40.00
instructio	.15.					
		1.0	0	2.	00	_
	t Preparer Contact Information					
Cost Repor	first name, last name and the title/position	LUCI A		GERBER		41.00
1.00 Enter the	e cost report preparer in columns 1, 2, and 3,					
1.00 Enter the held by th				1		11
1.00 Enter the held by th respective			1.0			1 40 00
11.00 Enter the held by th respective 12.00 Enter the	ly. employer/company name of the cost report	BLUE AND CO., L	LC			42.00
11.00 Enter the held by th respective Enter the preparer.		BLUE AND CO., L 502-992-3500	LC	LGERBER@BLUEAN	DCO. COM	42.00

Health Financial Systems SCHNECK N	EDI CAL CENTER	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0065	Period: From 01/01/2021	Worksheet S-2 Part II	
			Date/Time Pre 5/23/2022 3:0	pared: 5 pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	SENI OR MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	t			43.00
report preparer in columns 1 and 2, respectively.				

^{5/23/2022 3:05} pm

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	SCHNECK MEDIC	Provider C	CN: 15-0065	Peri od:	u of Form CMS-2 Worksheet S-3	
100111					From 01/01/2021 To 12/31/2021	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	63	22, 99	95 0.00	0	1.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		63	22, 99			
8.00	INTENSIVE CARE UNIT	31.00	18	6, 57	0. 00	0	
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	43.00					12.00
13.00 14.00	NURSERY	43.00	81	20 E4	0.00	0	13.00
14.00	Total (see instructions) CAH visits		81	29, 56	0.00	0	14.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116.00	2	73	30		24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC – CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		83				27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0				31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		0		32.00 32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges				1		33.01

HOSPI 1	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	SCHNECK MEDICA AL DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre	l
		I/P Dave	/ O/P Visits	/ Trins		5/23/2022 3:0 Equi val ents	5 pm
		I/r Days	/ U/F VISILS	/ 111ps	run nimen		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		1, 575	6, 61		10.00	1.00
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	333	500				2.00
3.00	HMO IPF Subprovider	0	500				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	28	0	4	7		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	20	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 881	1, 575	6,65	8		7.00
8.00	INTENSIVE CARE UNIT	552	170	2, 87	8		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	2 422	1, 147	1, 86		050 (0	13.00
14.00 15.00	Total (see instructions) CAH visits	2, 433	2, 892 0	11, 40	5 0.00 0	850. 69	14.00 15.00
16.00	SUBPROVIDER - IPF	0	0		0		16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3, 846	0	8, 76	0 0.00	16. 40	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE	150	0	15	5 0.00	10. 29	24.00
24.10	HOSPICE (non-distinct part)				0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)				0.00	877.38	
28.00	Observation Bed Days	_	384	1, 96	3		28.00
29.00	Ambul ance Trips	0			~		29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00 32.00	Employee discount days - IRF Labor & delivery days (see instructions)	0	94	15	-		31.00 32.00
32.00	Total ancillary labor & delivery room	0	94		2		32.00
32.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	0					33.01

ers	tle V 2.00	Disch Title XVIII 13.00	narges Title XIX	5/23/2022 3:05 Total All Patients	
aid Ti [.] ers	2.00				
		13,00		Patients	
00 12		13.00			
	0		14.00	15.00	
0. 00 0. 00 0. 00 0. 00	0	459 54 459	111 0 0	2, 148	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25 27.00 28.00
	0.00 0.00 0.00	0. 00 0. 00 0. 00	0. 00 0. 00 0. 00	0.00 0 459 389 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 0.00 0.00 0.00 0.00

SPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0065 P F T	eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/23/2022 3:0	par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	77, 136, 555	0	77, 136, 555	1, 824, 935. 95	42.27	1
00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2
50	A		0	0		0.00	0.00	
00	Non-physician anesthetist Part		642, 910	0	642, 910	6, 340. 00	101.41	3
00	B Physician-Part A -		503, 805	0	503, 805	3, 016. 00	167. 04	4
	Admi ni strati ve		000,000			0,010.00		
)1	Physicians - Part A - Teaching		0	0		0.00	0.00	
00	Physician and Non Physician-Part B		14, 481, 822	0	14, 481, 822	93, 654. 00	154.63	5
00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6
0	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	-
	approved program)	21.00	0	0		0.00	0.00	'
)1	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7
00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8
00	SNF	44.00	0	0	-	0.00		
00	Excluded area salaries (see instructions)		15, 536, 665	554	15, 537, 219	338, 893. 63	45.85	10
	OTHER WAGES & RELATED COSTS	1		1	1			1
00	Contract Labor: Direct Patient		3, 436, 782	0	3, 436, 782	29, 969. 22	114.68	11
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12
00	management and other management and administrative		Ū			0.00	0.00	
00	services Contract Labor: Physician-Part		429, 961	0	429, 961	1, 998. 00	215. 20	13
00	A - Administrative Home office and/or related		0					
	organization salaries and wage-related costs							
01	Home office salaries		0	0	0	0.00	0.00	14
02	Related organization salaries		0	0	0	0.00		
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	11
00	Home office and Contract		0	0	0	0.00	0.00	16
01	Physicians Part A - Teaching					0.00	0.00	
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
00	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 926, 779	0	10, 926, 779			17
55	instructions)		.5, 720, 117		, , 20, , , , ,			''
00	Wage-related costs (other)							18
00	(see instructions) Excluded areas		3, 237, 205	n	3, 237, 205			19
00	Non-physician anesthetist Part		0,207,203	0	0			20
00	A Non-physician anesthetist Part		93, 598	0	93, 598			21
00	B Physician Part A - Administrative		63, 093	0	63, 093			22
	Physician Part A - Teaching		0	0	0			22
	Physician Part B Wage-related costs (RHC/FQHC)		1, 850, 150	0	1, 850, 150			23
	Interns & residents (in an		0	0	0			24
50	approved program) Home office wage-related		0	0	0			25
51	(core) Related organization		~	_	_			25
ы	wage-related (core)		0					25
52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		Inlie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5,00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	735, 356	0	735, 35	6 15, 288. 88	48. 10	26.00
27.00	Administrative & General	5.00	9, 812, 323	0	9, 812, 32	3 221, 668. 70	44. 27	27.00
28.00	Administrative & General under		695, 658	0	695, 65	8 2, 426. 75	286.66	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 428, 498	0	1, 428, 49	8 46, 588. 63	30.66	30.00
31.00	Laundry & Linen Service	8.00	43, 579	0	43, 57	9 2, 726. 00	15.99	31.00
32.00	Housekeepi ng	9.00	1,022,422	0	1, 022, 42	2 59, 420. 03	17. 21	32.00
33.00	Housekeeping under contract		181, 820	0	181, 82	0 8, 432. 00	21.56	33.00
	(see instructions)							
34.00	Dietary	10.00	754, 256	-407, 105	347, 15	1 17, 227. 71	20. 15	34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteria	11.00	0	407, 105	407, 10	5 19, 701. 00		36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	
38.00	Nursing Administration	13.00	2, 509, 353	-554	2, 508, 79	9 59, 543. 44	42.13	38.00
39.00	Central Services and Supply	14.00	1, 005, 881	0	1, 005, 88	1 40, 629. 69	24. 76	39.00
40.00	Pharmacy	15.00	1, 637, 696	0	1, 637, 69	6 36, 375. 84	45.02	40.00
41.00	Medical Records & Medical	16.00	971, 614	0	971, 61	4 40, 464. 81	24. 01	41.00
40.00	Records Library	17.00	~				0.00	42.00
42.00	Social Service	17.00	012 001	0		0 0.00		42.00
43.00	Other General Service	18.00	913, 996	0	913, 99	6 21, 798. 08	41.93	43.00

^{5/23/2022 3:05} pm

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/23/2022 3:0	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		62, 889, 301	0	62, 889, 30	1 1, 735, 800. 70	36.23	1.00
	instructions)							
2.00	Excluded area salaries (see		15, 536, 665	554	15, 537, 21	9 338, 893. 63	45.85	2.00
	instructions)							
3.00	Subtotal salaries (line 1		47, 352, 636	-554	47, 352, 08	2 1, 396, 907. 07	33.90	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 866, 743	0	3, 866, 74	3 31, 967. 22	120. 96	4.00
	costs (see inst.)		-, ,		-,, -			
5.00	Subtotal wage-related costs		10, 989, 872	0	10, 989, 87	2 0.00	23. 21	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		62, 209, 251	-554	62, 208, 69	7 1, 428, 874. 29	43.54	6.00
7.00	Total overhead cost (see		21, 712, 452					
	instructions)		2., 712, 102			0,2,2,1.00	00.00	
				1	I	ļ	I I	I

Heal th	Financial Systems	SCHNECK MEDI CA	L CENTER			In I	Lieu of Form CMS-2	2552-10
HOSPI	FAL WAGE RELATED COSTS		Provi der	CCN: 1	5-0065	Period: From 01/01/20 To 12/31/20		pared:
							Amount	
							Reported 1.00	
	PART IV - WAGE RELATED COSTS						1.00	
	Part A - Core List							
	RETIREMENT COST							
1.00	401K Employer Contributions						0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrik	oution					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see						0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins						1, 434, 753	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)						
5.00	401K/TSA Plan Administration fees						0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	an					0	6.00
7.00	Employee Managed Care Program Administration	n 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 Thir	rd Party Administ	rator)				0	8.01
8.02	Health Insurance (Self Funded with a Third F	Party Administrate	or)				0	8.02
8.03	Health Insurance (Purchased)						9, 381, 851	8.03
9.00	Prescription Drug Plan						0	9.00
10.00	Dental, Hearing and Vision Plan						0	
11.00	Life Insurance (If employee is owner or bene						191, 359	
12.00	Accident Insurance (If employee is owner or						0	
13.00	Disability Insurance (If employee is owner of						180, 542	13.00
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary	y)				6, 467	
15.00	'Workers' Compensation Insurance						91, 714	15.00
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	aordi nary	accrua	l requir	ed by FASB 106	. 0	16.00
	Non cumulative portion)							
	TAXES							
	FICA-Employers Portion Only						4, 821, 069	
18.00	Medicare Taxes - Employers Portion Only						0	
19.00	Unemployment Insurance						0	
20.00	State or Federal Unemployment Taxes						0	20.00
	OTHER	D						
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost I	Reported o	n line	s 1 thro	ough 4 above. (see 0	21.00
22.00	Day Care Cost and Allowances							22.00
23.00	Tuition Reimbursement						63, 070	
24.00)					16, 170, 825	24.00
	Part B - Other than Core Related Cost							
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems	SCHNECK MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0065	Period: From 01/01/2021	Worksheet S-3 Part V	
			To 12/31/2021	Date/Time Pre 5/23/2022 3:0	pared: 5 pm
	Cost Center Description		Contract Labor	Benefit Cost	
			1,00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identi	fication:			
1.00	Total facility's contract labor and benefit	cost	3, 436, 782	16, 170, 825	1.00
2.00	Hospi tal		3, 436, 782	16, 170, 825	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice		0	0	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18.00

Health Financial Systems	SCHNECK MEDI				u of Form CMS-2	
HOME HEALTH AGENCY STATI STI CAL DATA		Provider C Component		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
				Home Health	5/23/2022 3:0 PPS	<u>s pili</u>
				Agency I		
0.00 County	· · · · ·			JACKSON 1.	00	0.00
0.00 00unty	Title V	Title XVIII	Title XIX	Other	Total	0.00
HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00 Home Health Aide Hours	0	959		0 1, 015	1, 974	1.00
2.00 Unduplicated Census Count (see instructions)	0.00			0 473.00 loyees (Full Ti		2.00
				i oyees (i ui i i ii		
	Enter the number		Staff	Contract	Total	
	your normal	WOLK WEEK				
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C)	1.00	2.00	3.00	
3.00 Administrator and Assistant Administrator(s)		40.00				3.00
 4.00 Director(s) and Assistant Director(s) 5.00 Other Administrative Personnel 			1. 0 0. 1			4.00 5.00
6.00 Direct Nursing Service			7.5			6.00
7.00 Nursing Supervisor			1.0			7.00
8.00 Physical Therapy Service 9.00 Physical Therapy Supervisor			4.3 0.0			8.00 9.00
10.00 Occupational Therapy Service			2.2	2 0.00	2.22	10.00
11.00 Occupational Therapy Supervisor 12.00 Speech Pathology Service			0.0			11.00 12.00
13.00 Speech Pathology Supervisor			0.0			13.00
14.00 Medical Social Service			0.0			14.00
15.00 Medical Social Service Supervisor 16.00 Home Health Aide			0.0			15.00 16.00
17.00 Home Health Aide Supervisor			0.0			17.00
18.00 Other (specify)			0.0	0 0.00	0.00 CBSA Data	18.00
					1.00	
HOME HEALTH AGENCY CBSA CODES19.00Enter in column 1 the number of CBSAs where					4	19.00
20.00 List those CBSA code(s) in column 1 serviced first code).	l during this co	ost reporting	period (line 2	20 contains the	18020	20.00
20. 01					31140	20.01
20. 02 20. 03					50002 99915	20. 02 20. 03
	Full Ep Without	oisodes With Outliers	LUDA Enisodes	S PEP Only	Total (cols.	
	Outliers			Epi sodes	1-4)	
PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00 Skilled Nursing Visits	1, 408	47				21.00
22.00 Skilled Nursing Visit Charges 23.00 Physical Therapy Visits	400, 998 1, 200	13, 395 23			446, 313 1, 263	
24.00 Physical Therapy Visit Charges	399, 600	7,659				
25.00 Occupational Therapy Visits	693	22	2	2 3	740	
26.00 Occupational Therapy Visit Charges 27.00 Speech Pathology Visits	230, 769 13	7, 326 0		6 999 1 0		26.00 27.00
28.00 Speech Pathology Visit Charges	4, 373	0				28.00
29.00 Medical Social Service Visits 30.00 Medical Social Service Visit Charges	5 2, 050	0		1 0 0 0	6 2, 460	29.00 30.00
31.00 Home Heal th Aide Visits	245	3		0 8		
32.00 Home Health Aide Visit Charges 33.00 Total visits (sum of lines 21, 23, 25, 27,	38, 465	471 95		0 1,256 3 34		
29, and 31)	3, 564					
34.00 Other Charges 35.00 Total Charges (sum of lines 22, 24, 26, 28,	0 1, 076, 255	0 28, 851		0 0 6 9,098	0 1, 160, 670	
30, 32, and 34) 36.00 Total Number of Episodes (standard/non	447		7			36.00
outlier) 37.00 Total Number of Outlier Episodes		6				37.00
38.00 Total Non-Routi ne Medical Supply Charges	25, 907	186	2, 04	8 345		

	Financial Systems		SCHNECK MEDI				u of Form CMS-2	
HOSPI 1	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provider CC Hospice CC	CN: 15-0065 √: 15-1529	Period: From 01/01/2021 To 12/31/2021		GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00		Facility	2	5.00		
	DADT I ENDOLLMENT DAVC FOD C		2.00	3.00	4.00	5.00	6.00	
1.00 2.00	PART I - ENROLLMENT DAYS FOR C Hospice Continuous Home Care Hospice Routine Home Care	DST REPORTING I	PERIODS BEGINN	ING BEFORE OCIC	DBER 1, 2015			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
5.00	Part II - CENSUS DATA FOR COST Number of patients receiving	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	1, 2015			6.00
5.00	hospice care							0.00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
3. 00	to Medicare Average Length of Stay (line 5							8.00
3.00	/ line 6)							8.00
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	al so include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
				1.00	2.00	3.00	through 3) 4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERLODS BEGL				4.00	
10.00	Hospice Continuous Home Care			0		0 0	0	10.00
11.00	Hospice Routine Home Care			10, 763	40	61 371	11, 595	11.00
12.00	Hospice Inpatient Respite Care			102		0 0		12.00
13.00	Hospice General Inpatient Care			48		5 0		13.00
14.00	Total Hospi ce Days					66 371	11, 750	14.00
	PART IV - CONTRACTED STATISTIC		SI KEPUKIING P		NG UN UR AFTE			
15.00	Hospice Inpatient Respite Care			0		0 0	0	15.00

Heal th	Financial Systems SCHNECK MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-0065	Peri od:	Worksheet S-1	0
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by Li	ne 202 colum	n 8)	0. 269639	1.00
1.00	Medicaid (see instructions for each line)	i vi ded by i i	110 202 COT UII	11 0)	0.207037	1.00
2.00	Net revenue from Medicaid				18, 524, 093	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ntal payment	ts from Medic	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	d		0	5.00
6.00	Medi cai d charges				74, 316, 066	6.00
7.00	Medicaid cost (line 1 times line 6)				20, 038, 510	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	1, 514, 417	8.00
	< zero then enter zero)	c	``			
0.00	Children's Health Insurance Program (CHIP) (see instructions	for each lir	ne)		0	0.00
9.00	Net revenue from stand-alone CHIP				0	9.00
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					10. 00 11. 00
12.00	Difference between net revenue and costs for stand-alone CHIP	(lino 11 mi	nue lino 0:	if < zoro thon		12.00
12.00	enter zero)		nus i ne 7,	II < Zero then	0	12.00
	Other state or local government indigent care program (see in	structions f	or each line)		
13.00	Net revenue from state or local indigent care program (Not in				0	13.00
14.00	Charges for patients covered under state or local indigent ca	re program ((Not included	ín lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line				0	15.00
16.00	Difference between net revenue and costs for state or local i	ndigent care	e program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, C					
	instructions for each line)	HIP and stat	terrocar rndr	gent care progra	ams (see	
17.00	Private grants, donations, or endowment income restricted to	fundi na char	rity care		0	17.00
18.00	Government grants, appropriations or transfers for support of				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc			s (sum of lines	1, 514, 417	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire f	acility	3, 116, 08	249, 700	3, 365, 788	20.00
201.00	(see instructions)	aonn cy	0, 110, 00	217,700	0,000,000	20100
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	840, 21	9 249, 700	1, 089, 919	21.00
	instructions)					
22.00	Payments received from patients for amounts previously writte	n off as		0 0	0	22.00
~~ ~~	charity care				1 000 010	
23.00	Cost of charity care (line 21 minus line 22)		840, 21	9 249,700	1, 089, 919	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati	ent days bey	vond a length	of stay limit	N 1.00	24.00
	imposed on patients covered by Medicaid or other indigent car		,			
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigent	t care progra	m's length of	0	25.00
	stay limit	-		-		
26.00	Total bad debt expense for the entire hospital complex (see i				8, 764, 453	
27.00	Medicare reimbursable bad debts for the entire hospital compl				214, 727	27.00
27.01	Medicare allowable bad debts for the entire hospital complex	(see instruc	ctions)		330, 349	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1	`	8, 434, 104	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	Instructions)	2, 389, 785	29.00
30.00 31.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus	Lino 20)			3, 479, 704 4, 994, 121	30.00
51.00	Trotal and enhoursed and uncompensated care cost (TTHE 19 plus	1116 30)			+, 774, 121	51.00

Forth (1/0/10/20) Forth (1/0/10/20) Forth (1/0/10/20) Forth (1/0/10/20) Forth (1/0/10/20) 1 Cost Center Description Salaries Other Total (Cost) Net assisted ass		n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	SCHNECK MEDICAL	CENTER Provider CC	:N: 15-0065 Pe	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10	
Upsite Center Description Sal and esc and biol Other (col. 2) Total (col. 1) (col. 2) Total (col. 2) (col. 4) Total (col. 2) (col. 4) 1.00 1000 2.00 3.00 4.00 5.00 5.00 1.00 0000 (AR R2) (CORT SR (RC AF NT AR DOB (Col. 3) 7.790 (Col. 3) 7.79					Fi	rom 01/01/2021	Date/Time Pre	pared:	
Image: statute in the statut		Cost Center Description	Salaries	Other	Total (col 1	Reclassi fi cat	5/23/2022 3:0	5 pm	
EXPROL COUNTRY 1.00 2.00 3.00 4.00 5.00 1.00 DUDO (AF REL COST SHUEG & FLXI ADD COUNTRY ELAPTISHED ON THE CAST SHUEG ADD COUNT SHUEG ADD COUNTRY ELAPTISHED ON THE CAST SHUEG ADD COUNT SHUEGANCY ADD COUNTRY ELAPTISHED ON THE CAST SHUEGANCY ADD COUNTRY ELAPTISHED ON THE CAST SHUEGANCY ADD COUNT SHUEGANCY ADD COUNTRY ELAPTISHED		cost center bescription	54141163	other			Trial Balance		
Indian Calman Calman Control 1.00 2.00 3.00 4.00 5.00 Design Control Control 11.515.60 11.515.60 4.63.472 2.00 Design Control Control Control Control 4.63.472 2.00 Design Control Control Control Control Control 4.63.472 2.00 Design Control Control Control Control Control Control Control 4.63.474 2.00 Control Contro						A-6)			
1.00 OUTOO CAP, REL COSTS-PLUCE & FLAX 1.1, 515, 666 11, 515, 666 -1, 155, 666 -1, 155, 666 -1, 155, 666 -4, 453, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 -4, 454, 474 <td< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td></td><td></td></td<>			1.00	2.00	3.00	4.00			
2.00 COUCH CAP, REL COSTS-WRELE EQUIP 0	1 00			11 515 404	11 515 (0)	2 725 547	7 700 050	1 00	
3.00 DOBOD (INTER CAPTIAL RELATED COSTS) 5.00 0.00 0.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.00000000000000000000000000000000000								•	
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54. 02 03450 MUCLEAR WEDIC (NE - DI AGNOSTIC 0 113, 974 -50. 085 63.08 54. 02 57. 00 05700 (STOC) TSCAN 225, 716 64.1132 996, 840 -157, 75 899, 733 57. 00 68. 00 06000 (LABORATORY NCCESSING, & TRANS. 0 222, 273 55. 563, 302 -2. 509, 462, 30. 76, 662 63. 00 60. 00 06000 (NTRAVENOUS THERAPY 1, 265, 569 560, 038 14. 825, 607 -299, 533 1, 526, 074 65. 00 66. 00 66.00 06000 (NTRAVENOUS THERAPY 1, 265, 569 513, 914 -2. 80, 914, 71 296, 71 1, 466, 609 66. 00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.01 445, 754 67. 00 457. 00 71. 746, 609 60. 00 60. 00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 71. 748, 403, 779 70. 00 71. 00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00<									
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90. 00 09000 CLINIC 0	/0.9/		184, 811	7, 103	191, 914	-4, 690	187, 224	/0.9/	
90. 02 09002 VEIN CENTER 407, 775 133, 414 541, 189 -132, 846 408, 343 90. 02 90. 03 09003 0BGYN 2, 400, 021 298, 620 2, 698, 641 -249, 369 2, 449, 272 90. 03 90. 04 NEUROSURGERY 1, 024, 806 52 1, 024, 858 -52 1, 024, 806 90. 04 90. 05 09005 SURGICAL ASSOCIATES 2, 085, 217 11, 879 2, 097, 096 -7, 689 2, 089, 407 90. 05 91. 00 09100 EMERGENCY 5, 187, 364 954, 648 6, 142, 012 -68, 210 6, 073, 802 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 734, 531 1, 243 735, 774 -162 735, 612 92.00 93. 00 D10100 HOME HEALTH ACENT 1, 583, 219 124, 173 1, 707, 392 -162, 153 1, 545, 239 101. 00 101.00 HOME HEALTH ACENT 473, 333 473, 333 -473, 333 0 113.00 118.0		09000 CLI NI C		-					
90.03 09003 0BGYN 2,400,021 298,620 2,699,641 -249,369 2,449,272 90.03 90.04 09004 NEUROSURGERY 1,024,806 52 1,024,858 -52 1,024,806 90.04 90.05 09005 SURGI CAL ASSOCI ATES 2,085,217 11,879 2,097,096 -7,689 2,089,407 90.05 91.00 09000 EMERGENCY 5,187,364 954,648 6,142,012 -68,210 6,073,802 91.00 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 734,531 1,243 735,774 -162 735,612 93.00 93.00 04952 BEHAVI ORAL HEALTH 734,531 1,243 735,774 -162,153 1,545,239 101.00 101.00 HORE HEALTH AGENCY 1,583,219 124,173 1,707,392 -162,153 1,545,239 101.00 113.00 INTEREST EXPENSE 667,994 143,463 811,457 162,707 974,164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63,851,103 89,179,568 153,030,671 0			-	-	-	-			
90.05 09005 SURGI CAL ASSOCI ATES 2,085,217 11,879 2,097,096 -7,689 2,089,407 90.05 91.00 09100 EMERGENCY 5,187,364 954,648 6,142,012 -68,210 6,073,802 91.00 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 734,531 1,243 735,774 -162 735,612 93.00 04952 BEHAVI ORAL HEALTH 734,531 1,243 735,774 -162 735,612 93.00 0100 HOME HEALTH AGENCY 1,583,219 124,173 1,707,392 -162,153 1,545,239 101.00 113.00 I1300 INTEREST EXPENSE 667,994 4473,333 473,333 -473,333 0 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63,851,103 89,179,568 153,030,671 0 153,030,671 180.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
91.00 09100 EMERGENCY 5, 187, 364 954, 648 6, 142, 012 -68, 210 6, 073, 802 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 734, 531 1, 243 735, 774 -162 735, 612 93.00 04952 BEHAVI ORAL HEALTH 734, 531 1, 243 735, 774 -162 735, 612 93.00 01.00 HOME HEALTH AGENCY 1, 583, 219 124, 173 1, 707, 392 -162, 153 1, 545, 239 101.00 92.00 SPECI AL PURPOSE COST CENTERS 667, 994 143, 463 811, 457 162, 707 974, 164 116.00 113.00 11300 INTEREST EXPENSE 667, 994 143, 463 811, 457 162, 707 974, 164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63, 851, 103 89, 179, 568 153, 030, 671 0 153, 030, 671 180.00 190.00 I9000 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.00 190.00 190.00 192.00 190.00 192.00 190.00 194.00 0 0									
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 93.00 04952 BEHAVI ORAL HEALTH 734, 531 1, 243 735, 774 -162 735, 612 93.00 0THER REIMBURSABLE COST CENTERS 01100 HOME HEALTH AGENCY 1, 583, 219 124, 173 1, 707, 392 -162, 153 1, 545, 239 101.00 10100 HOME HEALTH AGENCY 1, 583, 219 124, 173 1, 707, 392 -162, 153 1, 545, 239 101.00 SPECIAL PURPOSE COST CENTERS 5PECIAL PURPOSE COST CENTERS 473, 333 473, 333 -473, 333 0 113.00 113.00 11300 INTEREST EXPENSE 667, 994 143, 463 811, 457 162, 707 974, 164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63, 851, 103 89, 179, 568 153, 030, 671 0 153, 030, 671 180.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 192.00 192.00 194, 00 0 0									
OTHER REI MBURSABLE COST CENTERS 101.00 OTHER REI MBURSABLE COST CENTERS 101.00 101.00 101.00 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11600 HORSE EXPENSE 6667, 994 143, 463 811, 457 162, 707 974, 164 116.00 10 153, 030, 671 0 <th colspan<="" td=""><td></td><td>09200 OBSERVATION BEDS (NON-DISTINCT PART)</td><td>3, 107, 004</td><td>,,,,,,,,</td><td>5, 112, 012</td><td>50, 210</td><td></td><td>92.00</td></th>	<td></td> <td>09200 OBSERVATION BEDS (NON-DISTINCT PART)</td> <td>3, 107, 004</td> <td>,,,,,,,,</td> <td>5, 112, 012</td> <td>50, 210</td> <td></td> <td>92.00</td>		09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 107, 004	,,,,,,,,	5, 112, 012	50, 210		92.00
101.00 10100 HOME HEALTH AGENCY 1,583,219 124,173 1,707,392 -162,153 1,545,239 101.00 SPECI AL PURPOSE COST CENTERS 473,333 473,333 -473,333 0 113.00 113.00 INTEREST EXPENSE 667,994 143,463 811,457 162,707 974,164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63,851,103 89,179,568 153,030,671 0 153,030,671 188.00 NONREI MBURSABLE COST CENTERS 4,245,599 221,494 4,467,093 0 4,467,093 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 4,245,599 221,494 4,467,093 0 4,467,093 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.02 07952 EXTERNAL SVCS MARKETI NG 223,971 504,036 7	93.00		734, 531	1, 243	735, 774	-162	735, 612	93.00	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 473, 333 473, 333 -473, 333 0 113.00 116.00 HOSPI CE 667, 994 143, 463 811, 457 162, 707 974, 164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63, 851, 103 89, 179, 568 153, 030, 671 0 153, 030, 671 162, 707 974, 164 116.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00<	101.0		1, 583, 219	124, 173	1, 707, 392	-162, 153	1, 545, 239	101.00	
116.00 11600 HOSPICE 667,994 143,463 811,457 162,707 974,164 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 63,851,103 89,179,568 153,030,671 0 153,030,671 162,707 974,164 116.00 118.00 NONREI MBURSABLE COST CENTERS 89,179,568 153,030,671 0 153,030,671 162,707 974,164 116.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4,245,599 221,494 4,467,093 0 4,467,093 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.01 07951 JACKSON MOB 0 673,152 673,152 0 673,152 194.01 194.02 07952 EXTERNAL SVCS MARKETI NG 223,971 504,036 728,007 0 728,007 194.02		SPECIAL PURPOSE COST CENTERS							
SUBTOTALS SUBTOTALS <t< td=""><td></td><td></td><td>667 004</td><td></td><td></td><td></td><td></td><td></td></t<>			667 004						
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4, 245, 599 221, 494 4, 467, 093 0 4, 467, 093 192. 00 194. 00 07950 WELLNESS 0 0 0 0 194. 00 194. 01 07951 JACKSON MOB 0 673, 152 0 673, 152 194. 01 194. 02 07952 EXTERNAL SVCS MARKETI NG 223, 971 504, 036 728, 007 0 728, 007 194. 02									
192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 4, 245, 599 221, 494 4, 467, 093 0 4, 467, 093 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00 194.01 07951 JACKSON MOB 0 673, 152 673, 152 0 673, 152 194.01 194.02 07952 EXTERNAL SVCS MARKETING 223, 971 504, 036 728, 007 0 728, 007 194.02	100	NONREI MBURSABLE COST CENTERS							
194. 00 07950 WELLNESS 0 0 0 0 194. 00 194. 01 07951 JACKSON MOB 0 673, 152 673, 152 0 673, 152 194. 01 194. 02 07952 EXTERNAL SVCS MARKETING 223, 971 504, 036 728, 007 0 728, 007 194. 02			-		-	-			
194. 02 07952 EXTERNAL SVCS MARKETI NG 223, 971 504, 036 728, 007 0 728, 007 194. 02	194.0	0 07950 WELLNESS	0	0	0, 107, 073	0			
			0			-			
			223, 971	504, 036	128,007	0	128,007	[194. UZ	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider C		Period:	Worksheet A	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/23/2022 3:0	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 03 07953 WASHI NGTON CLINIC	226, 091	0	226, 091	0	226, 091	194.03
194.04 07954 PHYSICIAN OFFICES	1, 216, 805	181, 491	1, 398, 296	0	1, 398, 296	194.04
194. 05 07955 I NTEGRATED MEDI CI NE	557, 601	209, 630	767, 231	0	767, 231	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0	c c	0 0	0	194.06
194.07 07957 PRI MARY CARE	2, 643, 429	367, 146	3, 010, 575	0	3, 010, 575	194.07
194.0807958 EMPLOYER CLINIC	856, 234	94, 409	950, 643	0	950, 643	194.08
194.0907959 UROLOGY PROF	1,003,744	958, 296	1, 962, 040	0 0	1, 962, 040	194.09
194. 10 07960 SCOTTSBURG SPECIAL	0	3, 016	3, 016	0	3, 016	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0	c c	0 0	0	194.11
194. 12 07962 SPC	1, 673, 055	169, 219	1, 842, 274	0	1, 842, 274	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	638, 923	43, 276	682, 199	0	682, 199	194.13
200.00 TOTAL (SUM OF LINES 118 through 199)	77, 136, 555	92, 604, 733			169, 741, 288	200.00

^{5/23/2022 3:05} pm

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0065	Period: From 01/01/2021	Worksheet A
					To 12/31/2021	
	Cost Center Description	Adjustments	Net Expenses			5/23/2022 3:05
		(See A-8)	For			
		(Allocation			
	GENERAL SERVICE COST CENTERS	6.00	7.00			
00	00100 CAP REL COSTS-BLDG & FIXT	-535, 969	7, 254, 090			
00	00200 CAP REL COSTS-MVBLE EQUIP	0	4, 453, 474			
00	00300 OTHER CAPI TAL RELATED COSTS	0	0			
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,071,782	15, 185, 009			
)0)0	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-6, 624, 633 0	17, 890, 091 4, 376, 118			
00	00800 LAUNDRY & LINEN SERVICE	0	295, 347			
00	00900 HOUSEKEEPI NG	0	1, 418, 675			
	01000 DI ETARY	-30, 853	516, 458			1
		-356, 987	285, 851			1
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	3, 142, 097 1, 405, 689			1
	01500 PHARMACY	-239, 363	3, 113, 772			1
	01600 MEDICAL RECORDS & LIBRARY	-12, 567	1, 209, 499			1
00	01850 PHYSI CI AN PRI VATE PRACTI CE	0	1, 086, 270			1
00	01900 NONPHYSI CI AN ANESTHETI STS	-642, 910	0			1
00	INPATIENT ROUTINE SERVICE COST CENTERS	1 120 004	E 041 000			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 138, 086- 72, 029-	5, 861, 880 2, 744, 814			
	04300 NURSERY	, 2, 02,	1, 337, 199			4
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	-434, 636	6, 168, 292			5
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	710, 295 1, 037, 733			5
	05300 ANESTHESI OLOGY	-3, 465, 783	38, 114			5
	05400 RADI OLOGY-DI AGNOSTI C	0,100,700	1, 839, 249			5
	03630 ULTRA SOUND	-4,060	523, 794			5
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	63, 889			5
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	-20, 595	789, 078 381, 122			5
	06000 LABORATORY	-75, 384	3, 001, 478			6
	06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0	282, 273			e e
00	06400 I NTRAVENOUS THERAPY	0	333, 968			6
	06500 RESPI RATORY THERAPY	0	1, 526, 074			6
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 446, 609 485, 754			6
	06800 SPEECH PATHOLOGY	0	298, 744			6
	06900 ELECTROCARDI OLOGY	-1, 069	197, 907			6
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 643, 779			7
00	07200 IMPLANTABLE DEVICES CHARGED TO	0	4, 382, 648			7
00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	-334	12, 189, 629			7
	03952 WOUND CARE (DI ABETES CENTER)	0	404, 237			// ///////////////////////////////////
01	03953 OTHER ANCILLARY CMS LINE	0	0			7
	03951 CASE MANAGEMENT	0	0			7
	03950 PALN MANAGEMENT 03610 SLEEP LAB	-1,037,105	643, 878			7
	03480 ONCOLOGY	-711, 039	241, 489 1, 861, 252			7
	07697 CARDI AC REHABI LI TATI ON	0	187, 224			7
	OUTPATIENT SERVICE COST CENTERS					
		0	0			9
	09001 PALLIATIVE HEALTH 09002 VEIN CENTER	0 -315, 844	0 92, 499			ç
	09002 VEIN CENTER 09003 OBGYN	-315, 844 -1, 871, 367	92, 499 577, 905			9
	09004 NEUROSURGERY	-899, 023	125, 783			Ģ
05	09005 SURGI CAL ASSOCI ATES	-1, 825, 925	263, 482			ç
	09100 EMERGENCY	-2, 819, 073	3, 254, 729			9
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	-264, 070	471, 542			ç
00	OTHER REIMBURSABLE COST CENTERS	-204,070	471, 342			
1.00	10100 HOME HEALTH AGENCY	0	1, 545, 239			10
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE	0	074 164			11
5.00 3.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 -25, 470, 486	974, 164 127, 560, 185			11
J. UU	NONREIMBURSABLE COST CENTERS	-23, 470, 480	127, 300, 185			
). 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			19
2.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	4, 467, 093			19
	07950 WELLNESS	0	0			19
1 01	07951 JACKSON MOB	0	673, 152			19 19
	07952 EXTERNAL SVCS MARKETING		728, 007			

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2552-	-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC	CN: 15-0065	Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Preparec 5/23/2022 3:05 pm	d:
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
194.0407954 PHYSICIAN OFFICES	0	1, 398, 296			194. (04
194. 05 07955 I NTEGRATED MEDI CI NE	0	767, 231			194. (05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0			194. (06
194. 07 07957 PRI MARY CARE	0	3, 010, 575			194. (07
194.0807958 EMPLOYER CLINIC	0	950, 643			194. (80
194. 09 07959 UROLOGY PROF	0	1, 962, 040			194. (09
194. 10 07960 SCOTTSBURG SPECIAL	0	3, 016			194. 1	10
194. 11 07961 BEHAVI ORAL HEALTH	0	0			194.1	11
194. 12 07962 SPC	0	1, 842, 274			194.1	12
194. 13 07963 PULMONARY PROFESSI ONAL	0	682, 199			194. 1	13
200.00 TOTAL (SUM OF LINES 118 through 199)	-25, 470, 486	144, 270, 802			200. (00

^{5/23/2022 3:05} pm

CLASS	Financial Systems IFICATIONS		SCHNECK MEDIC	Provi der CCN: 15-0065	Period: From 01/01/2021	u of Form CMS-2552- Worksheet A-6
					To 12/31/2021	Date/Time Prepared 5/23/2022 3:05 pm
		Increases				<u>572372022 3.05 pm</u>
	Cost Center	Line #	Salary	Other		
	2.00 A - DEPRECIATION	3.00	4.00	5.00	<u> </u>	
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>4, 390, 5</u> 86		1.0
	TOTALS		0	4, 390, 586		
	B - PROPERTY INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	0	191, 706		1.0
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6 <u>2, 8</u> 88		2.0
	TOTALS C - CAFETERIA		0	254, 594		
	CAFETERIA	11.00	407, 105	235, 733		1.0
	TOTALS		407, 105	235, 733		
	D - BOND INTEREST CAP REL COSTS-BLDG & FIXT	1.00	0	473, 333		1.0
	TOTALS		0	473, 333		1.0
	E – NURSERY					
	NURSERY DELIVERY ROOM & LABOR ROOM	43.00 52.00	1, 086, 047 842, 827	251, 152 194, 906		1.0
00	TOTALS	<u>52.00</u>	1, 928, 874	446, 058		2.0
	F - NONPHYSICIAN ANESTHETIST	 				
	NONPHYSI CLAN ANESTHETI STS		<u>642, 910</u> 642, 910	<u>0</u>		1.0
	G - HOME HEALTH SOCIAL WORKER		572, 710	<u> </u>		
	HOME_HEALTH_AGENCY	101.00	554	<u>0</u>		1. C
	TOTALS H - DRUGS		554	0		
	DRUGS CHARGED TO PATIENTS	73.00	0	12, 189, 963		1.0
00		0.00	0	0		2.0
00 00		0. 00 0. 00	0 0	0		3. C 4. C
00		0.00	0	0		5.0
00		0.00	0	0		6. C
00 00		0.00 0.00	0	0		7.0
00		0.00	0	0		9.0
00		0.00	0	0		10.0
00 00		0. 00 0. 00	0	0		11. C
00		0.00	0	0		13. C
00		0.00	0	0		14.0
00 00		0.00 0.00	0	0		15. C
	TOTALS		<u>0</u>	12, 189, 963		
00	I - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	14 026 427		1.0
	PATIENTS	71.00	U	14, 026, 427		1.0
0		0.00	0	0		2.0
0		0.00 0.00	0 0	0		3. C 4. C
0		0.00	0	0		4. C 5. C
0		0.00	0	0		6. C
0 0		0.00 0.00	0 0	0		7. C 8. C
0		0.00	0	0		9. C
00		0.00	0	0		10.0
00 00		0.00 0.00	0	0		11. C
00		0.00	0	0		13.0
00		0.00	0	0		14. C
00 00		0.00 0.00	0	0 0		15. C
00		0.00	0	0		17.0
00		0.00	0	0		18. C
00 00		0.00 0.00	0	0		19. C 20. C
00		0.00	0	0		20.0
00		0.00	0	0		22.0
00 00		0.00 0.00	0 0	0		23. C 24. C
00		0.00	0	0		24.0
00		0.00	0	0		26. C
00		0. 00 0. 00	0	0		27.0
00 00		0.00	0 0	0		28. C 29. C
00		0.00	0	0		30. C
00		0.00	0	0		31.0

Heal th	Financial Systems		SCHNECK MEDIC	AL CENTER		In Lieu	ı of Form CMS-2552	2-10
RECLASS	SEFECATIONS			Provider C	CN: 15-0065	Peri od:	Worksheet A-6	
						From 01/01/2021 To 12/31/2021	Date/Time Prepare 5/23/2022 3:05 pm	ed:
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
32.00		0.00	0	0			32.	2.00
33.00		0.00	0	0			33.	3.00
34.00		0.00	0	0			34.	4.00
	TOTALS		0	14, 026, 427				
	J - IMPLANTABLE DEVICE							
1.00	IMPLANTABLE DEVICES CHARGED	72.00	0	4, 382, 648			1.	1.00
	TO PATIENTS							
	TOTALS		0	4, 382, 648				
	K - RESPIRATORY THERAPY DIREC	TOR						
1.00	SLEEP LAB	76.04	49, 933	0			1.	1.00
	TOTALS		49, 933	- <u> </u>				
	L - RADIOLOGY DIRECTOR							
1.00	ULTRA SOUND	54.01	24, 469	0			1.	1.00
2.00	NUCLEAR MEDICINE -	54.02	16, 312	0			2.	2.00
	DI AGNOSTI C							
3.00	CT SCAN	57.00	24, 469	0			3.	3.00
4.00	MAGNETIC RESONANCE IMAGING	58.00	24, 469	0			4.	4.00
	(MRI)							
	TOTALS		89, 719	0				
	M - HOSPICE RECLASS							
1.00	HOSPICE	116.00	162, 707	0			1.	1.00
	TOTALS		162, 707	0				
500.00	Grand Total: Increases		3, 281, 802	36, 399, 342			500.). 00

	Financial Systems		SCHNECK MEDIC		CCN: 15-0065	In Lie Period:	u of Form CMS-2552-10 Worksheet A-6
RECENS.				in ovrder v		From 01/01/2021 To 12/31/2021	Date/Time Prepared:
		Decreases					5/23/2022 3:05 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION	1 22					
1.00	CAP_REL_COSTS_BLDG_&_FLXT TOTALS		0	<u>4, 390, 586</u> 4, 390, 586		2	1.00
	B - PROPERTY INSURANCE		ų	4, 370, 380			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	254, 594	1:	2	1.00
2.00		0.00	<u>o</u>	0	1:	2	2.00
	TOTALS		0	254, 594			
1 00	C - CAFETERIA	10.00	407 105	225 722			1.00
1.00	DI ETARY	<u>10.00</u>	40 <u>7, 1</u> 05 407, 105	<u>235, 7</u> 33 235, 733		<u>)</u>	1.00
	D - BOND INTEREST		107,100	200,700			
1.00	INTEREST EXPENSE	113.00	0	473, 333	1	1	1.00
	TOTALS		0	473, 333			
1 00	E - NURSERY	20.00	1 000 074	444 050			1.00
1.00 2.00	ADULTS & PEDIATRICS	30. 00 0. 00	1, 928, 874	446, 058 C			1.00
2.00	TOTALS — — — —		1, 928, 874	446, 058		2	2.00
	F - NONPHYSICIAN ANESTHETIST		., 0, 0, 1				
1.00	ANESTHESIOLOGY	53.00	642, 910	0		2	1.00
	TOTALS		642, 910	0			
1.00	G - HOME HEALTH SOCIAL WORKER NURSING ADMINISTRATION		554	0			1.00
1.00	TOTALS	<u>13.00</u>	<u>554</u>	0		<u>)</u>	1.00
	H - DRUGS		554				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	489	(D	1.00
2.00	PHARMACY	15.00	0	11, 730, 179		o l	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	78, 232	(D D	3.00
4.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00	0	19,001			4.00
5.00 6.00	NUCLEAR MEDICINE -	54.00 54.02	0	21, 168 65, 763			5.00
0.00	DI AGNOSTI C	54. 02	0	05,705			0.00
7.00	CT SCAN	57.00	О	78, 915	(D	7.00
8.00	MAGNETIC RESONANCE I MAGING	58.00	0	30, 268	(C	8.00
0.00	(MRI)	(F. 00	0	2.047			0.00
9.00 10.00	RESPI RATORY THERAPY ELECTROCARDI OLOGY	65.00 69.00	0	2, 967 54, 060			9.00 10.00
11.00	WOUND CARE (DIABETES CENTER)	76.00	0	2, 027			11.00
12.00	PAIN MANAGEMENT	76.03	0	49, 560			12.00
13.00	ONCOLOGY	76.05	0	29	(o	13.00
14.00	OBGYN	90.03	0	46, 860		D D	14.00
15.00 16.00	SURGI CAL ASSOCI ATES EMERGENCY	90.05	0	788 9, 657			15.00 16.00
16.00	TOTALS	<u> </u>	0	<u>9, 657</u> 12, 189, 963			18.00
	I - MEDICAL SUPPLIES		V	12,107,703			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	32, 374	(D	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	921		D C	2.00
3.00	DIETARY	10.00	0	9, 736			3.00
4.00 5.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	5, 996 7, 538, 907			4.00 5.00
6.00	PHARMACY	15.00	0	177, 768			6.00
7.00	ADULTS & PEDIATRICS	30.00	0	649, 067			7.00
8.00	I NTENSI VE CARE UNI T	31.00	0	368, 721		o l	8.00
9.00	OPERATING ROOM	50.00	0	1, 512, 724		D	9.00
10.00	RECOVERY ROOM	51.00	0	66, 117			10.00
11.00 12.00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	0	30 20, 730			11.00
12.00	ULTRA SOUND	54.00	0	53, 293			13.00
14.00	NUCLEAR MEDICINE -	54.02	o	634			14.00
	DI AGNOSTI C						
15.00	CT SCAN	57.00	0	102, 729			15.00
16.00	MAGNETIC RESONANCE I MAGING	58.00	0	12, 259	(16.00
				2 500 442			17.00
17,00	(MRI)	60 00	0	2.009.407			
17.00 18.00		60.00 64.00	0 0	2, 509, 462 123, 757			18.00
	(MRI) LABORATORY				(b	18.00 19.00
18.00 19.00 20.00	(MRI) LABORATORY I NTRAVENOUS THERAPY RESPI RATORY THERAPY PHYSI CAL THERAPY	64.00 65.00 66.00	0 0 0	123, 757 246, 633 6, 677			18.00 19.00 20.00
18.00 19.00 20.00 21.00	(MRI) LABORATORY I NTRAVENOUS THERAPY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	64.00 65.00 66.00 67.00	0 0 0 0	123, 757 246, 633 6, 677 28, 160		D D D	18.00 19.00 20.00 21.00
18.00 19.00 20.00 21.00 22.00	(MRI) LABORATORY INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	64.00 65.00 66.00 67.00 68.00	0 0 0 0	123, 757 246, 633 6, 677 28, 160 1, 471			18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00 23.00	(MRI) LABORATORY INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY	64.00 65.00 66.00 67.00 68.00 69.00	0 0 0 0	123, 757 246, 633 6, 677 28, 160 1, 471 1, 535		D D D	18.00 19.00 20.00 21.00 22.00 23.00
18.00 19.00 20.00 21.00 22.00 23.00	(MRI) LABORATORY INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	64.00 65.00 66.00 67.00 68.00	0 0 0 0	123, 757 246, 633 6, 677 28, 160 1, 471			18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00	(MRI) LABORATORY INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY WOUND CARE (DIABETES CENTER) PAIN MANAGEMENT SLEEP LAB	64.00 65.00 66.00 67.00 68.00 69.00 76.00 76.03 76.04	0 0 0 0 0 0	123, 757 246, 633 6, 677 28, 160 1, 471 1, 535 36, 713			18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00
$\begin{array}{c} 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00 \end{array}$	(MRI) LABORATORY INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY WOUND CARE (DIABETES CENTER) PAIN MANAGEMENT	64.00 65.00 66.00 67.00 68.00 69.00 76.00 76.03		123, 757 246, 633 6, 677 28, 160 1, 471 1, 535 36, 713 17, 508			18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00

Heal th	Financial Systems		SCHNECK MEDIC	CAL CENTER		In Lieu	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-0065	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/23/2022 3:	epared: 05 pm
		Decreases						
	Cost Center	Line #	Sal ary		Wkst. A-7 Ref	· .		
	6. 00	7.00	8.00	9.00	10.00			
29.00	VEIN CENTER	90.02	0	132, 846		0		29.00
30.00	OBGYN	90. 03	0	202, 509		0		30.00
31.00	NEUROSURGERY	90.04	0	52		0		31.00
32.00	SURGI CAL ASSOCI ATES	90.05	0	6, 901		0		32.00
33.00	EMERGENCY	91.00	0	58, 553		0		33.00
34.00	BEHAVIORAL HEALTH	93.00	0	162		0		34.00
	TOTALS		0	14, 026, 427				
	J – IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	4, 382, 648		0		1.00
	PATI ENTS							
	TOTALS		0	4, 382, 648				
	K - RESPIRATORY THERAPY DIRE	CTOR						
1.00	RESPI RATORY_THERAPY	65.00	49, 933	0		0		1.00
	TOTALS		49, 933	0				
	L – RADI OLOGY DI RECTOR							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	89, 719	0		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00		0.00	0	0		0		4.00
	TOTALS		89, 719	0				
	M - HOSPICE RECLASS							
1.00	HOME_HEALTH_AGENCY	101.00	162, 707	0		0		1.00
	TOTALS		162, 707	0				
500.00	Grand Total: Decreases		3, 281, 802	36, 399, 342				500.00

	Financial Systems	SCHNECK MEDI					u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Fro To	riod: om 01/01/2021 12/31/2021		pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	10, 895, 446	26, 991		0	26, 991	0	1.00
2.00	Land Improvements	4, 802, 649	51, 299		0	51, 299	0	2.00
3.00	Buildings and Fixtures	145, 030, 178	7, 717, 961		0	7, 717, 961	0	3.00
4.00	Building Improvements	4, 709, 833	590, 654		0	590, 654	0	4.00
5.00	Fixed Equipment	7, 632, 223	465, 938		0	465, 938	0	5.00
6.00	Movable Equipment	55, 036, 237	6, 140, 752		0	6, 140, 752	0	6.00
7.00	HIT designated Assets	4, 279, 599	288, 300		0	288, 300	0	7.00
8.00	Subtotal (sum of lines 1-7)	232, 386, 165	15, 281, 895		0	15, 281, 895	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	232, 386, 165	15, 281, 895		0	15, 281, 895	0	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	10, 922, 437	0					1.00
2.00	Land Improvements	4, 853, 948	0					2.00
3.00	Buildings and Fixtures	152, 748, 139	0					3.00
4.00	Building Improvements	5, 300, 487	0					4.00
5.00	Fixed Equipment	8, 098, 161	0					5.00
6.00	Movable Equipment	61, 176, 989	0					6.00
7.00	HIT designated Assets	4, 567, 899	0					7.00
8.00	Subtotal (sum of lines 1-7)	247, 668, 060	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00		247, 668, 060	0					10.00

^{5/23/2022 3:05} pm

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Pre 5/23/2022 3:0	pared:
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	1		
1.00	CAP REL COSTS-BLDG & FIXT	11, 515, 606	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	11, 515, 606	0		0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	<u>WN 2, LINES 1 a</u>	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	11, 515, 606				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	11, 515, 606				3.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021		
	COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	186, 491, 071 61, 176, 989 247, 668, 060	0	186, 491, 071 61, 176, 989 247, 668, 060	0. 247012 1. 000000	0 0	1.00 2.00 3.00
Cost Center Description	Taxes	TION OF OTHER (Other Capital-Relat	Total (sum of		F CAPI TAL	
	6. 00	ed Costs 7.00	through 7) 8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	-				
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		7, 125, 020 4, 390, 586 11, 515, 606	0	1.00 2.00 3.00
			JMMARY OF CAPI		11,070	0.00
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	ENTERS 11, 954 0			0 0 0 0	7, 254, 090 4, 453, 474	1.00 2.00
3.00 Total (sum of lines 1-2)	11, 954	254, 594	(0 0	11, 707, 564	3.00

^{5/23/2022 3:05} pm

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0065	Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre 5/23/2022 3:0	pared: 5 pm
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1.00	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-461, 379	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
	discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	В	-82, 690,	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by	В	-74, 590	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	suppliers (chapter 8) Telephone services (pay	A	-8, 822	ADMINISTRATIVE & GENERAL	5.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		o		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-13, 230, 410			0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	0			0	12.00
	transactions (chapter 10)	A-0-1	U				
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -356, 685	CAFETERI A	0.00		13.00 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 patients						
17.00	Sale of drugs to other than	В	-334	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	patients Sale of medical records and	В	-12, 567	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
17.00	education (tuition, fees,		Ū		0.00		17.00
20.00	books, etc.) Vendi ng machi nes	В	- 302	CAFETERI A	11.00	0	20.00
	Income from imposition of interest, finance or penalty		0		0.00		
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
22.00	repay Medicare overpayments				(F. 00		23.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
21.00	therapy costs in excess of				00.00		21.00
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP	А		NONPHYSI CI AN ANESTHETI STS	19.00		28.00
28.00 29.00	Non-physician Anesthetist Physicians' assistant		-042, 910	NOW THEFT AN AMENTETISTS	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
20.00	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0.	ADULTS & PEDIATRICS	30.00		30. 99

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS T	TO F	XPENSES

DJUSTMENTS TO EXPENSES			Provider CCN: 15-0065 Pe	eri od:	Worksheet A-8	<u>2552-</u> }
			F	rom 01/01/2021		
			Te	5 12/31/2021	Date/Time Pre 5/23/2022 3:0	
			Expense Classification on	Worksheet A		-
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
_	(2)				Ref.	
	1.00	2.00	3.00	4.00	5.00	21
1.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
limitation (chapter 14)						
2.00 CAH HIT Adjustment for		0		0.00	0	32.
Depreciation and Interest		-			-	
3. 00 HOSPITAL ASSESSMENT FEE	A	-4, 182, 798	ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 01 ADMIN AND GENERAL MARKETING	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	
. 02 ADULTS AND PEDS MARKETING	A		ADULTS & PEDIATRICS	30.00	0	
. 03 PHYSICAL THERAPY MARKETING	A		PHYSI CAL THERAPY	66.00	0	
. 04 OB/GYN MARKETING	A		OBGYN	90.03	0	
. 05 EMERGENCY ROOM MARKETING	A		EMERGENCY	91.00	0	
. 06 PHYSI CAN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00	0	
. 07 MISC INCOME - DIETERY . 08 340B RETAIL PHARMACY EXP	B			10.00	0	
. 08 340B RETAIL PHARMACY EXP . 09 MISC INCOME - ADMIN & GENERAL	B		PHARMACY ADMI NI STRATI VE & GENERAL	15.00 5.00	0	
. 10 LOBBYING DUES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 11 TELEPHONE OPERATOR BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
. 12 CRNA OFFSET - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
. 13 APRN OFFSET	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 14 APRN OFFSET	А	-339, 738	ADULTS & PEDIATRICS	30.00	0	33
. 15 APRN OFFSET	A	-934	INTENSIVE CARE UNIT	31.00	0	33
. 16 APRN OFFSET	A		OPERATING ROOM	50.00	0	
. 17 APRN OFFSET	A		PAIN MANAGEMENT	76.03	0	
. 18 APRN OFFSET	A	-123, 055		90.03	0	
. 19 APRN OFFSET	A			90.04	0	
20 APRN OFFSET	A		SURGI CAL ASSOCI ATES	90.05	0	
21 APRN OFFSET	A			91.00	0	
. 22 APRN OFFSET . 23 APRN OFFSET - BENEFITS	A A		BEHAVIORAL HEALTH EMPLOYEE BENEFITS DEPARTMENT	93.00 4.00	0	
. 24 PA - OFFSET	A		EMERGENCY	4.00 91.00	0	
. 25 PA - OFFSET	A		INTENSIVE CARE UNIT	31.00	0	
. 26 PA - OFFSET	A		NEUROSURGERY	90.04	0	
. 27 PA BENEFITS OFFSET	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
. 28 EMPLOYEE PHARMACY OFFSET	В		PHARMACY	15.00	0	1 00
. 29 PHYSICIAN BENEFITS OFFSET	Ā		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
0.00 TOTAL (sum of lines 1 thru 49)		-25, 470, 486				50
(Transfer to Worksheet A,						
column 6, line 200.)						

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

Heal th	Financial Syste	ems	SCHNECK MEDICAL CENTER			In Lieu of Form CMS-2552-10			
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	-2	
						From 01/01/2021 To 12/31/2021		nared	
						10 12/31/2021	5/23/2022 3:0		
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov		
		Identifier	Remunerati on	Component	Component		ider Component		
							Hours		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	379	379	(211, 500		1.00	
2.00		ADMI NI STRATI VE & GENERAL	80, 221	0	80, 22			2.00	
3.00		NURSING ADMINISTRATION	0	0	(211, 500		3.00	
4.00		ADULTS & PEDIATRICS	787, 594		111, 300			4.00	
5.00		INTENSIVE CARE UNIT	69, 167	69, 167	(211, 500		5.00	
6.00		OPERATING ROOM	432, 900	432, 900	(246, 400	0	6.00	
7.00	53.00	ANESTHESI OLOGY	3, 465, 783	3, 465, 783	(239, 400	0	7.00	
8.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(271, 900	0	8.00	
9.00	54.01	ULTRA SOUND	4,060	4, 060	(271, 900	0	9.00	
10.00	57.00	CT SCAN	20, 595	20, 595	(271, 900	0	10.00	
11.00	60.00	LABORATORY	315, 661	0	315, 661	260, 300	1, 920	11.00	
12.00	65.00	RESPI RATORY THERAPY	0	0	(211, 500	0	12.00	
13.00	69.00	ELECTROCARDI OLOGY	9, 000	0	9,000	211, 500	78	13.00	
14.00	76.03	PAIN MANAGEMENT	777, 005	762, 005	15,000	211, 500	138	14.00	
15.00	76.04	SLEEP LAB	0	0	(211, 500	0	15.00	
16.00	76.05	ONCOLOGY	881, 459	528, 876	352, 583	3 211, 500	1, 676	16.00	
17.00	90.01	PALLIATIVE HEALTH	0	0	(211, 500	0	17.00	
18.00	90.02	VEIN CENTER	315, 844	315, 844	(211, 500	0	18.00	
19.00	90.03	OBGYN	1, 763, 362	1, 748, 362	15,000	237, 100	138	19.00	
20.00	90.04	NEUROSURGERY	685, 227	685, 227	(211, 500	0	20.00	
21.00	90.05	SURGI CAL ASSOCI ATES	1, 745, 888	1, 730, 888	15,000	211, 500	138	21.00	
22.00	91.00	EMERGENCY	2, 217, 232	2, 197, 232	20, 000	211, 500	520	22.00	
23.00	93.00	BEHAVI ORAL HEALTH	182, 008	182, 008	(181, 300	0	23.00	
200.00			13, 753, 385	12, 819, 620	933, 765	5	5, 014	200.00	

^{5/23/2022 3:05} pm

Heal th	Financial Syst	ems	SCHNECK MED	ICAL CENTER		In Li€	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	-2
						From 01/01/2021 To 12/31/2021		pared:
	-						5/23/2022 3:0	
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	9,00	Education	12 13.00	14.00	
1.00	1.00	EMPLOYEE BENEFITS DEPARTMENT	8.00	9.00	12.00	13.00	14.00	1.00
2.00		ADMINISTRATIVE & GENERAL	39, 656	1, 983		0	0	1.00 2.00
2.00		NURSING ADMINISTRATION	39,000	1, 983		0	0	2.00
3.00 4.00		ADULTS & PEDIATRICS	1, 627	81		0	0	3.00 4.00
4.00 5.00		INTENSIVE CARE UNIT	1, 027	01		0	0	4.00 5.00
6.00		OPERATING ROOM		0		0	0	6.00
7.00		ANESTHESI OLOGY				0	0	7.00
8.00		RADI OLOGY-DI AGNOSTI C				0	0	8.00
9,00		ULTRA SOUND		0		0	0	9.00
10.00		CT SCAN	0	0	0	0	0	10.00
11.00		LABORATORY	240, 277	12, 014		0	0	11.00
12.00		RESPI RATORY THERAPY	0	0	0	0	0	12.00
13.00		ELECTROCARDI OLOGY	7, 931	397	C C	0	0	13.00
14.00		PAIN MANAGEMENT	14, 032	702	C	0	0	14.00
15.00	76.04	SLEEP LAB	0	0	C	0	0	15.00
16.00	76.05	ONCOLOGY	170, 420	8, 521	C	0	0	16.00
17.00	90.01	PALLIATIVE HEALTH	0	0	C	0	0	17.00
18.00	90.02	VEIN CENTER	0	0	C	0	0	18.00
19.00	90.03	OBGYN	15, 731	787	C	0	0	19.00
20.00	90.04	NEUROSURGERY	0	0	C	0	0	20.00
21.00	90.05	SURGI CAL ASSOCI ATES	14, 032	702	C	0	0	21.00
22.00		EMERGENCY	52, 875	2, 644	C	0	0	22.00
23.00		BEHAVI ORAL HEALTH	0	0	C	0	0	23.00
200.00			556, 581	27, 831	C	0	0	200.00

^{5/23/2022 3:05} pm

Heal th	Financial Syst	ems	SCHNECK MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-0065	Peri od:	Worksheet A-8	-2
						From 01/01/2021 To 12/31/2021		
	Wkst. A Line #	Cost Contor (Dhusi si an	Provi der	Adjusted DCE	RCE	Adjustment	5/23/2022 3:0	15 pm
	WKSL A LINE #	Cost Center/Physician Identifier	Component	Adjusted RCE Limit	Di sal Lowance	Adj ustment		
		ruentirrei	Share of col.		Disarrowance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0		379		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	39, 656	40, 56	5 40, 565		2.00
3.00		NURSING ADMINISTRATION	0	0		0 0		3.00
4.00		ADULTS & PEDIATRICS	0	1, 627	109, 67			4.00
5.00		INTENSIVE CARE UNIT	0	0		0 69, 167		5.00
6.00		OPERATING ROOM	0	0		0 432, 900		6.00
7.00		ANESTHESI OLOGY	0	0		3, 465, 783		7.00
8.00		RADI OLOGY-DI AGNOSTI C	0	0		0 0		8.00
9.00		ULTRA SOUND	0	0		0 4,060		9.00
10.00		CT SCAN	0	0		20, 595		10.00
11.00		LABORATORY	0	240, 277	75, 38	4 75, 384		11.00
12.00		RESPI RATORY THERAPY	0	0		0 0		12.00
13.00		ELECTROCARDI OLOGY	0	7, 931	1, 06			13.00
14.00		PAIN MANAGEMENT	0	14, 032	96	8 762, 973		14.00
15.00		SLEEP LAB	0	0		0 0		15.00
16.00		ONCOLOGY	0	170, 420	182, 16	3 711, 039		16.00
17.00		PALLIATIVE HEALTH	0	0		0 0		17.00
18.00		VEIN CENTER	0	0		0 315,844		18.00
19.00		OBGYN	0	15, 731		0 1, 748, 362		19.00
20.00		NEUROSURGERY	0	0		0 685, 227		20.00
21.00		SURGI CAL ASSOCI ATES	0	14,032				21.00
22.00		EMERGENCY	0	52, 875		2, 197, 232		22.00
23.00		BEHAVI ORAL HEALTH	0		410 70	0 182,008		23.00
200.00	1		1 0	556, 581	410, 79	0 13, 230, 410		200.00

^{5/23/2022 3:05} pm

IST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/23/2022 3:0	
			CAPI TAL REL	ATED COSTS		0,20,2022 0.0	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
~~	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	7 054 000	7 05 4 000		1		1
00 00	00200 CAP REL COSTS-BLDG & FIXT	7, 254, 090 4, 453, 474		4, 453, 474			1. 2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 185, 009		, 433, 474 0			4.
00	00500 ADMI NI STRATI VE & GENERAL	17, 890, 091		1, 171, 543		22, 404, 223	5.
00	00700 OPERATION OF PLANT	4, 376, 118		402, 993		5, 576, 765	
00	00800 LAUNDRY & LINEN SERVICE	295, 347			,	331, 617	
00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 418, 675 516, 458		15, 078 29, 548		1, 761, 578 707, 750	
	01100 CAFETERI A	285, 851				475, 822	
	01300 NURSI NG ADMI NI STRATI ON	3, 142, 097		7, 333		4,064,668	
	01400 CENTRAL SERVICES & SUPPLY	1, 405, 689	162, 814	71, 827		1, 926, 823	14.
	01500 PHARMACY	3, 113, 772		83, 187		3, 736, 760	
	01600 MEDI CAL RECORDS & LI BRARY 01850 PHYSI CI AN PRI VATE PRACTI CE	1, 209, 499		1, 455		1, 512, 759 1, 346, 593	
	01900 NONPHYSICIAN ANESTHETISTS	1, 086, 270 0				1, 346, 593	
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	17.
. 00	03000 ADULTS & PEDI ATRI CS	5, 861, 880	746, 081	212, 425	1, 078, 106	7, 898, 492	30.
	03100 I NTENSI VE CARE UNI T	2, 744, 814					
. 00	04300 NURSERY	1, 337, 199	36, 280	C	309, 326	1, 682, 805	43.
. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	6, 168, 292	607, 997	683, 260	1, 086, 795	8, 546, 344	50.
	05100 RECOVERY ROOM	710, 295		411		985, 421	
	05200 DELIVERY ROOM & LABOR ROOM	1,037,733		C		1, 524, 310	
. 00	05300 ANESTHESI OLOGY	38, 114		50, 860		90, 605	
	05400 RADI OLOGY-DI AGNOSTI C	1, 839, 249		511, 229		2, 922, 939	
	03630 ULTRA SOUND	523, 794		32, 948		712, 513	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	63, 889		58, 320			
	05800 MAGNETIC RESONANCE IMAGING (MRI)	789, 078 381, 122		160, 409 219, 173		1, 066, 687 687, 577	
. 00	06000 LABORATORY	3, 001, 478		150, 625			
. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	282, 273		C		292, 268	
. 00	06400 I NTRAVENOUS THERAPY	333, 968		4, 990		510, 691	
. 00	06500 RESPIRATORY THERAPY	1, 526, 074		62, 161		1, 997, 813	
. 00 . 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 446, 609 485, 754		10, 407 1, 232		2, 103, 647 623, 951	
. 00	06800 SPEECH PATHOLOGY	298, 744		1, 232		390, 096	
	06900 ELECTROCARDI OLOGY	197, 907		84, 681		322, 977	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 643, 779	3, 907	C		9, 647, 686	71.
. 00	07200 IMPLANTABLE DEVICES CHARGED TO	4, 382, 648	0	C	0	4, 382, 648	72.
. 00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	12 100 (20	0			10 100 600	172
	03952 WOUND CARE (DIABETES CENTER)	12, 189, 629 404, 237		2, 762	0 104, 864	12, 189, 629 551, 348	
	03953 OTHER ANCI LLARY CMS LINE	0		2, 702	0	0	
. 02	03951 CASE MANAGEMENT	0	0	C	0	0	
	03950 PALN MANAGEMENT	643, 878		5, 735		932, 391	
	03610 SLEEP LAB	241, 489			07,222	316, 661	
	03480 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON	1, 861, 252 187, 224				2, 590, 124 289, 889	
. 7/	OUTPATIENT SERVICE COST CENTERS	107,224	41,742	8, 286	52, 637	209,009	1 '0.
. 00	09000 CLINIC	0	0	C	0	0	90.
	09001 PALLI ATI VE HEALTH	0	0	C	0	0	
	09002 VEIN CENTER	92, 499		3, 574		122, 257	
		577, 905				913, 873	
	09004 NEUROSURGERY 09005 SURGI CAL ASSOCI ATES	125, 783 263, 482		0 502		161, 608 465, 777	
	09100 EMERGENCY	3, 254, 729		48, 245		4, 340, 476	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			, 210	,.,.,	0	
	04952 BEHAVI ORAL HEALTH	471, 542	31, 349	0	133, 996	636, 887	
1. 00	OTHER REI MBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 545, 239	29, 946	522	451, 087	2, 026, 794	101.
3 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113
	11600 HOSPI CE	974, 164	29, 946	C	189, 687	1, 193, 797	
8.00		127, 560, 185					
	NONREIMBURSABLE COST CENTERS						1 .
0 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 4, 467, 093		C 1, 988			190.
			433, 804				

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part I Date/Time Pre 5/23/2022 3:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
194.0107951 JACKSON MOB	673, 152	0	(0 0	673, 152	194.01
194.0207952 EXTERNAL SVCS MARKETING	728, 007	36, 602	5, 018	63, 791	833, 418	194.02
194. 03 07953 WASHI NGTON CLINIC	226, 091	80, 051	(0 64, 395	370, 537	194.03
194. 04 07954 PHYSI CLAN OFFICES	1, 398, 296	86, 613	1, 619	9 89, 376	1, 575, 904	194.04
194. 05 07955 I NTEGRATED MEDI CI NE	767, 231	68, 274	(129, 875	965, 380	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0	(0 0	0	194.06
194. 07 07957 PRI MARY CARE	3, 010, 575	380, 475	34, 533	3 267, 978	3, 693, 561	194.07
194.0807958 EMPLOYER CLINIC	950, 643	136, 642	3, 768	3 198, 425	1, 289, 478	194.08
194.0907959 UROLOGY PROF	1, 962, 040	155, 550	7, 61	1 95, 615	2, 220, 816	194.09
194. 10 07960 SCOTTSBURG SPECIAL	3, 016	0	3, 939	9 0	6, 955	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0	(0 0	0	194.11
194. 12 07962 SPC	1, 842, 274	0	3, 355	5 153, 946	1, 999, 575	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	682, 199		1, 352	45, 751	767, 990	194.13
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)	144, 270, 802	7, 254, 090	4, 453, 474	4 15, 259, 086	144, 270, 802	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS Cost Center Description	SCHNECK MEDI	OPERATION OF	F	eri od: rom 01/01/2021 o 12/31/2021 HOUSEKEEPI NG	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/23/2022 3:0 DI ETARY	epared:
		E & GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	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	00.404.000					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	22, 404, 223 1, 158, 640	6, 735, 405				5.00
8.00	00800 LAUNDRY & LINEN SERVICE	68, 897	26, 053				8.00
9.00	00900 HOUSEKEEPI NG	365, 989	39, 991				9.00
10.00	01000 DI ETARY	147, 044	68, 654			945, 785	
11.00		98, 858	80, 831			0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	844, 484 400, 321	219, 153 177, 795			0	
15.00	01500 PHARMACY	776, 357	80, 106			0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	314, 294	27, 379			0	
18.00	01850 PHYSICIAN PRIVATE PRACTICE	279, 771	0			0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1, 641, 006	014 724	222.202	245 090	(EQ_0E7	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	792, 573	814, 734 413, 868				
43.00	04300 NURSERY	349, 623	39, 618			203, 720	
	ANCILLARY SERVICE COST CENTERS	, , ,					
50.00	05000 OPERATING ROOM	1, 775, 606	663, 941			0	
51.00	05100 RECOVERY ROOM	204, 733	104, 937			0	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	316, 694 18, 824	269, 209 1, 781	3, 470		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	607, 276	232, 967	-		0	
54.00	03630 ULTRA SOUND	148,033	232, 707			0	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	28, 137	9, 361	0		0	
57.00	05700 CT SCAN	221, 617	25, 473			0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	142, 852	17, 956			0	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	768, 265 60, 722	117, 239 10, 914			0	
64.00	06400 I NTRAVENOUS THERAPY	106, 102	84, 828			0	
65.00	06500 RESPI RATORY THERAPY	415,070	69, 171	0		0	
66.00	06600 PHYSI CAL THERAPY	437, 058	259, 330	20, 964		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	129, 633	0	-		0	
68.00	06800 SPEECH PATHOLOGY	81,047	8, 160			0	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 102 0	6, 855 4, 266			0	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	4,200			0	
	PATIENTS			_	_		
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 532, 489	0	-		0	
76.00	03952 WOUND CARE (DI ABETES CENTER)	114, 549	43, 118			0	
	03953 OTHER ANCILLARY CMS LINE 03951 CASE MANAGEMENT	0	0	0		0	
76.02	03950 PALN MANAGEMENT	193, 715	152, 094			0	
76.04	03610 SLEEP LAB	65, 790	17, 417			0	
76.05	03480 ONCOLOGY	538, 129	303, 753				
76.97	07697 CARDI AC REHABI LI TATI ON	60, 228	45, 583	0	14, 831	0	76.97
90.00	OUTPATI ENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.00	09001 PALLIATIVE HEALTH	0	0	0		0	
90.02	09002 VEIN CENTER	25, 400	0	0	0	0	
90.03	09003 OBGYN	189, 868	171, 686	0	55, 860	0	90.03
90.04	09004 NEUROSURGERY	33, 576	0	0	0	0	
90.05	09005 SURGI CAL ASSOCI ATES	96, 771	144, 079		46, 878	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	901, 786	314, 833	37, 740	102, 434	0	91.00
	04952 BEHAVI ORAL HEALTH	132, 321	34, 234	0	11, 138	0	
	OTHER REIMBURSABLE COST CENTERS			-			
101.00	10100 HOME HEALTH AGENCY	421, 091	32, 701	0	10, 640	0	101.00
110.00	SPECIAL PURPOSE COST CENTERS	1 1					1110 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	248, 026	32, 701	0	10, 640	0	113.00
118.00		18, 320, 367	5, 188, 349				
	NONREI MBURSABLE COST CENTERS		-,,		.,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 092, 754	473, 720				192.00
	07950 WELLNESS 07951 JACKSON MOB	120 055	0	0	0		194.00 194.01
	207951 JACKSON MOB	139, 855 173, 153	0 39, 970		13, 005		194.01
	07953 WASHINGTON CLINIC	76, 984	87, 417		28, 442		194.02
194.04	07954 PHYSICIAN OFFICES	327, 413	94, 583	0	30, 773		194.04 194.05

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2021	Worksheet B	
				To 12/31/2021	Part Date/Time Pre	pared:
					5/23/2022 3:0	<u>5 pm</u>
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0		0 C	0	194.06
194. 07 07957 PRI MARY CARE	767, 382	415, 484		0 135, 182	0	194.07
194.0807958 EMPLOYER CLINIC	267, 905	149, 215		D 48, 549	0	194.08
194. 09 07959 UROLOGY PROF	461, 401	169, 863		55, 267	0	194.09
194. 10 07960 SCOTTSBURG SPECIAL	1, 445	0		0 0	0	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0		0 0	0	194.11
194. 12 07962 SPC	415, 436	0		0 0	0	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	159, 559	42, 248		0 13, 746	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	22, 404, 223	6, 735, 405	426, 56	7 2, 169, 944	945, 785	202.00

^{5/23/2022 3:05} pm

	Financial Systems LOCATION - GENERAL SERVICE COSTS	SCHNECK MEDI	CAL CENTER Provider CC		eriod: com 01/01/2021	u of Form CMS-2 Worksheet B Part I Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	5/23/2022 3: 0 MEDI CAL RECORDS &	5 pm
		11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
G	ENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
$\begin{array}{c ccccc} 1 & 0 & 0 & 0 \\ 2 & 0 & 0 & 0 \\ 4 & 0 & 0 & 0 \\ 5 & 0 & 0 & 0 \\ 7 & 0 & 0 & 0 \\ 8 & 0 & 0 & 0 \\ 9 & 0 & 0 & 0 \\ 10 & 0 & 0 & 0 \\ 11 & 0 & 0 & 0 \\ 11 & 0 & 0 & 0 \\ 13 & 0 & 0 & 0 \\ 14 & 0 & 0 & 0 \\ 15 & 0 & 0 & 0 \\ 16 & 0 & 0 & 0 \\ 19 & 0 & 0 & 0 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY 011000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 014400 CENTRAL SERVICES & SUPPLY 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01850 PHYSI CI AN PRIVATE PRACTI CE 11900 NONPHYSI CI AN ANESTHETI STS NPATI ENT ROUTI NE SERVICE COST CENTERS	681, 810 32, 579 21, 397 19, 172 21, 375 11, 612 0	5, 232, 188 308, 259 276, 201 0 0 0	2, 892, 442 72, 438 23, 487 3, 626 0	4, 987, 097 0 0 0	1, 908, 202 0 0	18.00
	3000 ADULTS & PEDIATRICS	69, 180	996, 560	200, 731	0	86, 878	30.00
1	03100 I NTENSI VE CARE UNI T	36, 426	524, 766	33, 927	0	53, 128	•
	14300 NURSERY	14, 912	214, 826	0	0	35, 722	43.00
$\begin{array}{c cccccc} & & & & & \\ \hline & & & \\ 50, & 00 & & \\ 51, & 00 & & \\ 0, & 51, & 00 & & \\ 52, & 00 & & 0 & \\ 53, & 00 & & 0 & \\ 54, & 01 & & 0 & \\ 54, & 02 & & 0 & \\ 57, & 00 & & 0 & \\ 54, & 02 & & 0 & \\ 57, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 54, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 64, & 00 & & 0 & \\ 71, & 00 & & 0 & \\ 71, & 00 & & 0 & \\ 71, & 00 & & 0 & \\ 73, & 00 & & 0 & \\ 73, & 00 & & 0 & \\ 74, & 00 & & 0 & \\ 76, & 01 & & 0 & \\ 76, & 03 & & 0 & \\ 76, & 04 & & 0 & \\ 76, & 05 & & 0 & \\ \end{array}$	INCI LLARY SERVICE COST CENTERS J5000 OPERATI NG ROOM J5100 RECOVERY ROOM J5200 DELI VERY ROOM & LABOR ROOM J5200 DELI VERY ROOM & LABOR ROOM J5200 ANESTHESI OLOGY J5400 RADI OLOGY-DI AGNOSTI C J3630 ULTRA SOUND J3450 NUCLEAR MEDI CI NE - DI AGNOSTI C J5700 CT SCAN J5800 MAGNETI C RESONANCE I MAGI NG (MRI) J6600 LABORATORY J6600 LABORATORY J6600 INTRAVENOUS THERAPY J6600 PHYSI CAL THERAPY J6600 OCUPATI ONAL THERAPY J6600 DEECH PATHOLOGY J6800 SPEECH PATHOLOGY J7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS J7200 I MPLANTABLE DEVICES CHARGED TO PATI ENTS J7300 DRUGS CHARGED TO PATI ENTS J3952 WOUND CARE (DI ABETES CENTER) J3951 CASE MANAGEMENT J3950 PAI N MANAGEMENT J3480 ONCOLOGY J7697 CARDI AC REHABI LI TATI ON	57, 017 7, 924 11, 573 9, 881 21, 824 6, 047 124 4, 794 3, 821 33, 811 0 4, 488 16, 721 24, 599 5, 930 3, 399 1, 648 0 0 5, 776 0 0 11, 988 2, 298 16, 454 2, 994	821, 398 0 166, 719 0 314, 409 0 0 487, 084 0 0 487, 084 0 0 354, 382 0 0 23, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	374, 664 15, 391 0 156 72, 644 2, 603 94 11, 204 2, 014 81, 170 0 10, 179 33, 063 10, 149 2, 975 3, 109 6, 676 0 0 2, 684 0 0 0 10, 729 0 38, 933 4, 445	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	613, 600 45, 715 50, 393 37, 309 60, 296 25, 421 8, 752 126, 862 39, 999 133, 311 3, 120 13, 693 42, 785 35, 146 15, 619 7, 534 28, 599 38, 843 34, 745	50.00 51.00 52.00 53.00 54.01 54.02 57.00 58.00 60.00 63.00 64.00 65.00 66.00 67.00 68.00 67.00 68.00 71.00 72.00 73.00 76.01 76.01 76.03 76.04 76.05
0	UTPATIENT SERVICE COST CENTERS	_,	-	.,			
90.01 0 90.02 0 90.03 0 90.04 0 90.05 0 91.00 0 92.00 0 93.00 0	99000 CLINIC 99001 PALLIATIVE HEALTH 99002 VEIN CENTER 99003 OBGYN 99004 NEUROSURGERY 99005 SURGICAL ASSOCIATES 99100 EMERGENCY 99100 OBSERVATION BEDS (NON-DISTINCT PART) 94952 BEHAVIORAL HEALTH THER REIMBURSABLE COST CENTERS	0 2, 996 16, 314 4, 406 9, 590 51, 633 5, 222	0	0 0 1, 578 46, 282 967 3, 801 58, 358 2, 817	0 0 0 0 0 0 0	0 0 6,918 5,671 2,086 1,985 94,213 1,545	90. 03 90. 04 90. 05
	0100 HOME HEALTH AGENCY	0	0	33, 591	0	12, 111	101.00
<u>S</u> 113.001 116.001	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE 1600 HOSPICE	0	0	24, 667	0	12, 273	113. 00 116. 00
118.00 N	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	569, 526	5, 232, 188	1, 189, 152	4, 987, 097	1, 908, 202	118.00
190. 00 1 192. 00 1 194. 00 0 194. 01 0 194. 02 0 194. 03 0	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CIANS' PRI VATE OFFICES 97950 WELLNESS 97951 JACKSON MOB 97952 EXTERNAL SVCS MARKETING 97953 WASHINGTON CLINIC 97954 PHYSICIAN OFFICES	0 38, 697 0 3, 182 6, 294 11, 677	0 0 0 0 0 0	0 387, 274 0 23, 498 0 95, 708	0 0 0 0 0 0 0	0 0 0 0 0	190.00 192.00 194.00 194.01 194.02 194.03 194.03

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	pared [.]
				10 12/01/2021	5/23/2022 3:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O			RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194. 05 07955 I NTEGRATED MEDI CI NE	4, 339	0	561, 49	2 0	0	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0		0 0	0	194.06
194. 07 07957 PRI MARY CARE	0	0	260, 40	0 C	0	194.07
194.0807958 EMPLOYER CLINIC	12, 490	0	118, 76	9 0	0	194.08
194.0907959UROLOGY PROF	12, 639	0	98, 87	2 0	0	194.09
194. 10 07960 SCOTTSBURG SPECIAL	0	0	2,65	0 0	0	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0		0 0	0	194.11
194. 12 07962 SPC	18, 095	0	151, 97	4 O	0	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	4, 871	0	2,65	3 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	681, 810	5, 232, 188	2, 892, 44	2 4, 987, 097	1, 908, 202	202.00

^{5/23/2022 3:05} pm

COST ALLOCATION - GENERAL SERVI	CE COSTS		Provider CC	N: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre	
Cost Center Descrip	_	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/23/2022 3:0	/5 pm
	- FDC	18.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENT 1.00 00100 CAP REL COST CENT 2.00 00200 CAP REL COSTS BUD 4.00 00400 EMPLOYEE BENEFITS D 5.00 00500 ADMINISTRATIVE & GE 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SER 9.00 00900 HOUSEKEEPING 0 0 0.0000 DI 10.00 01000 DI ETARY 1.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINISTRAT 14.00 01400 CENTRAL SERVICES & 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & L 18.00 01850 PHYSICIAN PRIVATE P 9.00 01900 NONPHYSICIAN ANAESTH	& FIXT EQUI P EPARTMENT NERAL VI CE I ON SUPPLY I BRARY RACTI CE	1, 641, 602 0	0				1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 18.00 18.00
INPATIENT ROUTINE SERVICE		-					1
30.00 03000 ADULTS PEDI ATRICS 31.00 03100 INTENSI VE CARE UNI T 43.00 04300 NURSERY Interval Interval		0 0 0	0 0 0	12, 864, 82 6, 110, 80 2, 360, 09	04 0	12, 864, 821 6, 110, 804 2, 360, 098	
ANCI LLARY SERVICE COST CE 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LAB 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI 54.01 03630 ULTRA SOUND 54.02 03450 NUCLEAR MEDI CI NE - 57.00 05700 CT SCAN 58.00 06800 MAGNETI C RESONANCE 60.00 06000 LABORATORY 63.00 06300 BLOOD STORI NG, PROC 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 SPECH PATHOLOGY 64.00 06600 SPECH PATHOLOGY 65.00 06600 SPECH PATHOLOGY 67.00 07100 MEDI CAL SUPPLIES CH 71.00 07100 MEDI CAL SUPPLIES CH 72.00 07200 IMPLANTABLE DEVI CES	OR ROOM C DI AGNOSTI C I MAGI NG (MRI) ESSI NG, & TRANS. Y ARGED TO PATI ENTS CHARGED TO TI ENTS S CENTER) LI NE			13, 112, 47 1, 398, 26 2, 429, 95 159, 13 4, 344, 49 923, 21 184, 94 1, 464, 92 899, 66 5, 356, 83 370, 57 757, 58 2, 597, 12 3, 329, 65 778, 10 496, 00 478, 88 9, 692, 18 4, 417, 35 19, 867, 52 739, 44 1, 360, 53 417, 66 3, 632, 76 419, 14	79 0 33 0 58 0 55 0 10 0 11 0 15 0 16 0 17 0 10 0 11 0 125 0 137 0 141 0 155 0 16 0 17 0 133 0 122 0 133 0 142 0 155 0 16 0	2, 300, 098 13, 112, 479 1, 398, 263 2, 429, 958 159, 135 4, 344, 494 923, 218 184, 941 1, 464, 925 899, 662 5, 356, 837 370, 575 757, 581 2, 597, 129 3, 329, 651 778, 108 496, 000 478, 880 9, 692, 183 4, 417, 393 19, 867, 522 739, 447 0 1, 360, 538 417, 660 3, 632, 766 419, 143	50.00 51.00 52.00 54.01 54.01 54.02 57.00 58.00 60.00 63.00 64.00 65.00 66.00 67.00 68.00 67.00 68.00 71.00 72.00 73.00 76.01 76.01 76.03 76.04 76.05
OUTPATI ENT SERVICE COST 0 90.00 09000 CLINIC 90.01 09001 PALLIATIVE HEALTH 90.02 VEIN CENTER 90.03 90.04 09004 NEUROSURGERY 90.05 09005 SURGICAL ASSOCIATES 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (N 93.00 04952 BEHAVIORAL HEALTH OTHER REIMBURSABLE COST C 101.00 HOME HEALTH AGENCY	ON-DI STI NCT PART)	0 0 33, 778 183, 943 49, 685 108, 136 0 0		192, 92 1, 583, 49 252, 32 877, 01 6, 645, 31 824, 16	77 0 88 0 77 0 7 0 0 4 0	0 192, 927 1, 583, 497 252, 328 877, 017 6, 645, 317 824, 164 2, 536, 928	90.01 90.02 90.03 90.04 90.05 91.00 92.00 93.00
SPECIAL PURPOSE COST CENT 113.00 INTEREST EXPENSE 116.00 11600 118.00 SUBTOTALS (SUM OF L NONREI MBURSABLE COST CENT	INES 1 through 117)	0 375, 542	0	1, 522, 10 115, 398, 49	04 0	1, 522, 104 115, 398, 493	113. 00 116. 00
190. 00 19000 GI FT, FLOWER, COFFE 192. 00 19200 PHYSI CI ANS' PRI VATE 194. 00 07950 WELLNESS	E SHOP & CANTEEN	0 436, 326 0		7, 842, 54	0 0 46 0 0 0	7, 842, 546	190. 00 192. 00 194. 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/23/2022 3:0	
	OTHER GENERAL					
Cost Conton Description	SERVI CE PHYSI CI AN	NONPHYSI CI AN	Subtotal	Intern 9	Total	
Cost Center Description	PRIVATE	ANESTHETI STS	Subtotal	Intern & Residents	Total	
	PRACTICE	ANESTRETISTS		Cost & Post		
	TRACTICE			Stepdown		
				Adjustments		
	18.00	19.00	24.00	25.00	26.00	
194.0107951 JACKSON MOB	0	0	813, 00	7 0	813, 007	194.01
194.0207952 EXTERNAL SVCS MARKETING	35, 882	0	1, 122, 10	8 0	1, 122, 108	194.02
194. 03 07953 WASHINGTON CLINIC	70, 969	0	640, 64	3 0	640, 643	194.03
194. 04 07954 PHYSI CLAN OFFI CES	131, 663	0	2, 267, 72	1 0	2, 267, 721	
194. 05 07955 I NTEGRATED MEDI CI NE	48, 921	0	1, 879, 51	5 0	1, 879, 515	
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0		0 0		194.06
194. 07 07957 PRI MARY CARE	0	0	5, 272, 00		5, 272, 009	•
194.0807958 EMPLOYER CLINIC	140, 829		2,027,23		2, 027, 235	•
194. 09 07959 UROLOGY PROF	142, 514	0	3, 161, 37		3, 161, 372	
194. 10 07960 SCOTTSBURG SPECIAL	0	0	11, 05	0 0		194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0	0 700 44	0 0	-	194.11
194. 12 07962 SPC	204, 033		2, 789, 11		2, 789, 113	
194. 13 07963 PULMONARY PROFESSI ONAL	54, 923	0	1, 045, 99	0 0	1, 045, 990	
200.00 Cross Foot Adjustments		0		0 0		200.00
201.00 Negative Cost Centers	1 (11 (02	0	144 070 00			201.00
202.00 TOTAL (sum lines 118 through 201)	1, 641, 602	0	144, 270, 80	2 0	144, 270, 802	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDI	Provider C		In Lie Period: From 01/01/2021	u of Form CMS-: Worksheet B Part II	2552-10
					To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
			CAPI TAL REI	LATED COSTS		0,20,2022 0.0	
	Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 11, 970 41, 663 1, 875	74, 077 621, 348 390, 792 23, 858	1, 171, 543 402, 993 (3 1, 804, 861 3 835, 448 0 25, 733	74, 077 13, 194 1, 976 60	7.00 8.00
11.00 13.00 14.00 15.00 16.00 18.00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01600 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	6, 437 4, 132 0 0 1, 843 0 0 0 0	36, 621 62, 869 74, 020 200, 687 162, 814 73, 356 25, 072 0 0	29, 548 7, 333 71, 827 83, 187 1, 455	96, 549 74, 020 208, 020 7 236, 484 7 156, 543 5	1, 414 480 563 3, 470 1, 391 2, 265 1, 344 1, 364 2, 265	10.00 11.00 13.00 14.00 15.00 16.00 18.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	45, 545 1, 125 0	746, 081 378, 995 36, 280	66, 890		5, 235 3, 031 1, 502	31.00
50.00	05000 OPERATING ROOM	465, 991	607, 997	683, 260	1, 757, 248	5, 277	50.00
52.00 53.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	0 0 12, 160	96, 095 246, 525 1, 631 213, 337	(50, 860	246, 525 52, 491	867 1, 166 0 1, 744	53.00
54.01 54.02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE – DIAGNOSTIC 05700 CT SCAN	0	213, 337 19, 761 8, 572 23, 327	32, 948 58, 320	8 52, 709 0 66, 892	660 23 456	54.01 54.02
58.00 60.00 63.00 64.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	118, 430 16, 046 0 0	16, 443 107, 361 9, 995 77, 680	150, 625 (5 274, 032 0 9, 995	344 2, 129 0 457	60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	17, 334 0 0 0	63, 343 237, 479 0 7, 472	10, 40 1, 232	7 247, 886 2 1, 232	1, 681 1, 987 665 407	65.00 66.00 67.00 68.00
71.00 72.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	000000000000000000000000000000000000000	6, 277 3, 907 0		1 90, 958 2 3, 907 2 0	166 0 0	71.00 72.00
76. 00 76. 01 76. 02	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER) 03953 OTHER ANCILLARY CMS LINE 03951 CASE MANAGEMENT	16, 759 0 0	0 39, 485 0 0	(0 0 0 0	0 509 0 0	76.00 76.01 76.02
76. 04 76. 05 76. 97	03950 PAIN MANAGEMENT 03610 SLEEP LAB 03480 ONCOLOGY 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0 1, 996 0 0	139, 279 15, 950 278, 159 41, 742	(195, 215	0 17, 946 5 473, 374	697 288 1, 241 256	76. 04 76. 05
90.00	09000 CLI NI C	0	0	(0 0	0	90.00
90. 02 90. 03	09001 PALLIATIVE HEALTH 09002 VEIN CENTER 09003 OBGYN	000000000000000000000000000000000000000	0 0 157, 219		5 189, 684	0 127 710	90. 02 90. 03
90.05 91.00 92.00	09004 NEUROSURGERY 09005 SURGI CAL ASSOCI ATES 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0 0 193	0 131, 939 288, 305		132, 441	174 339 3, 638	90.05 91.00 92.00
	04952 BEHAVIORAL HEALTH OTHER REIMBURSABLE COST CENTERS	0	31, 349		31, 349	651	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	150	29, 946	522	2 30, 618	2, 190	101.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	62, 709 826, 358	29, 946 5, 837, 391		0 92, 655 1 11, 054, 040		113.00 116.00 118.00
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 WELLNESS	0 80	0 433, 804	1, 988	-		190. 00 192. 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/23/2022 3:0	pared: 5 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.0207952 EXTERNAL SVCS MARKETING	506	36, 602	5, 01	8 42, 126	310	194.02
194.03 07953 WASHINGTON CLINIC	0	80, 051	(0 80, 051	313	194.03
194.04 07954 PHYSICIAN OFFICES	70	86, 613	1, 61	9 88, 302	434	194.04
194. 05 07955 I NTEGRATED MEDI CI NE	60	68, 274	(0 68, 334	631	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0	(0 0	0	194.06
194. 07 07957 PRI MARY CARE	657	380, 475	34, 53	3 415, 665	1, 301	194.07
194.0807958 EMPLOYER CLINIC	0	136, 642	3, 76	8 140, 410	963	194.08
194.0907959UROLOGY PROF	0	155, 550	7, 61	1 163, 161	464	194.09
194. 10 07960 SCOTTSBURG SPECIAL	0	0	3, 93	9 3, 939	0	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0	(0 0	0	194.11
194. 12 07962 SPC	0	0	3, 35	5 3, 355	748	194.12
194.1307963 PULMONARY PROFESSI ONAL	0	38, 688	1, 35	40, 040	222	194.13
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)	827, 731	7, 254, 090	4, 453, 47	4 12, 535, 295	74, 077	202.00

^{5/23/2022 3:05} pm

	Financial Systems TION OF CAPITAL RELATED COSTS	SCHNECK MEDIC	AL CENTER Provider C	F	In Lieu eriod: rom 01/01/2021 o 12/31/2021	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/23/2022 3:0	pared:
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 818, 055					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	94, 019 5, 591	931, 443 3, 603				7.00
9.00	00900 HOUSEKEEPI NG	29, 698	5, 530		94, 974		9.00
10.00	01000 DI ETARY	11, 932	9, 494	0	978	119, 433	10.00
11.00	01100 CAFETERIA	8, 022	11, 178		1, 151	0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	68, 526 32, 484	30, 307 24, 587	0	3, 121 2, 532	0	
14.00	01500 PHARMACY	62, 998	11,078	-	1, 141	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	25, 504	3, 786		390	0	
18.00	01850 PHYSICIAN PRIVATE PRACTICE	22, 702	0	0	0	0	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	133, 161	112, 671	19, 053	11, 598	83, 326	30.00
31.00	03100 I NTENSI VE CARE UNI T	64, 314	57, 234		5, 894	36, 107	•
43.00	04300 NURSERY	28, 370	5, 479	796	564	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	144.000	01 017	0.400	0.455		1 50 00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	144, 083 16, 613	91, 817 14, 512	3, 600 0	9, 455 1, 494	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	25, 698	37, 229		3, 834	0	52.00
53.00	05300 ANESTHESI OLOGY	1, 528	246		25	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	49, 278	32, 217		3, 318	0	54.00
54.01	03630 ULTRA SOUND	12, 012	2, 984		307	0	54.01
54.02 57.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05700 CT SCAN	2, 283 17, 983	1, 295 3, 523		133 363	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 592	2, 483		256	0	57.00
60.00	06000 LABORATORY	62, 341	16, 213		1, 670	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	4, 927	1, 509	0	155	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	8, 610	11, 731	0	1, 208	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	33, 681 35, 465	9, 566		985 3, 693	0	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	10, 519	35, 863 0	1, 719 0	3, 093	0	67.00
68.00	06800 SPEECH PATHOLOGY	6, 577	1, 128		116	0	
69.00	06900 ELECTROCARDI OLOGY	5, 445	948	1, 563	98	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	590	0	61	0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	205, 549	0	0	o	0	73.00
	03952 WOUND CARE (DIABETES CENTER)	9, 295	5, 963	0	614	0	
	03953 OTHER ANCILLARY CMS LINE	0	0	0	0		76.01
	03951 CASE MANAGEMENT	0	0	0	0	0	
76. 03 76. 04	03950 PAIN MANAGEMENT 03610 SLEEP LAB	15, 719 5, 339	21, 033 2, 409		2, 166 248	0	
	03480 ONCOLOGY	43, 667	42,006		4, 326	0	1
	07697 CARDI AC REHABI LI TATI ON	4, 887	6, 304		649	0	
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 PALLIATIVE HEALTH	0	0	0	0	0	
	09002 VEIN CENTER	2, 061	0	0	0	0	•
90.03	09003 0BGYN	15, 407	23, 743	0	2, 445	0	
90.04	09004 NEUROSURGERY	2, 725	0	0	0	0	90.04
90.05	09005 SURGI CAL ASSOCI ATES	7, 853	19, 925		2, 052	0	90.05
91.00	09100 EMERGENCY	73, 176	43, 538	3, 095	4, 483	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	10, 737	4, 734	0	487	0	92.00 93.00
70.00	OTHER REIMBURSABLE COST CENTERS	10,707	1,701		107		70.00
101.00	10100 HOME HEALTH AGENCY	34, 170	4, 522	0	466	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	20, 126	4, 522	0	466	0	113.00 116.00
118.00		1, 486, 667	717, 500		72, 942	119, 433	
	NONREI MBURSABLE COST CENTERS	,,,				, 100	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
102 00	19200 PHYSICIANS' PRIVATE OFFICES	88, 672	65, 511	0	6, 746	0	192.00
	07950 WELLNESS	0	0		0		194.00 194.01
194.00		11 2/0					
194.00 194.01	07951 JACKSON MOB	11, 349 14, 051	0 5, 528	0 0	569		
194. 00 194. 01 194. 02		11, 349 14, 051 6, 247	0 5, 528 12, 089		569 1, 245	0	194.01 194.02 194.03
194.00 194.01 194.02 194.03 194.04	07951 JACKSON MOB 07952 EXTERNAL SVCS MARKETING	14, 051	5, 528	0		0 0 0	194.02

Heal th Financi	al Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
					10 12/31/2021	5/23/2022 3:0	
Сс	ost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	E & GENERAL	PLANT	LINEN SERVICI	Ξ		
		5.00	7.00	8.00	9.00	10.00	
194.0607956 SL	URGI CAL PROFESSI ONAL	0	0		0 0	0	194.06
194.0707957 PF	RIMARY CARE	62, 270	57, 457		0 5, 917	0	194.07
194.08 07958 EN	MPLOYER CLINIC	21, 739	20, 635		0 2, 125	0	194.08
194.0907959UF	ROLOGY PROF	37, 441	23, 490		0 2, 419	0	194.09
194. 10 07960 SC	COTTSBURG SPECIAL	117	0		0 0	0	194.10
194. 11 07961 BE	EHAVI ORAL HEALTH	0	0		0 0	0	194.11
194. 12 07962 SF	PC	33, 711	0		0 0	0	194.12
194. 13 07963 PL	ULMONARY PROFESSIONAL	12, 948	5, 843		0 602	0	194.13
200.00 Cr	ross Foot Adjustments						200.00
201.00 Ne	egative Cost Centers	0	0		0 0	0	201.00
202.00 TO	OTAL (sum lines 118 through 201)	1, 818, 055	931, 443	34, 98	7 94, 974	119, 433	202.00

^{5/23/2022 3:05} pm

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre	nared:
Cost Contor Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/23/2022 3: 0 MEDI CAL	
Cost Center Description	CAFETERIA	ADMI NI STRATI O	SERVICES &	PHARMACT	RECORDS &	
	11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	94, 934 4, 536	1				11.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 979		319, 19 [.]	1		14.00
15.00 01500 PHARMACY	2,670		7,99		(2, 110	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 18. 00 01850 PHYSI CI AN PRI VATE PRACTI CE	2, 976 1, 617	1	2, 59: 40		63, 119 0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	C			0 0	0	•
INPATIENT ROUTINE SERVICE COST CENTERS	0 (25	(0 F(4	22.15		2.0(4	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	9, 635 5, 072		22, 15 ⁻ 3, 74-		2, 864 1, 751	30.00
43. 00 04300 NURSERY	2, 076			0 0	1, 178	•
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	7, 939	49, 920	41, 34	5 0	20, 440	50.00
51.00 05100 RECOVERY ROOM	1, 103		1, 69		1, 507	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 611	10, 132	(0 0	1, 661	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 376 3, 039		1 [°] 8, 010		1, 230 1, 988	
54.01 03630 ULTRA SOUND	842		28		838	•
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	17	1	10		289	54.02
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	668 476	1	1, 230 22		4, 182 1, 319	•
60. 00 06000 LABORATORY	4, 708	1	8, 95		4, 395	•
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	C			0 0	103	•
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	625 2, 328	1	1, 12: 3, 64		451 1, 410	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	3, 425		1, 12		1, 159	
67.00 06700 OCCUPATI ONAL THERAPY	826	1	32		515	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	473		34: 73 ⁻		248 943	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C			0 0	1, 281	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	C	0	(0 0	1, 145	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	(261, 475	5, 219	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	804	0	290	5 0	262	76.00
76.01 03953 OTHER ANCILLARY CMS LINE 76.02 03951 CASE MANAGEMENT	0	0	(0	•
76. 03 03950 PALN MANAGEMENT	1, 669	0	1, 18	4 0	334	•
76.04 03610 SLEEP LAB	320			0 0	324	
76. 05 03480 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	2, 291 417		4, 29 49		1, 534 39	
OUTPATIENT SERVICE COST CENTERS			.,	· · ·		1
90. 00 09000 CLINIC	C	1			0	90.00
90. 01 09001 PALLI ATI VE HEALTH 90. 02 09002 VEI N CENTER	C 417		174	0 4 0	0 228	90.01 90.02
90. 03 09003 OBGYN	2, 271	0	5, 10	7 0	187	90.03
90. 04 09004 NEUROSURGERY 90. 05 09005 SURGI CAL ASSOCI ATES	614 1, 335		10 ⁻ 419		69 65	•
91. 00 09100 EMERGENCY	7, 189		6, 440		3, 106	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04952 BEHAVI ORAL HEALTH OTHER REI MBURSABLE COST CENTERS	727	0	31	1 0	51	93.00
101. 00 10100 HOME HEALTH AGENCY	C	0	3, 70	7 0	399	101.00
SPECIAL PURPOSE COST CENTERS		1				112 00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE		0	2, 72	2 0	405	113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	79, 300	317, 980	131, 22		63, 119	
NONREI MBURSABLE COST CENTERS						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 388	0	42, 73	0 0 7 0		190.00 192.00
194. 00 07950 WELLNESS	0,000	o o	, .0		0	194.00
194. 01 07951 JACKSON MOB 194. 02 07952 EXTERNAL SVCS MARKETI NG		0	() EO			194.01 194.02
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON_CLINIC	443 876		2, 593			194.02
194.0407954 PHYSICIAN OFFICES	1, 626	1	10, 56	2 0		194.04
5/23/2022 3:05 pm						

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
				10 12/31/2021	5/23/2022 3:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194. 05 07955 I NTEGRATED MEDI CI NE	604	0	61, 96	6 0	0	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0		0 0	0	194.06
194. 07 07957 PRI MARY CARE	0	0	28, 73	6 0	0	194.07
194.0807958 EMPLOYER CLINIC	1, 739	0	13, 10	7 0	0	194.08
194.0907959 UROLOGY PROF	1, 760	0	10, 91	1 0	0	194.09
194. 10 07960 SCOTTSBURG SPECIAL	0	0	29	2 0	0	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0		0 0	0	194.11
194. 12 07962 SPC	2, 520	0	16, 77	1 0	0	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	678	0	29	3 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	94, 934	317, 980	319, 19	1 261, 475	63, 119	202.00

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ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre	
Cost Center Description	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/23/2022 3: 0	5 pm
	18.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MVBLE EQUIP 4.00 O0400 EMPEDYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL 7.00 O0700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING GO1000 DI ETARY 11.00 01100 CAFETERIA GO1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES SUPPLY 15.00 01500 PHARMACY GO O1600 MEDICAL RECORDS & LI BRARY 18.00 01850 PHYSICIAN NAESTHER LI BRARY SUPON O1900 NONPHYSICIAN ANESTHETISTS	25, 983 0					1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0 0 0		1, 464, 30 657, 74 89, 30	18 0	1, 464, 309 657, 748 89, 301	31.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.01 03630 ULTRA SOUND 54.02 03450 NUCLEAR MEDICINE - DI AGNOSTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 LABORATORY 63.00 06300			2, 131, 12 134, 30 328, 14 56, 97 858, 4 ⁻ 70, 65 70, 94 212, 14 370, 75 404, 00 16, 68	00 0 11 0 13 0 15 0 39 0 12 0 17 0 38 0 17 0	2, 131, 124 134, 300 328, 141 56, 913 858, 415 70, 639 70, 942 212, 147 370, 738 404, 047 16, 689	51.00 52.00 53.00 54.00 54.01 54.02 57.00 58.00 60.00
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 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0 0 0 0 0 0 0 0 0		106, 8 196, 1 353, 8 14, 08 16, 76 102, 5 5, 8 1, 14	38 0 54 0 35 0 54 0 30 0 39 0		65.00 66.00 67.00 68.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 76.00 03952 WOUND CARE (DI ABETES CENTER) 76.01 03953 OTHER ANCI LLARY CMS LI NE 76.02 03951 CASE MANAGEMENT 76.03 03950 PAL N MANAGEMENT 76.04 03610 SLEEP LAB 76.05 03480 ONCOLOGY 76.97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS ONCOLOGY	0 0 0 0 0 0 0 0 0		472, 24 76, 74 187, 8 ⁻ 26, 8 572, 73 63, 0	19 0 0 0 0 0 16 0 74 0 35 0	472, 243 76, 749 0 187, 816 26, 874 572, 735 63, 071	76.00 76.01 76.02 76.03 76.04 76.05
90.00 09000 CLINIC 90.01 09001 PALLIATIVE HEALTH 90.02 09002 VEINCENTER 90.03 09003 0BGYN 90.04 09004 NEUROSURGERY 90.05 09005 SURGICAL ASSOCIATES 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04952 BEHAVIORAL HEALTH	0 0 535 2,911 786 1,712 0		7, 1 ⁻ 242, 46 4, 47 166, 14 526, 6 ⁻ 49, 04	55 0 75 0 11 0 14 0	0 7, 116 242, 465 4, 475 166, 141 526, 614 49, 047	90.01 90.02 90.03 90.04 90.05 91.00 92.00
OTHER REI MBURSABLE COST CENTERS	0		76, 07	72 0	<u>7</u> 6, 072	101.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 116.00 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0		121, 81	17 0	121, 817	113. 00 116. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CIANS' PRI VATE OFFICES 194.00 07950 WELLNESS	0 6, 907 0		653, 56	0 0	0 653, 565	190. 00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/23/2022 3:0	
Cost Center Description	OTHER GENERAL SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	18.00	19.00	24.00	25.00	26.00	
194.01 07951 JACKSON MOB	0		11, 34	9 0	11, 349	194.01
194.0207952 EXTERNAL SVCS MARKETING	568		66, 18	в о	66, 188	194.02
194.0307953 WASHINGTON CLINIC	1, 123		101, 94	4 0	101, 944	194.03
194.04 07954 PHYSICIAN OFFICES	2, 084		144, 00	3 0	144, 003	194.04
194. 05 07955 I NTEGRATED MEDI CI NE	774		159, 95	6 0	159, 956	194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0			o o	0	194.06
194. 07 07957 PRI MARY CARE	0		571, 34	6 0	571, 346	194.07
194.0807958 EMPLOYER CLINIC	2, 229		202, 94	7 0	202, 947	194.08
194.0907959 UROLOGY PROF	2, 256		241, 90	2 0	241, 902	194.09
194. 10 07960 SCOTTSBURG SPECIAL	0		4, 34	в о	4, 348	194.10
194. 11 07961 BEHAVI ORAL HEALTH	0			o o	0	194.11
194. 12 07962 SPC	3, 229		60, 33	4 0	60, 334	194.12
194. 13 07963 PULMONARY PROFESSI ONAL	869		61, 49	5 0	61, 495	194.13
200.00 Cross Foot Adjustments		0		o o	0	200.00
201.00 Negative Cost Centers	0	0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	25, 983	0	12, 535, 29	5 0	12, 535, 295	202.00

IST A	Financial Systems LLOCATION - STATISTICAL BASIS	SCHNECK MEDI	Provi der C		Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	382, 500		1			1.0
00 00 00 00 00 00 00 00 00 00 00 00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	3, 906 32, 763 20, 606 1, 258 1, 931 3, 315 3, 903 10, 582 8, 585	4, 348, 324 0 1, 143, 881 393, 478 0 14, 722 28, 850 0 7, 160 70, 131	53, 574, 89 9, 554, 34 1, 428, 49 43, 57 1, 022, 42 347, 15 407, 10 2, 508, 79 1, 005, 88	5 -22, 404, 223 8 0 9 0 2 0 1 0 5 0 9 0 1 0 1 0 1 0 0	5, 576, 765 331, 617 1, 761, 578 707, 750 475, 822 4, 064, 668 1, 926, 823	2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
o. 00 8. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01850 PHYSI CI AN PRI VATE PRACTI CE 01900 NONPHYSI CI AN ANESTHETI STS	3, 868 1, 322 0 0	81, 223 1, 421 0 0	971, 61 913, 99	4 O	3, 736, 760 1, 512, 759 1, 346, 593 0	16. 0 18. 0
	INPATIENT ROUTINE SERVICE COST CENTERS	20.242	202 402	2 705 04		7 000 400	1 20 0
). 00 . 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	39, 340 19, 984	207, 409 65, 311				
	04300 NURSERY	1, 913	00,011				
	ANCILLARY SERVICE COST CENTERS	32, 059	(/ 7 100	2 015 75	3 0	0 544 044	
). 00 . 00 2. 00 3. 00 4. 00 4. 01 4. 02	05100 DERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03450 NUCLEAR MEDI CINE - DI AGNOSTI C	52,059 5,067 12,999 86 11,249 1,042 452	667, 128 401 0 49, 659 499, 158 32, 170 56, 943	627, 13(842, 82 (1, 260, 88(477, 53)	6 0 7 0 0 0 9 0 3 0	8, 546, 344 985, 421 1, 524, 310 90, 605 2, 922, 939 712, 513 135, 427	51.0 52.0 53.0 54.0 54.0
2.00 3.00 0.00 3.00 4.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	1, 230 867 5, 661 527 4, 096	156, 622 213, 998 147, 069 0 4, 872	329, 59 248, 71 1, 539, 04 330, 22	D 0 7 0 6 0 0 0 0 0 0 0	1, 066, 687 687, 577 3, 697, 812 292, 268 510, 691	57.0 58.0 60.0 63.0 64.0
. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPLANTABLE DEVI CES CHARGED TO	3, 340 12, 522 0 394 331 206 0	60, 693 10, 161 1, 203 82, 682 0 0	1, 436, 53 480, 88 294, 50 119, 76	B 0 5 0 4 0	0	66. C 67. C 68. C 69. C 71. C
o. 00 o. 01 o. 02	PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER) 03953 OTHER ANCILLARY CMS LINE 03951 CASE MANAGEMENT	0 2, 082 0 0	0 2, 697 0 0	368, 17 (0 0 0 0	12, 189, 629 551, 348 0 0	76.0 76.0 76.0
	03950 PAIN MANAGEMENT 03610 SLEEP LAB	7, 344 841	5,600	503, 82 207, 93		932, 391 316, 661	
	03480 ONCOLOGY	14, 667	190, 606			2, 590, 124	
o. 97	07697 CARDIAC REHABILITATION	2, 201	8, 090	184, 81	1 0	289, 889	76.9
). 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 10	0	90.0
). 00). 01	09001 PALLI ATI VE HEALTH	0	0			0	
0. 02	09002 VEIN CENTER	0	3, 490			122, 257	90.
0.03		8, 290	31, 698			913, 873	
	09004 NEUROSURGERY 09005 SURGI CAL ASSOCI ATES	0 6, 957	0 490	,		161, 608 465, 777	
. 00	09100 EMERGENCY	15, 202	47, 106			4, 340, 476	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_				92.
	04952 BEHAVI ORAL HEALTH	1, 653	0	470, 46	1 0	636, 887	93.
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 579	510	1, 583, 77	3 0	2, 026, 794	101.
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	1, 579 307, 799		665, 99 48, 428, 05		1, 193, 797 88, 179, 834	
2.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 WELLNESS	0 22, 874 0	0 1, 941	1, 252, 58	0 0	0 5, 259, 645	190.

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021 Fo 12/31/2021	Worksheet B-1 Date/Time Pre 5/23/2022 3:0	epared:
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
194.01 07951 JACKSON MOB 194.02 07952 EXTERNAL SVCS MARKETING 194.03 07953 WASHINGTON CLINIC 194.04 07954 PHYSICIAN OFFICES 194.05 07955 INTEGRATED MEDICINE 194.06 07957 PRIMARY CARE 194.09 07957 PRIMARY CARE 194.09 07958 EMPLOYER CLINIC 194.09 07959 UROLOGY PROF 194.10 07960 SCOTTSBURG SPECIAL 194.11 07961 BEHAVI ORAL HEALTH 194.12 07962 SPC 194.13 07963 PULMONARY PROFESSI ONAL 200.00 Cross Foot Adj ustments	0 1, 930 4, 221 4, 567 3, 600 20, 062 7, 205 8, 202 0 0 0 2, 040	4, 900 0 1, 581 0 33, 718 3, 679 7, 431 3, 846 0 3, 276	223, 97 226, 09 313, 80 455, 99 940, 87 696, 67 335, 70 540, 50	1 0 1 0 4 0 5 0 6 0 0 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0	833, 418 370, 537 1, 575, 904 965, 380 0 3, 693, 561 1, 289, 478 2, 220, 816 6, 955	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 200. 00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, Part I)	7, 254, 090	4, 453, 474	15, 259, 08	6	22, 404, 223	201.00 202.00
203.00 204.00 Part I) 204.00 Part II)	18. 964941	1. 024182	0. 28481 74, 07		0. 207762 1, 818, 055	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00138	3	0. 016859	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI	CAL CENTER Provider CO		eri od:	u of Form CMS- Worksheet B-1	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/23/2022 3:0	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	
CENEDAL SEDVICE COST CENTEDS	7.00	8.00	9.00	10.00	11.00	
GENERALSERVICECOSTCENTERS1.0000100CAPRELCOSTS-BLDG & FIXT2.0000200CAPRELCOSTS-MVBLEEQUIP4.0000400EMPLOYEEBENEFITSDEPARTMENT5.0000500ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON	325, 225 1, 258 1, 931 3, 315 3, 903 10, 582	432, 012 2, 416 0 0 0	322, 036 3, 315 3, 903 10, 582	30, 286 0 0	1, 268, 155 60, 597	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 18.00 01850 PHYSICIAN PRIVATE PRACTICE 19.00 000 NONPHYSICIAN ANESTHETISTS	8, 585 3, 868 1, 322 0 0	0 0 0 0	3, 868 1, 322 0	0 0 0	39, 799 35, 660 39, 757 21, 598 0	15.00 16.00 18.00
30. 00 03000 ADULTS & PEDIATRICS	39, 340	235, 269	39, 340	21, 130	128, 665	30.00
31. 00 43. 00 04300 NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	19, 984 1, 913	20, 983 9, 826	19, 984	9, 156	67, 752 27, 736	31.00
50. 00 05000 OPERATI NG ROOM	32, 059	44, 449			106, 050	1
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 067 12, 999	0 3, 514	5, 067 12, 999		14, 738 21, 525	
53. 00 05300 ANESTHESI OLOGY	86	0	86	0	18, 379	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	11, 249 1, 042	36, 805 0			40, 593 11, 248	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	452	0			231	1
57.00 05700 CT SCAN	1, 230	0	1, 230		8, 917	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	867 5, 661	0	867 5, 661		6, 365 62, 887	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	527	0			02, 007	1
64.00 06400 I NTRAVENOUS THERAPY	4, 096	0			8, 348	1
65. 00 06500 RESPI RATORY THERAPY	3, 340	0	-,		31, 100	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	12, 522 0	21, 232 0			45, 754 11, 030	
68. 00 06800 SPEECH PATHOLOGY	394	0	394		6, 323	
69.00 06900 ELECTROCARDI OLOGY	331	19, 296			3, 065	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	206 0	0	206 C		0 0	1
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	l c	0	0	73.00
76.00 03952 WOUND CARE (DI ABETES CENTER)	2, 082	0	2,082	-	10, 744	
76.01 03953 OTHER ANCI LLARY CMS LINE	0	0	C	0	0	
76. 02 03951 CASE MANAGEMENT 76. 03 03950 PALN MANAGEMENT	0 7, 344	0	0 7, 344	0	0 22, 298	
76. 04 03610 SLEEP LAB	841	0	841		4, 275	
76. 05 03480 ONCOLOGY	14, 667	0			30, 605	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	2, 201	0	2, 201	0	5, 569	76.97
90. 00 09000 CLINIC	0	0	C	0	0	90.00
90. 01 09001 PALLI ATI VE HEALTH	0	0	C		0	90.01
90. 02 09002 VEIN CENTER	0	0	0	0	5, 572	
90. 03 09003 0BGYN 90. 04 09004 NEUROSURGERY	8, 290	0	8, 290	0	30, 343 8, 196	
90. 05 09005 SURGI CAL ASSOCI ATES	6, 957	0	6, 957	0	17, 838	
91.00 09100 EMERGENCY	15, 202	38, 222			96, 037	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93. 00 04952 BEHAVIORAL HEALTH	1 (52	0	1 (52	0	0 712	92.00 93.00
93. 00 04952 BEHAVI ORAL HEALTH OTHER REI MBURSABLE COST CENTERS	1, 653	0	1, 653	0	9, 713	93.00
101.00 10100 HOME HEALTH AGENCY	1, 579	0	1, 579	0	0	101.00
SPECIAL PURPOSE COST CENTERS						110.00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	1, 579	0	1, 579	0	0	113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	250, 524					
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 874	0	22, 874	-		192.00
194.00 07950 WELLNESS	0	0	C	0		194.00
194. 01 07951 JACKSON MOB 194. 02 07952 EXTERNAL SVCS MARKETING	0 1, 930	0	0 1,930	0		194.01 194.02
194. 02 07952 EXTERNAL SVCS MARKETING 194. 03 07953 WASHINGTON CLINIC	4, 221					194.02
5/23/2022 3:05 pm			· · · · ·			·

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
	PLANT	LINEN SERVICE	v · - ·	(MEALS	(HOURS OF	
	(SQUARE	(POUNDS OF	FEET)	SERVED)	SERVICE)	
	FEET)	LAUNDRY)		10.00	11.00	
	7.00	8.00	9.00	10.00	11.00	101.01
194. 04 07954 PHYSI CI AN OFFI CES	4, 567	0	4, 56		21, 719	
194. 05 07955 I NTEGRATED MEDI CI NE	3, 600	0	3,600	0 0		194.05
194. 06 07956 SURGI CAL PROFESSI ONAL	0	0	(0 0		194.06
194. 07 07957 PRI MARY CARE	20, 062		20, 06			194.07
194. 08 07958 EMPLOYER CLINIC	7, 205		7, 20			194.08
194. 09 07959 UROLOGY PROF	8, 202	0	8, 20	2 0		194.09
194. 10 07960 SCOTTSBURG SPECIAL	0	0		0 0		194.10
194. 11 07961 BEHAVI ORAL HEALTH	0	0	(0 0		194.11
194. 12 07962 SPC	0	0	(0 0		194.12
194.13 07963 PULMONARY PROFESSI ONAL	2,040	0	2, 040	0 0	9, 060	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 735, 405	426, 567	2, 169, 94	4 945, 785	681, 810	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	20. 709985	0. 987396	6. 73820	3 31. 228455	0. 537639	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	931, 443	34, 987	94, 97	4 119, 433	94, 934	204.00
205.00 Unit cost multiplier (Wkst. B, Part	2. 863996	0. 080986	0. 29491	3. 943505	0. 074860	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

^{5/23/2022 3:05} pm

Form Privation Privation Privation Privation Privation Cost Center Description AMMINISTRUID CENTRAL Privation	Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	SCHNECK MEDI	CAL CENTER	CN: 15-0065	In Lie Period:	u of Form CMS-: Worksheet B-1	
Cost Center Description NNR NO AUXIN STRUCT (UNECT) CentRat UNECT) PRAMACY (COSTLD (UNECT) PRAMACY (COSTLD (UNECT) PRAMACY (COSTLD (UNECT) PRAMACY (COSTLD (COSTL						Date/Time Pre	pared:
Cost Center Description Rest tip ADMINISTRATIO (VIECT) CONTRATION SUPPORT PMINUS SUPPORT PMINUS SUP					10 12/01/2021	5/23/2022 3:0	5 pm
April N TRATIC Stand UT Constant PRE Contex a. PRE Contex a. <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
N N UBENT OF CODE 0 FOULT OF CODE 0 FOUL OF CODE 0 FOUL O	Cost Center Description						
NUMBER CONSTRUCT CONSTRUCT CONSTRUCT CONSTRUCT 1.00 CONSTRUCT 13.00 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 10.00 2.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00							
Release Service Cost Centrels 13.00 14.00 15.00 16.00 15.00 <t< td=""><td></td><td>(DI RECT</td><td></td><td></td><td></td><td>(TIME</td><td></td></t<>		(DI RECT				(TIME	
Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>				15.00	,	· · · · · · · · · · · · · · · · · · ·	
2.00 002000 CAP REL COSTS-MURLE EQUIP 2.00 0.00 002000 ADMINISTRATIVE & GENERAL 2.00 0.00 000000 HOUSEREEVENTS 2.00 0.00 000000 HOUSEREEVENTS 2.00 0.00 000000 HOUSEREEVENTS 0.00 0.00 000000 HOUSEREEVENTS 0.00 0.00 000000 HOUSEREEVENTS 0.00 0.00 010000 HOUSEREEVENTS 0.00 0.00 000000 HOUSEREEVENTS 0.00	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	18.00	-
4.00 000000 EMPLOYEE BEREITS DEPARTMENT 4.00 4.00 7.00 00000 COVID OPEANTION OF PLAYT 5.00 5.00 7.00 00000 COVID OPEANTION OF PLAYT 5.00							•
5.00 BODOC JANNI NI STRATT WF & GENTRAL							
7.00 DOYNOJ OFFRATION OF PLANT 7.00 S0 00000 PLANT 8.00 0.00 PLANT 8.00 0.00 PLANT 8.00 9.00 PLANT 9.00 PLANT 9.00 9.00 PLANT 9.00							•
9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00							•
10.00 DITODOD DI ETARY 10.00 10.00 DITODOD DI ETARY 10.00 DITODOD CAPETERIA GOSTANA GOSTANA DITODOD DI ETARY 10.00 DITODOD CAPETERIA SENDELY 35, 700 1, 041, 133 DITODOD DI ETARY 10.00 DITODO CAPETERIA SENDELY 35, 700 1, 041, 133 DITODOD DI ETARY 10, 00 10.00 DITODO CAPATISES & SUPPLY 35, 700 1, 041, 133 DITODOD DI ETARY 10, 00 10.00 DITODOD DI CON MERTINE FRANCICES & CONCENTERS 0							•
11.00 01100 CAFETERIA 11.00							•
14.00 01400 CENTRAL SERVICES & SUPPLY 39, 799 1, 041, 133 427, 973, 878 15, 00 10.00 101500 MEDCARAMACY 0 8, 454 00 427, 973, 878 220, 774 16, 00 10.00 101500 MEDCARAMACY 0	11. 00 01100 CAFETERI A						•
15:00 01500 PIAMBACY 35:660 26:074 100 17:00			1 041 122				•
16.00 01400 MEDICAL RECORDS & LIBRARY 0 8,454 0 427,973,878 16.00 10.00 01900 0					0		•
10 0	16.00 01600 MEDICAL RECORDS & LIBRARY	0	8, 454		0 427, 973, 878		16.00
INPART FUNT_ROUTINE_SERVICE_COST_CENTERS INPART FUNT_ROUTINE_SERVICE_COST_CENTERS 0.0 0.00000 0.0000 0.0115 & PEDIATRICS 0 0 0.011, 944, 667 0 0 0.011, 944, 667 0 0.0100 0.011, 944, 667 0 0.0100 0.011, 944, 667 0 0.0100 0.0100 0.011, 944, 667 0 0.0100 0.0000							•
30. 00 02000 ABULTS & HEDLATRICS 128. 665 72. 253 0 19. 483, 810 0 30. 0 43. 00 04300 INTENSIVE CASE CONTENTER 27. 730 0 0 8, 011, 191 64 0 44. 00 OpbODD OPFRATING ROOM 0 0 137, 639, 721 0 0 0 55. 40 0 137, 639, 721 0 55. 00 55. 00 0 55. 00 0 10. 0500 0.0000 137, 639, 721 0 0 55. 00 55. 00 0 10. 0520, 80 55. 00 0 10. 0520, 80 55. 00 0 15. 00 0 10. 0520, 80 10. 0520, 80 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56		0	0		0 0	0	19.00
43. 00 0 0300 0 04000 0 04000	30. 00 03000 ADULTS & PEDI ATRI CS	128, 665					
AKCILLARY SERVICE COST CENTRES							•
50. 00 05000 (OPERATING ROOM 104, 800 134, 800 0 137, 639, 721 0 50. 50 51. 00 05100 (S100) RECOVERY ROOM 0 5.540 0 137, 639, 721 0 50. 50 52. 00 05200 (S200) RECOVERY ROOM 21, 525 50 0 113, 031, 034 52. 00 54. 00 05400 (RADI CLOY 0 56 0 8.367, 227 0 53. 00 54. 00 05400 (RADI CLOY 0 0 937 0 5.701, 098 64. 01 54. 00 05400 (RADI CLERA SUMANCE I MAGING (MRI) 0 4.033 0 28. 450, 719 0 57.00 57.00 57.00 66. 00 60.00 60		21, 130	0		0 8,011,181	0	43.00
52.00 05200 DELLVERY ROOM & LABOR ROOM 21,525 0 0 11,301,334 0 52.00 54.00 05400 RADILOCY 0 56 0 8,367,227 0 54.00 54.00 05400 RADILOCY-DIAGNOSTIC 0 937 0 57.01,98 0 54.00 54.00 05400 CTSCAN 0 937 0 57.01,98 0 54.00 57.00 057.00 057.00 057.00 65.00 0 65.00 65.00 65.00 65.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	50.00 05000 OPERATING ROOM	106, 050	134, 860		0 137, 639, 721	0	50.00
53. 00 6300 (AMESTHESI OLOGY 0 56 0 8. 367, 227 0 53. 00 54. 01 3630 (ULTRA SOUND 0 937 0 5. 701, 098 54. 01 0.0 0540 (ULCRA RUDLICAR NEDI CINE - DI AGNOSTI C 0 937 0 5. 701, 098 54. 01 0.0 0500 (T SCAN 0 0 7.00 8. 970, 427 0 56. 00 0.00 06000 (LABORATICRY 62. 887 229. 217 0 8. 970, 427 0 66. 00 0.00 06400 (INTRAVENUS) THERAPY 0 13. 662 0 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00		-					•
54.00 65400 RADI LOCY-DI AGNOSTI C 40, 593 20, 148 0 13, 522, 240 54.00 54.01 03630 NUCLEAR MEDI CI NE - DI AGNOSTI C 0 34 0 1, 962, 724 0 54.00 57.00 05700 CT SCAN 0 0, 33 0 1, 962, 724 0 54.00 58.00 05800 MAGNETI C RESONANCE INAGI NG (NRI) 0 725 0 8, 970, 427 0 58.00 0.00 06000 INTRAV NOS, PROCESSING, & TRANS. 0 0 0 640, 0 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00		1	-				•
54. 02 03450 NUCLEAR MEDICINE - DI AGNOSTIC 0 34 1,962,724 0 57.00 57. 00 05700 CT SCAN 0 4,033 028,500,719 57.00 63. 00 06000 LABORTTIC RESONANCE I MAGING (ML) 0 72.5 8,970,427 0 60.00 63. 00 LABORTTORY 62.887 29,217 0 9.977,660 64.00 64. 00 06400 INTRAVENDINE THERAPY 0 3,664 0.70,976 64.00 65. 00 06500 RESPI RATORY THERAPY 0 1,957 3,653 0 7,882,101 0 66.00 66.00 06600 PHYSICAL THERAPY 45,754 3,653 0 7,882,101 0 64.00 0.00 06900 ELECTROLARDIOLOGY 0 1,119 0 1,689,656 0 60.00 60.00 60.00 60.00 7,722,179 0 72.00 73. 00 07300 DTRA ANCILARGED TO PATIENTS 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00		-				-	•
57. 00 657.00 CT SCAN 0 4.03 0 28, 450, 179 0 57.00 80. 00 06600 MAGNETIC RESONANCE I MARING (MRI) 62, 887 29, 217 0 29, 997, 660 66.00 63.00 60. 00 06000 LABORATORY 0 3, 664 0 3, 070, 976 0 64.00 64.00 06400 INTENVENUUS THERAPY 0 1, 901 0 995, 202 6 65.00 06600 OCCUPATIONAL THERAPY 0, 1,071 0 3, 502, 915 6 67.00 06400 DELOR STORING INCENTHERAPY 0 1, 071 0 3, 502, 915 6		-					•
58. 00 0 68800 MACRETIC RESONANCE IMAGE INC 0 725 0 8, 970, 427 0 58. 00 60.00 60.00 06000 LABORATORY 62, 887 29, 217 0 9, 987, 660 0 60.00 60.00 06000 PINSICAL TRANSPORTS 0 11, 901 9, 595, 202 0 65. 00 66.00 06600 PHYSICAL TREAPY 0 11, 701 0 9, 595, 202 0 66. 00 66.00 06000 PHYSICAL TREAPY 0 1, 01 3, 502, 915 0 66. 00 66.00 06000 PEECH PATHOLOGY 0 1, 01 0 67. 00 77. 00 77. 00 77. 00							
63:00 00 00 699, 641 0 63:00 64:00 06400 INTRAVENDUS THERAPY 0 3, 664 0 9595, 202 0 65:00 66:00 06500 INTRAVENDUS THERAPY 45, 754 3, 664 0 7, 882, 101 0 66:00 66:00 06600 PHYSI CAL THERAPY 0 1, 071 0 3, 502, 915 0 67:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 77:00 76:00 76:00 76:00 70:00 70:00		-					•
64. 00 06400 INTRAVENUUS THERAPY 0 3,664 0 3,070,976 0 64.00 65.00 06500 PESPIR ATORY THERAPY 0 11,901 0 9,595,202 65.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 1,071 0 3,502,915 67.00 66.00 67.00 06700 OCLEATIONAL THERAPY 0 1,119 0 6.413,697 0 68.00 69.00 06800 SPECH PATHOLOGY 3,065 2,403 0 6.413,697 0 90.00 71.00 0 71.00 0 71.00 0 71.00 0 73.00 73.00 73.00 73.00 76.01 76.01 76.01 76.01 76.01 76.01 76.01 76.01 76.03 76.01 76.03 76.01 76.03 76.01 76.03 76.01 76.01 76.03 76.01 76.03 76.01 76.03 76.01 76.03 76.01 76.03 76.01							•
65:00 06500 PRESPIRATORY HERAPY 0 11,901 0 9,595,202 0 65:00 66:00 06600 PHSICAL THERAPY 45,754 3,653 0 7,882,101 0 66:00 67:00 00000 PHSICAL THERAPY 0 1,109 1,689,655 0 68:00 68:00 SPECH PATHOLOGY 0 1,119 0 1,689,655 0 68:00 00 OTION MEICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 8,711,100 0 7,72,00 72:00 OTZON DRUICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 7,782,179 0 7,200 70:00 03952 WOUND CARE (DI ABETES CENTER) 0 9 0 0 0 0 7,802 7,802 7,802 7,802 7,802 7,802 7,802 7,802 7,802 7,802 7,802 7,601 7,601 7,601 7,601 7,601 7,601 7,		-	-			-	•
67.00 06700 0CCUPATI ONAL THERAPY 0 1.071 0 3.502,915 0 67.00 68.00 068000 SPECH PATHOLOGY 0 1.019 0 1.699,656 0 68.00 69.00 06900 ELECTROCARDI OLOGY 3.065 2.403 0 6.413,697 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 7.792,179 0 72.00 73.00 73.00 73.00 0.00 0 0 0 7.792,179 0 76.00 73.00 76.00 03953 OTHA ANCE MENT 0 0 0 0 0 0 76.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.01 76.01 76.01 76.01 76.01 76.01 76.01		-					•
68: 00 068:00 SPECH PATHOLOGY 0 1, 119 0 1, 689, 656 0 68: 00 69: 00 0000 ELECTCRORDIOLOGY 3, 065 2, 403 0 6, 413, 697 0 69: 00 71: 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 7, 792, 179 0 71: 00 72: 00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 73: 00 74: 00 76: 00							•
69.00 00900 ELECTROCARD LOGY 3,065 2,403 0 6,413,697 0 9,00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 8,711,100 0 71.00 72.00 D7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0 0 0 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.00 73.060 73.00 73.060 73.00 73.05 0 0 0 0 0 0 74.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.01 76.02 76.02 76.02 76.02 76.03 76.02 76.03 76.03 76.03 76.03 76.03 76.03 76.03 76.03 76.03 76.03 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 76.05 7							
72.00 O72.00 IMPLANTABLE DEVI CES CHARGED TO PATIENTS 0 0 7, 792, 179 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 35, 502, 750 0 73.00 76.00 03952 WOUND CARE (DI ABETES CENTER) 0 966 0 1, 781, 249 0 76.00 76.02 03951 CASE MAAGEMENT 0 0 0 0 76.00 76.03 0350 PAIN MANAGEMENT 0 3, 862 0 2, 273, 175 0 76.03 76.04 03610 SLEEP LAB 0 0 0 2, 203, 747 76.03 70.07 07697 CARDIA C REHABILITATION 0 1, 600 0 2, 992 76.97 00 09000 CLINIC 0		-					•
PATLENTS PATLENTS O D 73.00 07300 DRUGS CHARGED TO PATLENTS 0 0 0 35, 502, 750 0 73.00 76.00 03952 WOUND CARE (DLABETES CENTER) 0 966 0 1, 781, 249 0 76.00 76.01 03952 WOUND CARE (DLABETES CENTER) 0 0 0 0 0 76.00 76.02 03951 CASE MAAGEMENT 0 3, 862 0 2, 203, 747 0 76.03 76.05 03480 ONCOLOGY 0 14, 014 0 10.438, 145 0 76.05 76.07 07677 CARDIAC REHABILLITATION 0 1, 600 0 0.00 90.00 90.00 09000 CLINIC 0		3	0		0,711,100		
73.00 ORUGS CHARGED TO PATIENTS 0 100 35, 502, 750 73.00 73.00 76.00 03952 WOUND CARE (DI ABETES CENTER) 0 966 0 1, 781, 249 0 76.00 76.01 03953 OTHER ANCI LLARY CMS LINE 0 0 0 0 76.01 76.02 03951 CASE MANAGEMENT 0 3, 862 0 2, 273, 175 0 76.03 76.04 03610 SLEEP LAB 0 0 0 2, 203, 747 0 76.04 76.07 76797 CARO LAC EHABILITATION 0 14, 014 0 10.438, 145 0 76.07 0.00 09000 CLINIC 0		0	0		0 7, 792, 179	0	72.00
76.01 03953 OTHER ANCILLARY CMS LINE 0 0 0 0 76.01 76.02 03951 CASE MANAGEMENT 0 0 0 0 76.02 76.03 03950 PAIN MANAGEMENT 0 3.862 0 2,273,175 0 76.04 76.04 0310 SLEEP LAB 0 0 0 2,203,747 0 76.05 76.97 07697 CARDIAC REHABILITATION 0 14.014 0 10,438,145 0 76.05 0.00 09000 CLINIC 0 0 0 0 90.01 90.01 90.01 90.01 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.		0	0	10	0 35, 502, 750	0	73.00
76.02 03951 CASE MANAGEMENT 0 0 0 0 76.02 76.03 03950 PAIN MANAGEMENT 0 3,862 0 2,273,175 0 76.03 76.04 0310 SLEEP LAB 0 0 0 2,203,747 0 76.03 76.05 03480 ONCOLOGY 0 14,014 0 10,438,145 0 76.97 00 0747 CARDI AC REHABI LI TATI ON 0 1,600 0 262,992 0 76.97 00 09000 CLINIC 0 0 0 0 0 90.00 <t< td=""><td></td><td>0</td><td></td><td></td><td>0 1, 781, 249</td><td></td><td></td></t<>		0			0 1, 781, 249		
76.03 03950 PAIN MANAGEMENT 0 3,862 0 2,273,175 0 76.03 76.04 03610 SLEEP LAB 0 0 0 2,203,747 0 76.03 76.05 03400 NCLOOGY 0 14,014 0 10,438,145 0 76.05 76.97 07697 CARDIAC REHABILITATION 0 1,600 0 262,992 0 76.97 0000 CLINIC 0 0 0 0 0 0 90.00 90.01 09001 PALLIATIVE HEALTH 0 0 0 0 90.03 90.03 060YN 0 1,659 0 1,271,861 30,343 90.03 90.03 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 21,128,668 0 91.00 92.00 92.00 92.00		0	0			-	
76. 05 03480 ONCOLOGY 0 14, 014 0 10, 438, 145 0 76. 05 76. 97 07697 CARDIAC REHABILITATION 0 1, 600 0 262, 992 0 76. 97 90.00 09000 CLINIC 0		0	3, 862		0 2, 273, 175	-	•
76. 97 07697 CARDI AC REHABI LI TATI ON 0 1, 600 0 262, 992 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 00 0 0 90. 00		0	0				
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0		-					•
90.00 09000 CLINIC 0		<u> </u>	1,600		0 202, 992	0	/0.9/
90.02 09002 VEIN CENTER 0 568 0 1, 551, 423 5, 572 90.02 90.03 09003 0BGYN 0 16, 659 0 1, 271, 861 30, 343 90.03 90.04 09004 NEUROSURGERY 0 348 0 467, 714 8, 196 90.04 90.05 SURGI CAL ASSOCI ATES 0 1, 368 0 445, 264 17, 838 90.05 91.00 09100 EMERGENCY 96, 037 21, 006 0 21, 128, 668 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 1,014 0 346, 424 0 93.00 93.00 04952 BEHAVI ORAL HEALTH 0 12,091 0 2,716,051 0 101.00 101.00 HOME HEALTH AGENCY 0 12,091 0 2,716,051 0 101.00 113.00 11300 INTEREST EXPENSE 0 8,879 0 2,752,352 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034	90. 00 09000 CLINIC	0				0	
90.03 09003 0BGYN 0 16,659 0 1,271,861 30,343 90.03 90.04 09004 NEUROSURGERY 0 348 0 467,714 8,196 90.04 90.05 09005 SURGI CAL ASSOCI ATES 0 1,368 0 445,264 17,838 90.05 91.00 OP100 EMERGENCY 96,037 21,006 0 21,128,668 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 96,037 21,006 0 21,128,668 0 91.00 93.00 04952 BEHAVI ORAL HEALTH 0 1,014 0 346,424 0 93.00 01.00 HOME HEALTH AGENCY 0 12,091 0 2,716,051 0 101.00 SPECI AL_PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 8,879 0 2,752,352 0 116.00 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034 100 427,973,878 61,949 18.00 NONREI MBURSABLE COST CENTERS		0	-		-	-	•
90. 04 09004 NEUROSURGERY 0 348 0 467, 714 8, 196 90. 04 90. 05 09005 SURGI CAL ASSOCI ATES 0 1, 368 0 445, 264 17, 838 90. 05 91. 00 09100 EMERGENCY 96, 037 21, 006 0 21, 128, 668 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 1, 014 0 346, 424 0 93. 00 04952 BEHAVI ORAL HEALTH 0 1, 014 0 346, 424 0 93. 00 011.00 10100 HOME HEALTH AGENCY 0 12, 091 0 2, 716, 051 0 101. 00 SPECI AL PURPOSE COST CENTERS 0 12, 091 0 2, 752, 352 0 116.00 113. 00 11400 HOSPI CE 0 8, 879 0 2, 752, 352 0 116.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 675, 523 428, 034 100 427, 973, 878 61, 949 18. 00 NONREI MBURSABLE COST CENTERS 0 0 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>		0					•
91.00 09100 EMERGENCY 96,037 21,006 0 21,128,668 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 1,014 0 346,424 0 92.00 93.00 04952 BEHAVI ORAL HEALTH 0 1,014 0 346,424 0 93.00 01 010100 HOME HEALTH AGENCY 0 12,091 0 2,716,051 0 101.00 SPECIAL PURPOSE COST CENTERS 0 12,091 0 2,752,352 0 116.00 116.00 11060 HOSPI CE 0 8,879 0 2,752,352 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034 100 427,973,878 61,949 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 192.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 192.00 192.00 0 0 0 0 0 0 <td>90. 04 09004 NEUROSURGERY</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	90. 04 09004 NEUROSURGERY	0					•
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 04952 0 1,014 0 346,424 0 93.00 93.00 0H952 0H952 0EHAVI ORAL HEALTH 0 1,014 0 346,424 0 93.00 01 010100 HOME HEALTH AGENCY 0 12,091 0 2,716,051 0 101.00 SPECIAL PURPOSE COST CENTERS 0 12,091 0 2,752,352 0 16.00 113.00 11400 HOSPI CE 0 8,879 0 2,752,352 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034 100 427,973,878 61,949 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 139,399 0 0 71,976 192.00 194.00 07950 WELLNESS 0 0 0		0					•
93. 00 04952 BEHAVI ORAL HEALTH 0 1,014 0 346,424 0 93. 00 OTHER REI MBURSABLE COST CENTERS 0 12,091 0 2,716,051 0 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 2,752,352 0 116.00 116.00 100 427,973,878 61,949 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 100 427,973,878 61,949 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 190.00 190.00 190.00 190.00 0 0 0 0 0 0 0 0 190.00 190.00 190.00 190.00 0 0 0 0 0 0 0 0 190.00 190.00 190.00 190.00 190.00 190.00 0 0 0 0 0 0 0		96, 037	21,006		0 21, 128, 668	0	
101.00 10100 HOME HEALTH AGENCY 0 12,091 0 2,716,051 0 101.00 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 8,879 0 2,752,352 0 113.00 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034 100 427,973,878 61,949 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 139,399 0 0 0 192.00 194.00 07950 WELLNESS 0 0 0 0 0 194.00	93. 00 04952 BEHAVI ORAL HEALTH	0	1, 014		0 346, 424	0	
SPECI AL_PURPOSE_COST_CENTERS 113.00 INTEREST_EXPENSE 113.00 116.00 INTEREST_EXPENSE 0 116.00 HOSPI CE 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675, 523 116.00 100 427, 973, 878 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675, 523 118.00 NONRELMBURSABLE COST CENTERS 118.00 1190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 139, 399 0 0 71, 976 192.00 194.00 07950 WELLNESS 0 0 0 0 194.00			10,004	1	0 0 74 (054		101 00
113.00 INTEREST EXPENSE 0 8,879 0 2,752,352 0 116.00 116.00 11600 HOSPI CE 0 8,879 0 2,752,352 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675,523 428,034 100 427,973,878 61,949 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 139,399 0 0 71,976 192.00 194.00 07950 WELLNESS 0 0 0 0 0 194.00		0	12, 091	1	<u>u</u> 2, 716, 051	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 675, 523 428, 034 100 427, 973, 878 61, 949 118.00 NONREI MBURSABLE COST CENTERS 100 0 0 0 0 190.00							113.00
NONRE MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 139, 399 0 0 71, 976 192.00 194.00 07950 WELLNESS 0 0 0 0 0 194.00	116. 00 11600 HOSPI CE						116.00
190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192. 00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 139, 399 0 0 71, 976 192.00 194. 00 07950 WELLNESS 0 0 0 0 0 194.00		675, 523	428, 034	10	<u>iuj 427, 973, 878</u>	61, 949	118.00
192. 00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 139, 399 0 0 71, 976 192. 00 194. 00 07950 WELLNESS 0 0 0 0 0 194. 00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		
	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-			-		
	194. 00 07950 WELLNESS 5/23/2022 3:05 pm	0	0	1	0 0	0	194.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021 Fo 12/31/2021	Worksheet B-1 Date/Time Pre	epared:
					5/23/2022 3:0	<u>15 pm</u>
					OTHER GENERAL	
			DUADUADA		SERVI CE	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PHYSI CI AN	
	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	PRI VATE	
	N	SUPPLY	REQUIS.)	LI BRARY	PRACTI CE	
	(DI RECT	(COSTED		(GROSS	(TIME	
	NRSING HRS)	REQUIS.)	15.00	CHARGES)	SPENT)	
194.0107951 JACKSON MOB	13.00	14.00	15.00	16.00	18.00	194.01
	0	0 450		0		194.01
194. 02 07952 EXTERNAL SVCS MARKETI NG 194. 03 07953 WASHI NGTON CLI NI C	0	8, 458		0		194.02
194. 04 07954 PHYSI CLAN OFFICES	0	24 450				194.03
194. 05 07955 I NTEGRATED MEDI CI NE	0	34, 450 202, 109				194.04
194. 06 07956 SURGI CAL PROFESSI ONAL	0	202, 109				194.05
194. 0707950 SURGICAL PROFESSIONAL 194. 0707957 PRIMARY CARE	0	93, 731				194.06
194. 08 07958 EMPLOYER CLINIC	0	42, 751		0		194.07
194. 09/07959 UROLOGY PROF	0	42, 731				194.08
194. 10/07960 SCOTTSBURG SPECIAL	0	954				194.09
194. 11 07961 BEHAVI ORAL HEALTH	0	7J4 0				194.10
194. 12/07962 SPC	0	54, 703				194.11
194. 13 07963 PULMONARY PROFESSI ONAL	0	955				194.12
200.00 Cross Foot Adjustments	0	755	l i	0	9,000	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	5, 232, 188	2, 892, 442	4, 987, 09	1, 908, 202	1, 641, 602	
Part I)	0,202,100	2,072,112	1, 707, 07	1, 700, 202	1,011,002	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 745388	2, 778168	49, 870. 97000	0. 004459	6.062113	203.00
204.00 Cost to be allocated (per Wkst. B,	317, 980	319, 191				204.00
Part II)	0177700	0177171	201, 11		20, 700	201100
205.00 Unit cost multiplier (Wkst. B, Part	0. 470717	0. 306580	2, 614. 75000	0. 000147	0. 095950	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems	SCHNECK MEDI CAL			of Form CMS-2552	2-10
CUST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-0065	Period: From 01/01/2021	Worksheet B-1	
		1 1		To 12/31/2021	Date/Time Prepar 5/23/2022 3:05 p	
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS				
		(ASSI GNED				
		TIME) 19.00				
1.00	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
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00 7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE					3.00
9. 00 10. 00	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY 01100 CAFETERI A). 00 1. 00
	01300 NURSI NG ADMI NI STRATI ON					3.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					4.00 5.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16	5.00
	01850 PHYSICIAN PRIVATE PRACTICE 01900 NONPHYSICIAN ANESTHETISTS	0				3.00 9.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS					. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0). 00 1. 00
	04300 NURSERY	0				3.00
50.00	ANCI LLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0				0.00 1.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			52	2.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0				3.00 4.00
	03630 ULTRA SOUND	0				4. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0				4.02
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				7.00 3.00
60.00	06000 LABORATORY	0			60	0. 00
63.00 64.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0				3.00 4.00
65.00	06500 RESPI RATORY THERAPY	0			65	5.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0				5.00 7.00
	06800 SPEECH PATHOLOGY	0				3.00
	06900 ELECTROCARDI OLOGY	0				9.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	0				1.00 2.00
	PATIENTS					
	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER)	0				3.00 5.00
76.01	03953 OTHER ANCILLARY CMS LINE	0			76	5. 01
	03951 CASE MANAGEMENT 03950 PALN MANAGEMENT	0				5. 02 5. 03
	03610 SLEEP LAB	0				5.04
	03480 ONCOLOGY 07697 CARDIAC REHABILITATION	0				5.05 5.97
70. 77	OUTPATIENT SERVICE COST CENTERS				/0	1. 77
	09000 CLINIC 09001 PALLIATIVE HEALTH	0). 00). 01
	09002 VEIN CENTER	0). 01). 02
	09003 0BGYN	0			90	0. 03
	09004 NEUROSURGERY 09005 SURGI CAL ASSOCI ATES	0). 04). 05
91.00	09100 EMERGENCY	0			91	1.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04952 BEHAVIORAL HEALTH	0				2.00 3.00
93.00	OTHER REIMBURSABLE COST CENTERS				93). 00
101.00	10100 HOME HEALTH AGENCY	0			101	1.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				113	3.00
116.00	11600 HOSPI CE				116	5.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0			118	3. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				0. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 WELLNESS	0				2.00 4.00
	07950 WELLINESS 07951 JACKSON MOB	0				4.00 4.01
	07952 EXTERNAL SVCS MARKETING 07953 WASHINGTON CLINIC	0				4. 02 4. 03
	07953 WASHINGTON CLINIC				194	. 03

Health Financial S	Systems	SCHNECK MEDI CAL	_ CENTER		In Lie	u of Form CMS-2552-10
COST ALLOCATION -	STATI STI CAL BASI S		Provi der	CCN: 15-0065	Peri od:	Worksheet B-1
					From 01/01/2021 To 12/31/2021	Date/Time Prepared:
						5/23/2022 3:05 pm
Cost	Center Description	NONPHYSI CI AN				
		ANESTHETI STS				
		(ASSI GNED				
		TIME) 19.00				
194. 04 07954 PHYSI	CLAN OFFLCES	0				194.04
194. 05 07955 I NTEG		0				194.05
194.0607956 SURGI	CAL PROFESSI ONAL	0				194.06
194. 07 07957 PRI MA	RY CARE	0				194.07
194.0807958 EMPLO	YER CLINIC	0				194.08
194. 09 07959 UROLO	GY PROF	0				194.09
194. 10 07960 SCOTT		0				194.10
194. 11 07961 BEHAV	I ORAL HEALTH	0				194. 11
194. 12 07962 SPC		0				194.12
194.13 07963 PULMO		0				194.13
	Foot Adjustments					200.00
	ive Cost Centers					201.00
202.00 Cost Part	to be allocated (per Wkst. B, I)	0				202.00
	cost multiplier (Wkst. B, Part I)	0. 000000				203.00
204.00 Cost Part	to be allocated (per Wkst. B, II)	0				204.00
	cost multiplier (Wkst. B, Part	0. 000000				205.00
)						
	adjustment amount to be allocated					206.00
	Wkst. B-2)					007 00
	unit cost multiplier (Wkst. D, III and IV)					207.00

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	narod
				10 12/31/2021	5/23/2022 3:0	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	12, 864, 821		12, 864, 82	1 109, 673	12, 974, 494	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 110, 804		6, 110, 80		6, 110, 804	
43. 00 04300 NURSERY	2, 360, 098		2, 360, 09		2, 360, 098	
ANCI LLARY SERVI CE COST CENTERS	_,,					1
50.00 05000 OPERATI NG ROOM	13, 112, 479		13, 112, 47	9 0	13, 112, 479	50.00
51.00 05100 RECOVERY ROOM	1, 398, 263		1, 398, 26	3 0	1, 398, 263	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 429, 958		2, 429, 95	8 0	2, 429, 958	52.00
53. 00 05300 ANESTHESI OLOGY	159, 135		159, 13	5 0	159, 135	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 344, 494		4, 344, 49	4 0	4, 344, 494	
54.01 03630 ULTRA SOUND	923, 218		923, 21		923, 218	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	184, 941		184, 94		184, 941	
57.00 05700 CT SCAN	1, 464, 925		1, 464, 92		1, 464, 925	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	899, 662		899, 66		899, 662	
60. 00 06000 LABORATORY	5, 356, 837		5, 356, 83		5, 432, 221	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	370, 575		370, 57		370, 575	
64.00 06400 INTRAVENOUS THERAPY	757, 581	0	757, 58		757, 581	
65. 00 06500 RESPIRATORY THERAPY	2, 597, 129	0			2, 597, 129	
66. 00 06600 PHYSI CAL THERAPY	3, 329, 651	0			3, 329, 651 778, 108	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	778, 108 496, 000	0	778, 10 496, 00		496,000	•
69. 00 06900 ELECTROCARDI OLOGY	498,000	0	478, 88		498,000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 692, 183		9, 692, 18		9, 692, 183	•
72. 00 07200 I MPLANTABLE DEVI CES CHARGED TO	4, 417, 393		4, 417, 39		4, 417, 393	
PATIENTS	1, 117, 070		1, 11, 0,	Ű	1, 117, 070	/2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	19, 867, 522		19, 867, 52	2 0	19, 867, 522	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	739, 447		739, 44		739, 447	
76.01 03953 OTHER ANCILLARY CMS LINE	0			0 0	0	76.01
76.02 03951 CASE MANAGEMENT	0			0 0	0	76.02
76. 03 03950 PALN MANAGEMENT	1, 360, 538		1, 360, 53	8 968	1, 361, 506	76.03
76.04 03610 SLEEP LAB	417, 660		417, 66	0 0	417, 660	76.04
76. 05 03480 ONCOLOGY	3, 632, 766		3, 632, 76		3, 814, 929	
76. 97 07697 CARDI AC REHABI LI TATI ON	419, 143		419, 14	3 0	419, 143	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 PALLI ATI VE HEALTH	102 027			0 0	102 027	
90. 02 09002 VEI N CENTER 90. 03 09003 0BGYN	192, 927 1, 583, 497		192, 92 1, 583, 49		192, 927 1, 583, 497	•
90. 04 09004 NEUROSURGERY	252, 328		252, 32		252, 328	
90. 05 09005 SURGI CAL ASSOCI ATES	877,017		877, 01		877, 985	
91. 00 09100 EMERGENCY	6, 645, 317		6, 645, 31		6, 645, 317	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 967, 860		2, 967, 86		2, 967, 860	
93. 00 04952 BEHAVI ORAL HEALTH	824, 164		824, 16		824, 164	•
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2, 536, 928		2, 536, 92	8	2, 536, 928	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	1, 522, 104		1, 522, 10		1, 522, 104	
200.00 Subtotal (see instructions)	118, 366, 353	0			118, 736, 578	
201.00 Less Observation Beds	2, 967, 860	-	2, 967, 86		2, 967, 860	
202.00 Total (see instructions)	115, 398, 493	0	115, 398, 49	3 370, 225	115, 768, 718	202.00

OMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/23/2022 3:0	epared:)5 pm
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. d	6 Cost or Other	TEFRA	
	·			+ col. 7)	Ratio	Inpati ent	
				· · ·		Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDI ATRI CS	13, 985, 221		13, 985, 22	1		30.0
1.00	03100 INTENSIVE CARE UNIT	11, 914, 667		11, 914, 66	7		31.0
	04300 NURSERY	8, 011, 181		8, 011, 18	1		43.0
	ANCI LLARY SERVI CE COST CENTERS						
0.00	05000 OPERATING ROOM	13, 741, 695	123, 898, 026	137, 639, 72	1 0. 095267	0.000000	50.0
	05100 RECOVERY ROOM	791, 662	9, 460, 726			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	10, 660, 302	641, 032			0.000000	
	05300 ANESTHESI OLOGY	939, 213	7, 428, 014			0.000000	
	05400 RADI OLOGY-DI AGNOSTI C		12, 922, 107			0.000000	
	03630 ULTRA SOUND	600, 133					
		361, 530	5, 339, 568			0.000000	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	8, 958	1, 953, 766			0. 000000	
7.00	05700 CT SCAN	1, 269, 635	27, 181, 084			0.000000	
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	364, 153	8, 606, 274			0.000000	
0.00	06000 LABORATORY	4, 686, 357	25, 210, 703	29, 897, 06		0.000000	
3.00	06300 BLOOD STORING, PROCESSING, & TRANS.	203, 001	496, 640	699, 64	1 0. 529664	0.000000	63.0
4.00	06400 INTRAVENOUS THERAPY	236, 655	2, 834, 321	3, 070, 97	6 0. 246691	0.000000	64.0
5.00	06500 RESPI RATORY THERAPY	5, 855, 275	3, 739, 927	9, 595, 20	2 0. 270670	0.000000	65.0
6.00	06600 PHYSI CAL THERAPY	577, 534	7, 304, 567	7, 882, 10	0. 422432	0.000000	66.0
7.00	06700 OCCUPATI ONAL THERAPY	504, 829	2, 998, 086			0.000000	
8.00	06800 SPEECH PATHOLOGY	686, 495	1,003,161	1, 689, 65		0.000000	
9.00	06900 ELECTROCARDI OLOGY	751, 975	5, 661, 722			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 221, 881	6, 489, 219			0. 000000	
2.00	07200 IMPLANTABLE DEVICES CHARGED TO	982, 178	6, 810, 001	7, 792, 17		0. 000000	
0 00	PATIENTS	F 005 440	00 / / 7 007	05 500 75	0 0 550/05	0 000000	70.0
	07300 DRUGS CHARGED TO PATIENTS	5, 835, 443	29,667,307			0.000000	
	03952 WOUND CARE (DI ABETES CENTER)	58, 124	1, 723, 125			0.000000	
	03953 OTHER ANCILLARY CMS LINE	0	0		0 0. 000000	0.000000	
	03951 CASE MANAGEMENT	0	0		0 0. 000000	0.00000	
	03950 PAIN MANAGEMENT	0	2, 273, 175			0.00000	
	03610 SLEEP LAB	1,000	2, 202, 747			0.000000	
	03480 ONCOLOGY	38, 251	10, 399, 894	10, 438, 14	5 0. 348028	0.000000	76.0
6.97	07697 CARDIAC REHABILITATION	143	262, 849	262, 99	2 1. 593748	0.000000	76.9
	OUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLINIC	0	0		0 0. 000000	0.000000	90.0
	09001 PALLI ATI VE HEALTH	0	0		0 0. 000000	0.000000	
	09002 VEIN CENTER	0	1, 551, 423			0. 000000	
	09003 0BGYN	200, 000	1,071,861	1, 271, 86		0. 000000	
	09004 NEUROSURGERY	46,000	421, 714			0.000000	
	09005 SURGI CAL ASSOCI ATES	40,000	445, 174			0.000000	
	09100 EMERGENCY	1, 462, 973	19, 665, 695			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	184, 459	5, 314, 130				
3.00	04952 BEHAVI ORAL HEALTH	0	346, 424	346, 42	4 2. 379061	0.000000	1 93.0
	OTHER REIMBURSABLE COST CENTERS		0.74/.054	0.74/.05	-		
01.00	10100 HOME HEALTH AGENCY	0	2, 716, 051	2, 716, 05	1		101.0
	SPECIAL PURPOSE COST CENTERS	1 1			1		
	11300 INTEREST EXPENSE						113.0
	11600 HOSPI CE	0	2, 752, 352				116.0
00.00		87, 181, 013	340, 792, 865	427, 973, 87	8		200.0
01.00							201.0
02.00	Total (see instructions)	87, 181, 013	340, 792, 865	427, 973, 87	8		202.0

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	SCHNECK MEDICA	Provider CCN: 15-0065	Peri od:	u of Form CMS- Worksheet C	-2552-10
COMPUT	ATTON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0085	From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pro 5/23/2022 3:0	epared:
			Title XVIII	Hospi tal	PPS	us pili
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					1 20 00
1	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY					31.00
	ANCI LLARY SERVICE COST CENTERS					43.00
	05000 OPERATING ROOM	0. 095267				50.00
	05100 RECOVERY ROOM	0. 136384				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 215015				52.00
53.00	05300 ANESTHESI OLOGY	0. 019019				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 321285				54.00
	03630 ULTRA SOUND	0. 161937				54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.094227				54.02
	05700 CT SCAN	0.051490				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0. 100292 0. 181697				58.00 60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 529664				63.00
	06400 I NTRAVENOUS THERAPY	0. 246691				64.00
	06500 RESPI RATORY THERAPY	0. 270670				65.00
	06600 PHYSI CAL THERAPY	0. 422432				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 222132				67.00
68.00	06800 SPEECH PATHOLOGY	0. 293551				68.00
	06900 ELECTROCARDI OLOGY	0. 074832				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 112624				71.00
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO	0. 566901				72.00
72 00						72 00
	07300 DRUGS CHARGED TO PATIENTS 03952 WOUND CARE (DIABETES CENTER)	0. 559605 0. 415128				73.00
	03953 OTHER ANCI LLARY CMS LINE	0. 000000				76.01
	03951 CASE MANAGEMENT	0. 000000				76.02
	03950 PAIN MANAGEMENT	0. 598945				76.03
76.04	03610 SLEEP LAB	0. 189523				76.04
76.05	03480 ONCOLOGY	0. 365480				76.05
	07697 CARDIAC REHABILITATION	1. 593748				76.97
	OUTPATIENT SERVICE COST CENTERS					
		0. 000000				90.00
	09001 PALLIATIVE HEALTH 09002 VEIN CENTER	0.000000				90.01
	09002 VEIN CENTER 09003 OBGYN	0. 124355 1. 245024				90.02
	09003 NEUROSURGERY	0. 539492				90.03
	09005 SURGI CAL ASSOCI ATES	1. 971830				90.05
	09100 EMERGENCY	0. 314517				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 539749				92.00
93.00	04952 BEHAVI ORAL HEALTH	2. 379061				93.00
	OTHER REIMBURSABLE COST CENTERS					_
	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					440.00
	11300 INTEREST EXPENSE					113.00
116.00 200.00	11600 HOSPICE					116.00 200.00
200.00						200.00
201.00	Less Observation Beds					

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	narod
				10 12/31/2021	5/23/2022 3:0	
		Ti tl	e XIX	Hospi tal	Cost	<u>o p</u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	12, 864, 821		12, 864, 82	1 109, 673	12, 974, 494	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 110, 804		6, 110, 80		6, 110, 804	
43. 00 04300 NURSERY	2, 360, 098		2, 360, 09		2, 360, 098	1
ANCI LLARY SERVI CE COST CENTERS	_,,					
50.00 05000 OPERATI NG ROOM	13, 112, 479		13, 112, 47	9 0	13, 112, 479	50.00
51.00 05100 RECOVERY ROOM	1, 398, 263		1, 398, 26	3 0	1, 398, 263	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 429, 958		2, 429, 95	8 0	2, 429, 958	52.00
53. 00 05300 ANESTHESI OLOGY	159, 135		159, 13	5 0	159, 135	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 344, 494		4, 344, 49	4 0	4, 344, 494	
54.01 03630 ULTRA SOUND	923, 218		923, 21		923, 218	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	184, 941		184, 94		184, 941	
57.00 05700 CT SCAN	1, 464, 925		1, 464, 92		1, 464, 925	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	899, 662		899, 66		899, 662	
60. 00 06000 LABORATORY	5, 356, 837		5, 356, 83		5, 432, 221	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	370, 575		370, 57		370, 575	
64. 00 06400 I NTRAVENOUS THERAPY	757, 581	0	757, 58		757, 581	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 597, 129	0			2, 597, 129	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	3, 329, 651 778, 108	0	3, 329, 65 778, 10		3, 329, 651 778, 108	
68. 00 06800 SPEECH PATHOLOGY	496,000	0	496, 00		496,000	1
69. 00 06900 ELECTROCARDI OLOGY	478, 880	0	478, 88		479,949	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 692, 183		9, 692, 18		9, 692, 183	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	4, 417, 393		4, 417, 39		4, 417, 393	1
PATIENTS	1, 11, 0, 0		.,, .,		.,,	12.00
73.00 07300 DRUGS CHARGED TO PATIENTS	19, 867, 522		19, 867, 52	2 0	19, 867, 522	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	739, 447		739, 44	7 0	739, 447	76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0			0 0	0	76.01
76.02 03951 CASE MANAGEMENT	0			0 0	0	76.02
76.03 03950 PALN MANAGEMENT	1, 360, 538		1, 360, 53		1, 361, 506	1
76.04 03610 SLEEP LAB	417, 660		417,66		417, 660	1
76. 05 03480 ONCOLOGY	3, 632, 766		3, 632, 76		3, 814, 929	1
76. 97 07697 CARDI AC REHABI LI TATI ON	419, 143		419, 14	3 0	419, 143	76.97
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09000 CETNIC 90. 01 09001 PALLI ATI VE HEALTH	0			0 0	0	
90. 02 09002 VEIN CENTER	192, 927		192, 92		192, 927	
90. 03 09003 0BGYN	1, 583, 497		1, 583, 49		1, 583, 497	1
90. 04 09004 NEUROSURGERY	252, 328		252, 32		252, 328	1
90. 05 09005 SURGI CAL ASSOCI ATES	877,017		877,01		877, 985	
91. 00 09100 EMERGENCY	6, 645, 317		6, 645, 31			1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 967, 860		2, 967, 86		2, 967, 860	
93. 00 04952 BEHAVI ORAL HEALTH	824, 164		824, 16	4 0	824, 164	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2, 536, 928		2, 536, 92	8	2, 536, 928	101.00
SPECIAL PURPOSE COST CENTERS	1		1	1		
113.00 11300 I NTEREST EXPENSE	1 500 15		1 500 15		4 500 453	113.00
116.00 11600 HOSPI CE	1, 522, 104	~	1, 522, 10		1, 522, 104	
200.00Subtotal (see instructions)201.00Less Observation Beds	118, 366, 353	0			118, 736, 578	
201.00Less Observation Beds202.00Total (see instructions)	2, 967, 860 115, 398, 493	0	2, 967, 86 115, 398, 49		2, 967, 860 115, 768, 718	
	115, 370, 493	0	115, 370, 49	570, 225	115,700,710	202.00

MPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/23/2022 3:0	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
. 00 03000	ADULTS & PEDIATRICS	13, 985, 221		13, 985, 22	1		30
. 00 03100	INTENSIVE CARE UNIT	11, 914, 667		11, 914, 66			31
. 00 04300	NURSERY	8, 011, 181		8, 011, 18	1	1	43
ANCI LL	LARY SERVICE COST CENTERS						
. 00 05000	OPERATING ROOM	13, 741, 695	123, 898, 026	137, 639, 72	0. 095267	0.00000	50
	RECOVERY ROOM	791, 662	9, 460, 726			0.00000	51
	DELIVERY ROOM & LABOR ROOM	10, 660, 302	641,032			0.000000	
	ANESTHESI OLOGY	939, 213	7, 428, 014			0.000000	
	RADI OLOGY-DI AGNOSTI C	600, 133	12, 922, 107			0.000000	
	ULTRA SOUND	361, 530	5, 339, 568			0.000000	
	NUCLEAR MEDICINE - DIAGNOSTIC	8, 958	1, 953, 766			0.000000	
	CT SCAN	1, 269, 635	27, 181, 084			0.000000	
	MAGNETIC RESONANCE IMAGING (MRI)	364, 153	8, 606, 274			0.000000	
			25, 210, 703				
		4, 686, 357				0.000000	
	BLOOD STORING, PROCESSING, & TRANS.	203, 001	496, 640			0.000000	
	I NTRAVENOUS THERAPY	236, 655	2,834,321			0.00000	
	RESPI RATORY THERAPY	5, 855, 275	3, 739, 927			0.00000	
	PHYSI CAL THERAPY	577, 534	7, 304, 567			0.00000	
	OCCUPATIONAL THERAPY	504, 829	2, 998, 086			0.00000	
	SPEECH PATHOLOGY	686, 495	1, 003, 161			0.00000	
. 00 06900	ELECTROCARDI OLOGY	751, 975	5, 661, 722	6, 413, 69	0. 074665	0.000000	60
. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 221, 881	6, 489, 219	8, 711, 10	0 1. 112624	0.000000	7
	I MPLANTABLE DEVICES CHARGED TO PATIENTS	982, 178	6, 810, 001	7, 792, 17	9 0. 566901	0. 000000	72
. 00 07300	DRUGS CHARGED TO PATIENTS	5, 835, 443	29, 667, 307	35, 502, 75	0 0. 559605	0.00000	73
	WOUND CARE (DIABETES CENTER)	58, 124	1, 723, 125	1, 781, 24	9 0. 415128	0.000000	76
. 01 03953	OTHER ANCILLARY CMS LINE	0	0		0 0.000000	0.000000	76
	CASE MANAGEMENT	0	0		0 0.000000	0.000000	70
. 03 03950	PAIN MANAGEMENT	0	2, 273, 175	2, 273, 17	5 0. 598519	0.000000	70
04 03610	SLEEP LAB	1,000	2, 202, 747	2, 203, 74	0. 189523	0.000000	70
05 03480	ONCOLOGY	38, 251	10, 399, 894	10, 438, 14	5 0. 348028	0.000000	70
97 07697	CARDI AC REHABI LI TATI ON	143	262, 849			0.00000	70
	TIENT SERVICE COST CENTERS				· · · · ·		1
	CLINIC	0	0		0 0.000000	0.00000	90
	PALLIATIVE HEALTH	0	0		0 0. 000000	0.000000	
	VEIN CENTER	Ő	1, 551, 423			0.000000	
03 09003		200, 000	1,071,861			0.000000	
	NEUROSURGERY	46,000	421, 714			0.000000	
	SURGI CAL ASSOCI ATES	40,000	445, 174			0.000000	
	EMERGENCY	1, 462, 973	19, 665, 695			0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	1, 402, 973	5, 314, 130				
	BEHAVIORAL HEALTH	184, 459	5, 314, 130			0.000000	
	REIMBURSABLE COST CENTERS	0	340, 424	340, 42	2.3/9001	0.00000	1 73
	HOME HEALTH AGENCY	0	2 714 051	2, 716, 05	1		110-
		0	2, 716, 051	2,710,05	<u> </u>		10'
	AL PURPOSE COST CENTERS	1			1		1
	INTEREST EXPENSE		0 750 050	0 750 05	_	1	113
5.0011600		0	2,752,352				116
	Subtotal (see instructions)	87, 181, 013	340, 792, 865	427, 973, 87	δ		200
	Less Observation Beds						201
2.00	Total (see instructions)	87, 181, 013	340, 792, 865	427, 973, 87	8		202

	inancial Systems TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0065	Peri od:	u of Form CMS- Worksheet C	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pr	epared:
				lleastel	5/23/2022 3:	05 pm
	Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	Cost	
	cost center bescription	Ratio				
		11.00				
LIN	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS					30. 00
31.00 03	3100 I NTENSI VE CARE UNI T					31.00
43.00 04	4300 NURSERY					43.00
AN	NCILLARY SERVICE COST CENTERS					
50.00 05	5000 OPERATING ROOM	0. 000000				50.00
51.00 05	5100 RECOVERY ROOM	0. 000000				51.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	5300 ANESTHESI OLOGY	0. 000000				53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	3630 ULTRA SOUND	0. 000000				54.01
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				54.02
	5700 CT SCAN	0. 000000				57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
1	6000 LABORATORY	0. 000000				60.00
	6300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000				63.00
	6400 INTRAVENOUS THERAPY	0. 000000				64.00
	6500 RESPI RATORY THERAPY	0. 000000				65.00
	6600 PHYSI CAL THERAPY	0. 000000				66.00
	6700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	6800 SPEECH PATHOLOGY	0. 000000				68.00
	6900 ELECTROCARDI OLOGY	0. 000000				69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07	7200 IMPLANTABLE DEVICES CHARGED TO	0. 000000				72.00
70 00 0	PATIENTS	0,000000				70.00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	3952 WOUND CARE (DIABETES CENTER)	0. 000000				76.00
	3953 OTHER ANCI LLARY CMS LINE	0. 000000				76.0
	3951 CASE MANAGEMENT	0. 000000				76.02
	3950 PALN MANAGEMENT	0. 000000				76.0
	3610 SLEEP LAB 3480 ONCOLOGY	0. 000000				76.02
1	7697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
	JTPATIENT SERVICE COST CENTERS	0.000000				- /0. //
	9000 CLINIC	0. 000000				90.00
	9001 PALLI ATI VE HEALTH	0. 000000				90.0
	9002 VEIN CENTER	0. 000000				90.02
	9003 OBGYN	0. 000000				90.03
	9004 NEUROSURGERY	0. 000000				90.04
	9005 SURGI CAL ASSOCI ATES	0. 000000				90.05
	9100 EMERGENCY	0. 000000				91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
93.00 04	4952 BEHAVI ORAL HEALTH	0. 000000				93.00
го	THER REIMBURSABLE COST CENTERS					
101.0010	0100 HOME HEALTH AGENCY					101.00
	PECIAL PURPOSE COST CENTERS					
	1300 INTEREST EXPENSE					113.00
	1600 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	SCHNECK MEDICAL CENTER			In Lie	In Lieu of Form CMS-2	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2021	Part I	
				Го 12/31/2021	Date/Time Pre 5/23/2022 3:0	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	,	Related Cost	, , , , , , , , , , , , , , , , , , ,	col. 4)	
	B, Part II,		(col. 1 -		· · ·	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 464, 309	1, 290	1, 463, 019	9 8, 574	170.63	30.00
31. 00 I NTENSI VE CARE UNI T	657, 748		657, 748	3 2, 878	228.54	31.00
43.00 NURSERY	89, 301		89, 30	1, 869	47.78	43.00
200.00 Total (lines 30 through 199)	2, 211, 358		2, 210, 068	3 13, 321		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	1, 853					30.00
31.00 INTENSIVE CARE UNIT	552	126, 154				31.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	2,405	442, 331				200.00

^{5/23/2022 3:05} pm

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0065	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/23/2022 3:0	eparec)5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
00 05000 OPERATING ROOM	2, 131, 124				67, 924	50.0
00 05100 RECOVERY ROOM	134, 300	10, 252, 388	0. 01309	253, 999	3, 327	51.0
00 05200 DELIVERY ROOM & LABOR ROOM	328, 141	11, 301, 334	0. 02903	36 737, 028	21, 400	52.0
00 05300 ANESTHESI OLOGY	56, 913	8, 367, 227	0. 00680	230, 869	1, 570	53.0
00 05400 RADI OLOGY-DI AGNOSTI C	858, 415	13, 522, 240	0. 06348	32 281, 868	17, 894	54.0
01 03630 ULTRA SOUND	70, 639	5, 701, 098	0. 01239	90 101, 420	1, 257	54.0
02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	70, 942	1, 962, 724	0. 03614	15 8, 004	289	54.
00 05700 CT SCAN	212, 147	28, 450, 719	0.00745	816, 350	6, 088	57.
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	370, 738	8, 970, 427	0. 04132	131, 373	5, 430	58.
00 06000 LABORATORY	404, 047				15, 488	
00 06300 BLOOD STORING, PROCESSING, & TRANS.	16, 689				2, 172	
00 06400 I NTRAVENOUS THERAPY	106, 875				2, 797	
00 06500 RESPIRATORY THERAPY	196, 138				36, 262	
00 06600 PHYSI CAL THERAPY	353, 854				11, 480	
00 06700 OCCUPATI ONAL THERAPY	14, 085				938	
00 06800 SPEECH PATHOLOGY	16, 764				333	
00 06900 ELECTROCARDI OLOGY	102, 530		1		4, 820	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 839				449	
00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1, 145				63	
00 07300 DRUGS CHARGED TO PATIENTS	472, 243	35, 502, 750	0.01330	1, 668, 854	22, 199	73.
00 03952 WOUND CARE (DI ABETES CENTER)	76, 749				409	
01 03953 OTHER ANCI LLARY CMS LINE	0				0	
02 03951 CASE MANAGEMENT	0		1		0	
03 03950 PALN MANAGEMENT	187, 816	2, 273, 175	1		0	
04 03610 SLEEP LAB	26, 874				8	
05 03480 ONCOLOGY	572, 735				2,066	
97 07697 CARDI AC REHABI LI TATI ON	63, 071	262, 992			34	
OUTPATIENT SERVICE COST CENTERS						1
00 09000 CLINIC	0	0	0.0000	0 0	0	90.
01 09001 PALLIATIVE HEALTH	0	l o			0	
02 09002 VEIN CENTER	7, 116	1, 551, 423			0	90.
03 09003 0BGYN	242, 465				44	
04 09004 NEUROSURGERY	4, 475				0	
05 09005 SURGI CAL ASSOCI ATES	166, 141	445, 264			0	
00 09100 EMERGENCY	526, 614				13, 170	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	334, 956				1, 633	
00 04952 BEHAVI ORAL HEALTH	49,047				1,035	
D. 00 Total (lines 50 through 199)	8, 181, 627			14, 235, 247		

Health Financial Systems	SCHNECK MEDI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	THER PASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	5/23/2022 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	n Cost	Medi cal	
	Post-Stepdown	-	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		o o	0	31.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien ⁻	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	8, 57	4 0.00	1, 853	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2,87	8 0.00	552	31.00
43. 00 04300 NURSERY		0	1, 86			
200.00 Total (lines 30 through 199)		0	13, 32			200.00
Cost Center Description	Inpati 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
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 0					1-00.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/23/2022 3:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist Cost	Program Post-Stepdown	Program	Post-Stepdown Adjustments		
			Adjustments		naj do tinor to		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01	03630 ULTRA SOUND	0	l o		0 0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 0	0	54.02
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS	-	-			-	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	0	0	1	0 0	0	76.00
76.01	03953 OTHER ANCILLARY CMS LINE	0	0		0 0	0	76.01
76.02	03951 CASE MANAGEMENT	0	0		0 0	0	76.02
76.03	03950 PALN MANAGEMENT	0	0		0 0	0	76.03
76.04	03610 SLEEP LAB	0	0		0 0	0	76.04
76.05	03480 ONCOLOGY	0	0		0 0	0	76.05
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 PALLI ATI VE HEALTH	0	0		0 0	0	90.01
90.02	09002 VEIN CENTER	0	0		0 0	0	90.02
90.03	09003 OBGYN	0	0		0 0	0	90.03
90.04	09004 NEUROSURGERY	0	0		0 0	0	90.04
90.05	09005 SURGI CAL ASSOCI ATES	0	0		0 0	0	90.05
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
93.00	04952 BEHAVI ORAL HEALTH	0	0		0 0	0	93.00
200.00		0	0		0 0	0	200.00
		•		•			•

Health Financial Systems	SCHNECK MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A THROUGH COSTS	NCI LLARY SERVI CE OTHER PA	.SS Provider C		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	epared:)5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	AII Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS				107 (00 704	0.000000	50.00
50.00 05000 OPERATING ROOM		0 0		0 137, 639, 721	0.000000	
51.00 05100 RECOVERY ROOM		0 0		0 10, 252, 388		
52.00 05200 DELIVERY ROOM & LABOR ROOM		0 0		0 11, 301, 334		
53.00 05300 ANESTHESI OLOGY		0 0		8, 367, 227	0.000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0 0		13, 522, 240		1
54.01 03630 ULTRA SOUND		0 0		5, 701, 098		
54.02 03450 NUCLEAR MEDICINE - DIAGNOST	T C	0 0		1, 962, 724		
57.00 05700 CT SCAN		0 0		28, 450, 719		
58.00 05800 MAGNETIC RESONANCE I MAGING	(MRI)	0 0		0 8, 970, 427	0. 000000	
60.00 06000 LABORATORY		0 0		29, 897, 060		
63.00 06300 BLOOD STORING, PROCESSING,	& TRANS.	0 0	(0 699, 641	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY		0 0		3, 070, 976		
65.00 06500 RESPI RATORY THERAPY		0 0		9, 595, 202	0. 000000	
66.00 06600 PHYSI CAL THERAPY		0 0	(7, 882, 101	0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY		0 0		3, 502, 915	0. 000000	
68.00 06800 SPEECH PATHOLOGY		0 0		0 1, 689, 656		
69. 00 06900 ELECTROCARDI OLOGY		0 0		0 6, 413, 697		
71.00 07100 MEDICAL SUPPLIES CHARGED TO		0 0		0 8, 711, 100		1
72.00 07200 I MPLANTABLE DEVI CES CHARGED PATI ENTS) TO	0 0		7, 792, 179	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0 0		35, 502, 750		73.00
76.00 03952 WOUND CARE (DIABETES CENTER	?)	0 0		0 1, 781, 249	0.000000	76.00
76.01 03953 OTHER ANCILLARY CMS LINE		0 0	(0 0	0.000000	76.01
76.02 03951 CASE MANAGEMENT		0 0	(0 0	0.000000	76.02
76.03 03950 PAIN MANAGEMENT		0 0	(2, 273, 175	0.000000	76.03
76.04 03610 SLEEP LAB		0 0	(2, 203, 747	0.000000	76.04
76. 05 03480 ONCOLOGY		0 0	(0 10, 438, 145	0.000000	76.05
76. 97 07697 CARDI AC REHABI LI TATI ON		0 0	(262, 992	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC		0 0		0 0	0.000000	90.00
90. 01 09001 PALLI ATI VE HEALTH		0 0	(0 0	0.000000	90.01
90. 02 09002 VEIN CENTER		o o	(0 1, 551, 423	0. 000000	90.02
90. 03 09003 OBGYN		o o	(0 1, 271, 861	0. 000000	90.03
90. 04 09004 NEUROSURGERY		o o	(O 467, 714	0. 000000	90.04
90. 05 09005 SURGI CAL ASSOCI ATES		o o	(0 445, 264	0. 000000	90.05
91.00 09100 EMERGENCY		o 0	(21, 128, 668	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART)	o o	(5, 498, 589	0. 000000	92.00
93. 00 04952 BEHAVI ORAL HEALTH		o 0	(346, 424	0. 000000	93.00
200.00 Total (lines 50 through 199	2)	o o	(388, 594, 406		200.00
· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems	SCHNECK MEDIC			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/23/2022 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	T					
50. 00 05000 OPERATI NG ROOM	0. 000000	4, 387, 000		0 21, 233, 144	0	
51.00 05100 RECOVERY ROOM	0. 000000	253, 999		0 1, 714, 521	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	737, 028		0 1, 098	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	230, 869		0 1, 207, 807	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	281, 868		0 1, 850, 015	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	101, 420		0 985, 288	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	8, 004		0 536, 419	0	54.02
57.00 05700 CT SCAN	0. 000000	816, 350		0 5, 506, 540	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	131, 373		0 1, 992, 448	0	58.00
60. 00 06000 LABORATORY	0. 000000	1, 145, 962		0 2, 433, 240	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	91, 036		0 107, 302	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	80, 360		0 499, 209	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 774, 002		0 584, 118	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	255, 724		0 40, 299	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	233, 350		0 154, 046	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	33, 536		0 12, 046	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	301, 491		0 1, 254, 193	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	670, 145		0 1, 116, 141	0	71.00
72.00 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0. 000000	429, 503		0 1, 703, 776	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 668, 854		0 8, 413, 546	0	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0. 000000	9, 490		0 547, 838	0	76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0. 000000	0		0 0	0	76.01
76. 02 03951 CASE MANAGEMENT	0. 000000	0		0 0	0	76.02
76. 03 03950 PALN MANAGEMENT	0. 000000	0		0 384, 098	0	76.03
76. 04 03610 SLEEP LAB	0. 000000	653		0 370, 906	0	76.04
76. 05 03480 ONCOLOGY	0. 000000	37,653		0 3, 165, 039	0	76.05
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	143		0 76, 442	0	76.97
OUTPATIENT SERVICE COST CENTERS			[
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 PALLI ATI VE HEALTH	0. 000000	0		0 0	0	90.01
90. 02 09002 VEI N CENTER	0. 000000	0		0 444, 948	0	90.02
90. 03 09003 0BGYN	0. 000000	233		0 250, 789	0	90.03
90. 04 09004 NEUROSURGERY	0. 000000	0		0 55, 488	0	90.04
90. 05 09005 SURGI CAL ASSOCI ATES	0. 000000	0		0 47, 160	0	90.05
91.00 09100 EMERGENCY	0. 000000	528, 391		0 3, 084, 836	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	26, 810		0 1, 106, 295	0	92.00
93. 00 04952 BEHAVI ORAL HEALTH	0. 000000	0		0 0 0 60, 879, 035	0	
200.00 Total (lines 50 through 199)		14, 235, 247		0 60, 879, 035		200.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-0065	Period:	Worksheet D	2552-10
/					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	epared:
					lleenitel	5/23/2022 3:0)5 pm
				2 XVIII Charges	Hospi tal	PPS Costs	
	Cost Center Description	Cost to	PPS	Charges	Cost	PPS Services	
	cost center bescription	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Servi ces (see	Servi ces	Servi ces Not	(300 1131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 095267			0 0	2, 022, 818	
	O RECOVERY ROOM	0. 136384			0 0	233, 833	51.00
	O DELIVERY ROOM & LABOR ROOM	0. 215015			0 0	236	
	O ANESTHESI OLOGY	0. 019019			0 0	22, 971	
	0 RADI OLOGY-DI AGNOSTI C	0. 321285			0 0	594, 382	
	O ULTRA SOUND	0. 161937			0 0	159, 555	
	ONUCLEAR MEDICINE - DIAGNOSTIC	0. 094227			0 0	50, 545	
	O CT SCAN	0. 051490			0 0	283, 532	
58.00 05800	O MAGNETIC RESONANCE IMAGING (MRI)	0. 100292			0 0	199, 827	
		0. 179176			0 0	435, 978	
	O BLOOD STORING, PROCESSING, & TRANS.	0. 529664			0 0	56, 834	
	O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY	0. 246691 0. 270670	499, 209 584, 118		0 0	123, 150 158, 103	
	O PHYSICAL THERAPY	0. 270870			0 0	17, 024	
	O OCCUPATI ONAL THERAPY	0. 222132			0 0	34, 219	
	O SPEECH PATHOLOGY	0. 293551	12, 046		0 0	3, 536	
	0 ELECTROCARDI OLOGY	0. 074665			0 0	93, 644	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 112624			0 0	1, 241, 845	
	O I MPLANTABLE DEVICES CHARGED TO	0, 566901	1, 703, 776		0 0	965, 872	
	PATIENTS		.,		-		
73.00 07300	O DRUGS CHARGED TO PATIENTS	0. 559605	8, 413, 546		0 11, 612	4, 708, 262	73.00
	2 WOUND CARE (DIABETES CENTER)	0. 415128	547, 838		0 0	227, 423	76.00
	3 OTHER ANCILLARY CMS LINE	0. 000000	0		0 0	0	76.01
	1 CASE MANAGEMENT	0. 000000			0 0	0	76.02
	O PAIN MANAGEMENT	0. 598519			0 0	229, 890	
	OSLEEP LAB	0. 189523			0 0	70, 295	
	O ONCOLOGY	0. 348028			0 0	1, 101, 522	
76.97 0769	7 CARDI AC REHABI LI TATI ON	1. 593748	76, 442	2	0 0	121, 829	76.97
	ATIENT SERVICE COST CENTERS	0.00000					
		0. 000000			0 0	0	
	1 PALLI ATI VE HEALTH	0. 000000			0 0	0	
	2 VEIN CENTER 3 OBGYN	0. 124355			0 0	55, 332	
	4 NEUROSURGERY	1. 245024			0 0	312, 238	
		0. 539492				29, 935	
	5 SURGI CAL ASSOCI ATES 0 EMERGENCY	1. 969656 0. 314517			0 0 0 0	92, 889 970, 233	
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 539749			0 0	597, 122	
	2 BEHAVIORAL HEALTH	2, 379061			0 0	0 0 0	
200.00	Subtotal (see instructions)	2. 377001	60, 879, 035		0 11, 612	15, 214, 874	
200.00	Less PBP Clinic Lab. Services-Program		00, 077, 035		0 0	15, 214, 074	200.00
	Only Charges				- -		

PPORTI ONMEN	IT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 5/23/2022 3:	reparec
			Title	e XVIII	Hospi tal	PPS	<u> </u>
		Cos					
	Cost Center Description	Cost	Cost	1			
	•	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
ANCI LL	ARY SERVICE COST CENTERS	· · · · · ·					
0.00 05000	OPERATING ROOM	0	()			50. (
1.00 05100	RECOVERY ROOM	0	(51.0
	DELIVERY ROOM & LABOR ROOM	0	C				52.0
	ANESTHESI OLOGY	0	(•			53.0
	RADI OLOGY-DI AGNOSTI C	0	(•			54.0
	ULTRA SOUND	0	(•			54.0
	NUCLEAR MEDICINE - DIAGNOSTIC	0	(1			54.0
	CT SCAN	0	(57.0
	MAGNETIC RESONANCE IMAGING (MRI)	0	(•			58.0
	LABORATORY	0	(1			60.
	BLOOD STORING, PROCESSING, & TRANS.	0	(•			63.
	INTRAVENOUS THERAPY	0	(64.
	RESPIRATORY THERAPY	-	(65.
		0	(1			
	PHYSI CAL THERAPY	0		1			66.
	OCCUPATIONAL THERAPY	0	(•			67.0
	SPEECH PATHOLOGY	0	(•			68.
	ELECTROCARDI OLOGY	0	(69.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	•			71.
	IMPLANTABLE DEVICES CHARGED TO	0	C				72.0
	PATIENTS						
	DRUGS CHARGED TO PATIENTS	0	6, 498	•			73.0
	WOUND CARE (DIABETES CENTER)	0	(76.0
	OTHER ANCILLARY CMS LINE	0	(•			76.
	CASE MANAGEMENT	0	(•			76.
	PAIN MANAGEMENT	0	(76.
6.04 03610	SLEEP LAB	0	(1			76.
	ONCOLOGY	0	(76.
	CARDIAC REHABILITATION	0	(76.
	FIENT SERVICE COST CENTERS						
0.00 09000	CLINIC	0	(90.
0.01 09001	PALLIATIVE HEALTH	0	(90.
0.02 09002	VEIN CENTER	0	(90.
0.03 09003		0	(90.
0.04 09004	NEUROSURGERY	0	(90.
	SURGI CAL ASSOCI ATES	0	C				90.
	EMERGENCY	0	C	•			91.
	OBSERVATION BEDS (NON-DISTINCT PART)	0	(•			92.
	BEHAVI ORAL HEALTH	0	(•			93.
	Subtotal (see instructions)	0	6, 498	1			200.
	Less PBP Clinic Lab. Services-Program	0	0,470				200.
	Only Charges						201.
1 1		1		1			1

APPORTI ONMI	ancial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND		CAL CENTER Provider	CCN: 15-0065	Peri od:	worksheet D	2002 10
	ent of medioxe, offick hearth services and			con. 13 0005	From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	epared:
						5/23/2022 3:0)5 pm
			II.	tle XIX	Hospi tal	Cost	
	Cast Castas Description	Cost to	DDC	Charges	Cast	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio From	Reimbursed	Reimbursed e Services	I Reimbursed Services Not	(see inst.)	
		Worksheet C,	Services (se inst.)	Subject To			
		Part I, col.	inst.)	Ded. & Coin			
		9		(see inst.			
		1.00	2.00	3.00	4.00	5.00	
ANCL	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	O OPERATING ROOM	0. 095267		0	0 1, 733, 123	0	50.00
	0 RECOVERY ROOM	0. 136384		0	0 172, 514		
	0 DELIVERY ROOM & LABOR ROOM	0. 215015		0	0 31,038		
	0 ANESTHESI OLOGY	0. 019019		0	0 167, 916		
	0 RADI OLOGY-DI AGNOSTI C	0. 321285		0	0 182, 440		
	O ULTRA SOUND	0. 161937		0	0 91,846		
	O NUCLEAR MEDICINE - DIAGNOSTIC	0. 094227		0	0 17, 100		
	O CT SCAN	0. 051490		0	0 461, 121		
	0 MAGNETIC RESONANCE IMAGING (MRI)	0. 100292		0	0 129, 324		
	0 LABORATORY	0. 179176		0	0 413, 652		
	0 BLOOD STORING, PROCESSING, & TRANS.	0. 529664		0	0 4, 127		
	0 INTRAVENOUS THERAPY	0. 246691		0	0 27, 216		
	0 RESPIRATORY THERAPY	0. 240091		0			
	0 PHYSI CAL THERAPY	0. 270870		0			
	0 OCCUPATIONAL THERAPY	0. 222132		0	0 98, 572 0 41, 713		
	0 SPEECH PATHOLOGY	0. 222132		0	0 41, 593		
				0			
		0.074665		0			
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 112624		0	0 163, 796		
72.00 0720	O IMPLANTABLE DEVICES CHARGED TO	0. 566901		0	0 0	0	72.00
72 00 0720	PATIENTS				0 000 100		72 00
	O DRUGS CHARGED TO PATIENTS	0. 559605		0	0 233, 130		
	2 WOUND CARE (DIABETES CENTER)	0. 415128		0	0 24, 986		
	3 OTHER ANCILLARY CMS LINE	0.00000		0	0 0		
	1 CASE MANAGEMENT	0.00000		0	0 0	-	
	O PALN MANAGEMENT	0. 598519		0	0 35,724		
	0 SLEEP LAB	0. 189523		0	0 32, 352		
	O ONCOLOGY	0. 348028		0	0 112, 742		
	17 CARDI AC REHABI LI TATI ON	1. 593748		0	0 1, 143	0	76.97
	ATLENT SERVICE COST CENTERS	0.00000					
	OCLINIC	0. 000000		0	0 0		
	1 PALLI ATI VE HEALTH	0. 000000		0	0 0		
	2 VEIN CENTER	0. 124355		0	0 24, 238		
	13 OBGYN	1. 245024		0	0 59,013		
	4 NEUROSURGERY	0. 539492		0	0 9,744		
	5 SURGI CAL ASSOCI ATES	1. 969656		0	0 6, 648		
	O EMERGENCY	0. 314517		0	0 549,636		
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 539749		0	0 97, 331		
	2 BEHAVI ORAL HEALTH	2. 379061		0	0 0		
200.00	Subtotal (see instructions)			0	0 5, 107, 916		200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)			0	0 5, 107, 916		202.00

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0065	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 5/23/2022 3:	
		Ti tl	e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
00 05000 OPERATING ROOM	0	165, 109				50.0
00 05100 RECOVERY ROOM	0	23, 528				51.0
00 05200 DELIVERY ROOM & LABOR ROOM	0	6,674	1			52.0
00 05300 ANESTHESI OLOGY	0	3, 194				53.0
00 05400 RADI OLOGY-DI AGNOSTI C	0	58, 615				54.
01 03630 ULTRA SOUND	0	14, 873				54.
02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	1, 611				54.
00 05700 CT SCAN	0	23, 743				57.
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	12, 970				58.
00 06000 LABORATORY	0	74, 117				60.
	-					
00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	2, 186				63.
00 06400 I NTRAVENOUS THERAPY	0	6, 714				64.
00 06500 RESPI RATORY THERAPY	0	16, 855				65.
00 06600 PHYSI CAL THERAPY	0	41, 640				66.
00 06700 OCCUPATI ONAL THERAPY	0	9, 266				67.
00 06800 SPEECH PATHOLOGY	0	12, 210				68.
00 06900 ELECTROCARDI OLOGY	0	6, 113				69.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	182, 243				71.
00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0				72.
PATIENTS						
00 07300 DRUGS CHARGED TO PATIENTS	0	130, 461				73.
00 03952 WOUND CARE (DIABETES CENTER)	0	10, 372				76.
01 03953 OTHER ANCILLARY CMS LINE	0	0	1			76.
02 03951 CASE MANAGEMENT	0	0				76.
03 03950 PALN MANAGEMENT	0	21, 381				76.
04 03610 SLEEP LAB	0	6, 131				76.
05 03480 0NC0L0GY	0	39, 237				76.
97 07697 CARDI AC REHABI LI TATI ON	0	1, 822				76.
OUTPATIENT SERVICE COST CENTERS	-	.,				
00 09000 CLINIC	0	0				90.
01 09001 PALLI ATI VE HEALTH	0	0				90.
02 09002 VEIN CENTER	0	3, 014				90.
03 09003 0BGYN	0	73, 473				90.
04 09004 NEUROSURGERY						90.
		5, 257				
	0	13, 094				90.
00 09100 EMERGENCY	0	172, 870				91.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	52, 534				92.
00 04952 BEHAVI ORAL HEALTH	0	0				93.
0.00 Subtotal (see instructions)	0	1, 191, 307				200.
Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
2.00 Net Charges (line 200 - line 201)	0	1, 191, 307				202.

	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0065	Period: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre	
		Title XVIII	Hospi tal	5/23/2022 3: 0 PPS	15 pr
	Cost Center Description		lioopi tui		
[PART I - ALL PROVIDER COMPONENTS			1.00	
	NPATIENT DAYS Inpatient days (including private room days and swing-bed da	ve oveluding nowhern)		8, 621	1 1
	Inpatient days (including private room days, excluding swing-			8, 574	
	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	
	do not complete this line.			((11	
00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private n		er 31 of the cost	6, 611 47	4
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7
	reporting period		i or or the cost	0	<i>'</i>
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (evoludin	a swina-bed and	1, 853	9
,0	newborn days) (see instructions)		g swing bed and	1,000	´
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	28	10
00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,		room days) arter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including prive	to room days)	0	13
00	after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			0	
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	243.34	17
00	reporting period			0.40.04	10
00	Medicare rate for swing-bed SNF services applicable to servi- reporting period	ces after December 31 of	the cost	243.34	18
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 c	f the cost	231.10	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	231.10	20
	reporting period			2011.10	20
	Total general inpatient routine service cost (see instruction			12, 974, 494	
. 00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	ber 31 of the cost repor	ting period (line	11, 437	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)		31 1		
	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er 31 of the cost report	ing period (line	0	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		11, 437 12, 963, 057	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus the 20)		12, 903, 037	2'
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l		cuons)	0. 00 0. 00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost		ifferential (line		
ł	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (se			1, 511. 90	38
. 00 1		-			
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog			2, 801, 551 0	

OMPUTATION OF INPATIENT OPERATING COST	oonneon mebro	AL CENTER Provider C		eriod:	u of Form CMS-2 Worksheet D-1	
MPUTATION OF INPATIENT OPERATING COST		Provider C	F	rom 01/01/2021 o 12/31/2021		epared
		Title	XVIII	Hospi tal	PPS	JS pili
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.0
Intensive Care Type Inpatient Hospital Unit 3.00 INTENSIVE CARE UNIT		2 070	2, 123. 28	EE2	1, 172, 051	1 42 0
3. 00 I NTENSI VE CARE UNI T 4. 00 CORONARY CARE UNI T	6, 110, 804	2, 878	2, 123. 28	552	1, 172, 051	43.C
5. 00 BURN INTENSIVE CARE UNIT						45.0
5. 00 SURGICAL INTENSIVE CARE UNIT						46.0
7. 00 OTHER SPECIAL CARE (SPECIFY)			<u> </u>			47.0
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost (W	kst. D-3, col. 3	, line 200)			3, 849, 090	48.0
9.00 Total Program inpatient costs (sum of lines			ons)		7, 822, 692	
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program in	patient routine	services (fro	n Wkst. D, sum	of Parts I and	442, 331	50.0
) 1.00 Pass through costs applicable to Program in	natient ancillar	v services (f	rom Wkst D si	um of Parts II	239, 544	51.0
and IV)		y 301 V1003 (1	0m wk3t. b, 3t		207, 044	51.0
2.00 Total Program excludable cost (sum of lines					681, 875	
3.00 Total Program inpatient operating cost excl		lated, non-ph	ysician anesthe	etist, and	7, 140, 817	53.0
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
4.00 Program di scharges					0	54.0
5.00 Target amount per discharge					0.00	
5.00 Target amount (line 54 x line 55)					0	
7.00 Difference between adjusted inpatient opera	ting cost and ta	rget amount (ine 56 minus I	ine 53)	0	
3.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost r	enorting period	ending 1996	undated and cor	mounded by the	0.00	
market basket	cporting period	chung 1770,		ipounded by the	0.00	37.
0.00 Lesser of lines 53/54 or 55 from prior year					0.00	
1.00 If line 53/54 is less than the lower of lin					0	61.
which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
2.00 Relief payment (see instructions)					0	62.0
3.00 Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	63.0
PROGRAM INPATIENT ROUTINE SWING BED COST						
 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only) 	sts through Dece	mber 31 of th	e cost reportir	ng period (See	6, 814	64.0
5.00 Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reporting	period (See	0	65.0
instructions)(title XVIII only)						
5.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	55)(title XVIII	only). For	6, 814	66.0
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost re	porting period	0	67.0
(line 12 x line 19)	ne costs through	December 31	Ji the cost rep	Joi tring period	0	07.
3.00 Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repor	rting period	0	68. (
(line 13 x line 20)			(0)			
P. 00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	69.
0.00 Skilled nursing facility/other nursing faci						70.
1.00 Adjusted general inpatient routine service	cost per diem (I					71.0
2.00 Program routine service cost (line 9 x line			25)			72.
3.00 Medically necessary private room cost appli 4.00 Total Program general inpatient routine ser	0					73. 74.
5.00 Capital -related cost allocated to inpatient	•			art II, column		75.
26, line 45)				,		
5.00 Per diem capital -related costs (line 75 ÷ 1						76.
7.00 Program capital-related costs (line 9 x lin 3.00 Inpatient routine service cost (line 74 min						77. 78.
9.00 Aggregate charges to beneficiaries for exce		rovi der recor	ds)			78.
0.00 Total Program routine service costs for com				us line 79)		80.
1.00 Inpatient routine service cost per diem lim						81.
2.00 Inpatient routine service cost limitation (82.
 3.00 Reasonable inpatient routine service costs 4.00 Program inpatient ancillary services (see i 	•	5)				83. 84.
5.00 Utilization review - physician compensation		ns)				85.
5.00 Total Program inpatient operating costs (su	m of lines 83 th					86.
PART IV - COMPUTATION OF OBSERVATION BED PA						1
					1 0/2	
7.00 Total observation bed days (see instruction 3.00 Adjusted general inpatient routine cost per		line 2)			1, 963 1, 511. 90	

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/23/2022 3:0	pared: 5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 464, 309	12, 974, 494	0. 11286	2, 967, 860	334, 956	90.00
91.00 Nursing Program cost	0	12, 974, 494	0.00000	0 2, 967, 860	0	91.00
92.00 Allied health cost	0	12, 974, 494	0.0000	2, 967, 860	0	92.00
93.00 All other Medical Education	0	12, 974, 494	0.00000	2, 967, 860	0	93.00

^{5/23/2022 3:05} pm

MPUT	Financial Systems SCHNECK MEDICA ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0065	Peri od:	u of Form CMS-2 Worksheet D-1		
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pare	
		T' LL S VI V		5/23/2022 3:0		
	Cost Center Description	Title XIX	Hospi tal	Cost		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	INPATIENT DAYS	I		0. (01		
	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			8, 621 8, 574	1.	
	Private room days (excluding swing-bed and observation bed d		rivate room days,	0, 374	3	
	do not complete this line.	5, 5, 5,				
00	Semi-private room days (excluding swing-bed and observation		01 -5	6, 611	4	
00	Total swing-bed SNF type inpatient days (including private r reporting period	com days) through becemb	er 31 of the cost	47	5	
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6	
	reporting period (if calendar year, enter 0 on this line)				_	
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	7	
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8	
	reporting period (if calendar year, enter 0 on this line)					
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excludin	g swing-bed and	1, 575	9	
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10	
	through December 31 of the cost reporting period (see instru					
	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	11	
	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12	
	through December 31 of the cost reporting period					
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar	(IX only (including priva	te room days)	0	13	
	Medically necessary private room days applicable to the Prog			0	14	
	Total nursery days (title V or XIX only)		5 /	1, 869	15	
	Nursery days (title V or XIX only)			1, 147	16	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	243.34	17	
	reporting period	eee thi eagit becomen et		210101		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	243.34	18	
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	231.10	19	
	reporting period			001 10		
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of	the cost	231.10	20	
. 00	Total general inpatient routine service cost (see instruction	ons)		12, 864, 821	21	
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	11, 437	22	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	or 21 of the cost reporti	na poriod (lino A	0	23	
	x line 18)	a si oi the cost reporti	ng period (inne d	0	23	
	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24	
	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25	
	x line 20)		g per lou (i i i e o	0	20	
	Total swing-bed cost (see instructions)			11, 437		
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		12, 853, 384	27	
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28	
	Private room charges (excluding swing-bed charges)			0		
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	1 + 1 = 28		0 0. 000000		
	Average private room per diem charge (line 29 ÷ line 3)	÷ 1111e 28)		0.000000		
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
	Average per diem private room charge differential (line 32 m	, ,	ctions)	0.00		
	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)			0.00	35 36	
	General inpatient routine service cost net of swing-bed cost		ifferential (line	-		
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	UISTMENTS				
				1, 499. 11	38	
. 00 [
. 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog	ne 38)		2, 361, 098	39 40	

	Financial Systems TATION OF INPATIENT OPERATING COST	SCHNECK MEDI	CAL CENTER Provider C		In Lie eriod:	u of Form CMS- Worksheet D-1	
COMPUT	ATTON OF INFATIENT OPERATING COST		Provider C		rom 01/01/2021		epared:
			Ti tl	e XIX	Hospi tal	Cost	, piii
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDV (+; +Lo V & VIV oply)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 360, 098	1, 869	1, 262. 76	1, 147	1, 448, 386	42.00
43.00	INTENSIVE CARE UNIT	6, 110, 804	2, 878	2, 123. 28	170	360, 958	43.00
44.00	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.00
47.00	Cost Center Description	I					47.00
						1.00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			anc)		955, 597 5, 126, 039	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 40) (see mistruction	0115)		5, 120, 039	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
-1							
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (†	rom Wkst. D, su	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line	52)					_
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operat	ing cost and ta	irget amount (line 56 minus l	ine 53)	0	
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	onding 1004	undated and cor	nounded by the	0.00	
57.00	market basket	por tring period	enuring 1990,	upuateu anu com	ipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	icti ons)			0	63.00
44 00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Door	mbor 21 of th	a agat raparti	a paried (See	0	44.00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece		e cost reportin	ig period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost rep	orting period	0	67.00
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repor	ting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70.00	Skilled nursing facility/other nursing facil	2		• • •			70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ iine	2)			71.00
73.00	Medically necessary private room cost applic		line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, Pa	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu			-1 - 2			78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				IS Line 70)		79.00
	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I)				82.00
83.00	Reasonable inpatient routine service costs (is)				83.00
84.00	Program inpatient ancillary services (see in						84.00
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
87.00	Total observation bed days (see instructions)				1, 963	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 499. 11 2, 942, 753	
00 00							

Health Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		pared: 5 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 464, 309	12, 864, 821	0. 11382	3 2, 942, 753	334, 953	90.00
91.00 Nursing Program cost	0	12, 864, 821	0.00000	0 2, 942, 753	0	91.00
92.00 Allied health cost	0	12, 864, 821	0. 00000	0 2, 942, 753	0	92.00
93.00 All other Medical Education	0	12, 864, 821	0. 00000	0 2, 942, 753	0	93.00

^{5/23/2022 3:05} pm

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0065	Peri od:	Worksheet D-3	2552
		. 10 0000	From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
D. 00 03000 ADULTS & PEDIATRICS			3, 206, 286		30.
1. 00 03100 I NTENSI VE CARE UNI T 3. 00 04300 NURSERY			3, 063, 984		31. 43.
ANCI LLARY SERVICE COST CENTERS					43.
D. 00 05000 OPERATI NG ROOM		0. 09526	4, 387, 000	417, 936	50.
1. 00 05100 RECOVERY ROOM		0. 13638		34, 641	51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 21501		158, 472	
3. 00 05300 ANESTHESI OLOGY		0. 01901		4, 391	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 32128		90, 560	
I. 01 03630 ULTRA SOUND		0. 16193		16, 424	54
1. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 09422	8, 004	754	54
7. 00 05700 CT SCAN		0. 05149	816, 350	42, 034	57
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 10029	92 131, 373	13, 176	58
0. 00 06000 LABORATORY		0. 18169	97 1, 145, 962	208, 218	60
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 52966	54 91, 036	48, 218	63
1. 00 06400 I NTRAVENOUS THERAPY		0. 24669		19, 824	
5. 00 06500 RESPI RATORY THERAPY		0. 27067		480, 169	
5. 00 06600 PHYSI CAL THERAPY		0. 42243		108, 026	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 22213		51, 835	
3. 00 06800 SPEECH PATHOLOGY		0. 29355		9, 845	
9. 00 06900 ELECTROCARDI OLOGY		0.07483		22, 561	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 11262		745, 619	
2. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 56690		243, 486	
		0. 55960		933, 899	
5. 00 03952 WOUND CARE (DIABETES CENTER) 5. 01 03953 OTHER ANCILLARY CMS LINE		0. 41512		3, 940	
5. 02 03951 CASE MANAGEMENT		0.00000		0	
5. 03 03950 PALN MANAGEMENT		0. 59894		0	
5. 04 03610 SLEEP LAB		0. 18952		124	
5. 05 03480 ONCOLOGY		0. 36548		13, 761	
5. 97 07697 CARDIAC REHABILITATION		1. 59374		228	
OUTPATIENT SERVICE COST CENTERS					
D. 00 09000 CLINIC		0.00000	0 00	0	90
D. 01 09001 PALLI ATI VE HEALTH		0.00000		0	90
0. 02 09002 VEIN CENTER		0. 12435		0	90
0. 03 09003 0BGYN		1. 24502		290	
0. 04 09004 NEUROSURGERY		0. 53949		0	90
0. 05 09005 SURGI CAL ASSOCI ATES		1.97183		0	
1.00 09100 EMERGENCY		0. 31451		166, 188	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53974		14, 471	
8. 00 04952 BEHAVI ORAL HEALTH		2. 37906		0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)	racc (line (1))		14, 235, 247	3, 849, 090	
D1.00Less PBP Clinic Laboratory Services-Program only chaD2.00Net charges (line 200 minus line 201)	rges (Trne 61)		14 225 247		201 202
		1	14, 235, 247		1204

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0065	Peri od:	Worksheet D-3	2552-1
NIATENT ANGLEART SERVICE COST ALLORTIONMENT	in ovider c	CN. 15-0005	From 01/01/2021		,
	Component	CCN: 15-U065	To 12/31/2021	Date/Time Pre 5/23/2022 3:0	epared
	Title	× XVIII	Swing Beds - SNI		
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS					30.0
1. 00 03100 I NTENSI VE CARE UNI T 3. 00 04300 NURSERY					31.0
ANCI LLARY SERVICE COST CENTERS					43. C
0. 00 05000 OPERATI NG ROOM		0.0952	67 0	0	50. C
1. 00 05100 RECOVERY ROOM		0. 1363			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2150		-	
3. 00 05300 ANESTHESI OLOGY		0.0190		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3212			
4. 01 03630 ULTRA SOUND		0. 1619			
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 0942			
7. 00 05700 CT SCAN		0.0514			
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1002			
0. 00 06000 LABORATORY		0. 1816		434	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 5296		0	63.0
4.00 06400 INTRAVENOUS THERAPY		0. 2466	91 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY		0. 2706	70 5, 571	1, 508	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 4224	32 11, 899	5, 027	66.0
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2221	32 0	0	67.0
8.00 06800 SPEECH PATHOLOGY		0. 2935	51 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY		0. 0748	32 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1126	24 2, 601	2, 894	71.0
2.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 5669	01 0	0	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5596	05 6, 869	3, 844	73.0
6.00 03952 WOUND CARE (DIABETES CENTER)		0. 4151	28 0	0	76.0
6.01 03953 OTHER ANCILLARY CMS LINE		0.0000	00 0	0	76.
6. 02 03951 CASE MANAGEMENT		0.0000	00 0	0	
6. 03 03950 PAIN MANAGEMENT		0. 5989			76.0
6.04 03610 SLEEP LAB		0. 1895			
6. 05 03480 ONCOLOGY		0. 3654			
6. 97 07697 CARDI AC REHABI LI TATI ON		1. 5937	48 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS		0.0000	0.0		
		0.0000			
0. 01 09001 PALLI ATI VE HEALTH		0.0000			
0. 02 09002 VEI N CENTER		0. 1243		-	
0. 03 09003 0BGYN 0. 04 09004 NEUROSURGERY		1.2450			
0. 04 09004 NEUROSURGERY 0. 05 09005 SURGI CAL_ASSOCI ATES		0. 5394 1. 9718			
1. 00 09100 EMERGENCY		1		-	
		0. 3145 0. 5397		-	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 3. 00 04952 BEHAVI ORAL HEALTH		2. 3790		-	
00.00 Total (sum of lines 50 through 94 and 96 through 98)		2.3790		-	
00.00 [10.01 (Sull 01 11) Hes SO through 94 and 90 through 98)			31, 102		
01.00 Less PBP Clinic Laboratory Services-Program only charg	$\alpha \in (\lim_{n \to \infty} 41)$		0		201.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0065	Peri od:	Worksheet D-3	}
	in ovrider o	0000	From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
	Ti tl	e XIX	Hospi tal	Cost	o piii
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
		1	1 000 500		1
30. 00 03000 ADULTS & PEDIATRICS			1, 028, 580		30.0
31.00 03100 INTENSIVE CARE UNIT			438, 072		31.0
43. 00 04300 NURSERY			1, 761, 774		43.0
		0.0050/	7 757 000	70 101	
50. 00 05000 OPERATING ROOM		0.09526			
51.00 OS100 RECOVERY ROOM		0. 13638		5, 916	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 21501		332, 097	
53.00 05300 ANESTHESI OLOGY		0.01901		3,003	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 32128		9,467	
54. 01 03630 ULTRA SOUND		0. 16193		4, 223	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 09422		0	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 05149		3, 687	
		0. 10029		2, 117	
		0. 17917		83, 107	
53. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 54. 00 06400 INTRAVENOUS THERAPY		0. 52966		7, 350 3, 030	
55. 00 06500 RESPIRATORY THERAPY		0. 24669		79, 347	
56. 00 06600 PHYSI CAL THERAPY		0. 27087		8, 109	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 22213		3, 588	
58. 00 06800 SPEECH PATHOLOGY		0. 22213		5, 580	
59. 00 06900 ELECTROCARDI OLOGY		0. 27353		3, 206	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 11262		147, 557	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		0. 56690		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 55960			
76. 00 03952 WOUND CARE (DI ABETES CENTER)		0. 41512		3, 630	
76. 01 03953 OTHER ANCI LLARY CMS LINE		0. 00000		0,000	
76. 02 03951 CASE MANAGEMENT		0. 00000		0	
76. 03 03950 PALN MANAGEMENT		0. 59851		0	
76. 04 03610 SLEEP LAB		0. 18952		0	
76. 05 03480 ONCOLOGY		0. 34802		27	
76. 97 07697 CARDI AC REHABI LI TATI ON		1. 59374		0	
OUTPATI ENT SERVI CE COST CENTERS					1
90. 00 09000 CLINIC		0.00000	0 00	0	90.0
PO. 01 09001 PALLI ATI VE HEALTH		0.00000	0 0	0	90.0
90. 02 09002 VEIN CENTER		0. 12435	55 0	0	90.0
20. 03 09003 OBGYN		1. 24502	24 0	0	90.0
PO. 04 09004 NEUROSURGERY		0. 53949	92 0	0	90.0
20. 05 09005 SURGI CAL ASSOCI ATES		1. 96965		0	90.0
91. 00 09100 EMERGENCY		0. 31451	54, 894	17, 265	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53974		0	92.0
93. 00 04952 BEHAVI ORAL HEALTH		2. 37906	61 0	0	93.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 015, 895	955, 597	200.0
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			4, 015, 895		202.0

alth Financial Systems SCHNECK MEDI IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	CAL CENTER Provider C	CN: 15-0065	Peri od:	u of Form CMS-: Worksheet D-3	
			From 01/01/2021		
	Component	CCN: 15-U065	To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
	Ti tl	e XIX	Swing Beds - NF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					1 20
0. 00 03000 ADULTS & PEDIATRICS					30.
I. 00 03100 I NTENSI VE CARE UNI T 3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					43.
0. 00 05000 OPERATI NG ROOM		0.0952	67 C	0	50.
00 05100 RECOVERY ROOM		0. 13638			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2150			
B. 00 05300 ANESTHESI OLOGY		0. 0190			
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 32128			
I. 01 03630 ULTRA SOUND		0. 16193			
I. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.09422		0	54
7. 00 05700 CT SCAN		0.05149			57
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 10029	92 C	0	58
0. 00 06000 LABORATORY		0. 1791	76 C	0	60
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 52966	64 C	0	63
I. 00 06400 I NTRAVENOUS THERAPY		0. 2466	91 C	0	64
5. 00 06500 RESPI RATORY THERAPY		0. 2706	70 C	0	65.
6. 00 06600 PHYSI CAL THERAPY		0. 42243	32 C	0	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 22213	32 C	0	67
3. 00 06800 SPEECH PATHOLOGY		0. 29355			68
2. 00 06900 ELECTROCARDI OLOGY		0.07466			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 11262			
2.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 56690			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 55960			
5. 00 03952 WOUND CARE (DIABETES CENTER)		0. 41512			
5. 01 03953 OTHER ANCILLARY CMS LINE		0.0000			
0. 02 03951 CASE MANAGEMENT		0.0000			
5. 03 03950 PALN MANAGEMENT		0. 5985			
5. 04 03610 SLEEP LAB		0. 18952			
5. 05 03480 ONCOLOGY		0. 34802			
0. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		1. 59374	48 C	0	76
0. 00 09000 CLINIC		0.0000	00 00	0	90
0. 01 09000 CETNIC 0. 01 09001 PALLIATIVE HEALTH		0.00000			
D. 02 09002 VEIN CENTER		0. 1243			
0. 03 09003 0BGYN		1. 24502			
0. 04 09004 NEUROSURGERY		0. 53949			
0. 05 09005 SURGI CAL ASSOCI ATES		1. 96965			
. 00 09100 EMERGENCY		0. 3145			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53974			
00 04952 BEHAVI ORAL HEALTH		2. 37900			
00.00 Total (sum of lines 50 through 94 and 96 through 98)		2.07700			200
01.00 Less PBP Clinic Laboratory Services-Program only char	aes (line 61)		C		201
22.00 Net charges (line 200 minus line 201)	3 (s or)		C		202

	Financial Systems SCHNECK MEDICAL ATION OF REIMBURSEMENT SETTLEMENT	_ CENTER Provider CCN: 15-0065	Peri od:	u of Form CMS-2 Worksheet E	2552-1(
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	pared:	
		Title XVIII	Hospi tal	5/23/2022 3:0 PPS		
			nospi tui			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(500	0 3, 420, 056		
	instructions)	0.1				
1.02	DRG amounts other than outlier payments for discharges occurr instructions)	C		1, 510, 454		
1.03	DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	0 0			1.03	
1.04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for discharges occurring	on or after	0	1.04	
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00	
2.01	Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.02	
2.03	Outlier payments for discharges occurring prior to October 1	-		125, 034		
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		261,000	2.04	
3.00	Managed Care Simulated Payments			0	3.00	
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	erting period (see instr	uctions)	75.49	4.00	
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending or	0.00	5.00	
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-	on to the cap for	0.00	6.00	
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under	0.00 0.00	7.00 7.01			
	cost report straddles July 1, 2011 then see instructions.					
8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.	0.00	8.00			
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl	0.00	8.01			
8. 02	report straddles July 1, 2011, see instructions.					
9.00	under § 5506 of ACA. (see instructions)					
	FTE count for allopathic and osteopathic programs in the curr			0.00		
11.00	FTE count for residents in dental and podiatric programs.	ent year from your reco	1 43	0.00		
	Current year allowable FTE (see instructions)			0.00		
13.00	Total allowable FTE count for the prior year.		1007	0.00		
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Se	ptember 30, 1997,	0.00		
	Sum of lines 12 through 14 divided by 3.			0.00		
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo			0.00	16.00 17.00	
	Adjusted rolling average FTE count	Suie			18.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4	·).		0.000000		
	Prior year resident to bed ratio (see instructions)			0.000000	20.00	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		
	IME payment adjustment (see instructions)			0		
22.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA		0	22.01	
23.00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$.		CFR 412.105	0.00	23.00	
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00	
	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00		
	Resident to bed ratio (divide line 25 by line 4)			0.000000		
	IME payments adjustment factor. (see instructions)			0.000000		
	IME add-on adjustment amount (see instructions)	2		0		
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)	.)		0		
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29.00	
	Disproportionate Share Adjustment					
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ctions)	4.56		
	Percentage of Medicaid patient days (see instructions)			30.29		
JZ. UU	Sum of lines 30 and 31)		34.85 12.00		
	Allowable disproportionate share percentage (see instructions					

ALCOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0065	Peri od:	Worksheet E	
			From 01/01/2021 To 12/31/2021		pare
				5/23/2022 3:0	5 pm
		Title XVIII	Hospi tal	PPS On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)		0.00000000		
5. 02	Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (see 1, 788, 769	1, 139, 158	35.
- 02	instructions)	t amount (and instructions)	1, 337, 901	287, 130	25
5.03 5.00	Pro rata share of the hospital uncompensated care paymen Total uncompensated care (sum of columns 1 and 2 on line	. ,	1, 625, 031		36.
5.00	Additional payment for high percentage of ESRD beneficia				30.
0. 00	Total Medicare discharges (see instructions)		0		40
1.00	Total ESRD Medicare discharges (see instructions)		0		41
1.01	Total ESRD Medicare covered and paid discharges (see ins	tructions)	0		41
2.00	Divide line 41 by line 40 (if less than 10%, you do not	qualify for adjustment)	0.00		42
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43
. 00	Ratio of average length of stay to one week (line 43 div	ided by line 41 divided by	7 0.00000		44
- 00	days)	ti ana)	0.00		4
5.00 5.00	Average weekly cost for dialysis treatments (see instruc		0.00		45
. 00 . 00	Total additional payment (line 45 times line 44 times li Subtotal (see instructions)	ne 41.01)	7, 089, 491		40
3.00	Hospital specific payments (to be completed by SCH and M	DH small rural bosnitals	7,009,491		48
. 00	only. (see instructions)		0		
				Amount	
				1.00	
. 00	Total payment for inpatient operating costs (see instruc			7, 089, 491	
). 00	Payment for inpatient program capital (from Wkst. L, Pt.	I and Pt. II, as applicabl	e)	433, 998	
. 00	Exception payment for inpatient program capital (Wkst. L			0	51
2.00	Direct graduate medical education payment (from Wkst. E- Nursing and Allied Health Managed Care payment	4, TTHE 49 SEE THSTRUCTIONS).	0	
l. 00	Special add-on payments for new technologies			192, 446	
I. 01	Islet isolation add-on payment			0	
5.00	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
3.00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0	58
9.00	Total (sum of amounts on lines 49 through 58)			7, 715, 935	
). 00	Primary payer payments			0	60
. 00	Total amount payable for program beneficiaries (line 59	minus line 60)		7, 715, 935	
2.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			541, 052 0	
. 00 . 00	Allowable bad debts (see instructions)			58, 743	
5.00	Adjusted reimbursable bad debts (see instructions)			38, 183	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		26, 103	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		7, 213, 066	
3. 00	Credits received from manufacturers for replaced devices			0	68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and	96).(For SCH see instructi	ons)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
0.50	Rural Community Hospital Demonstration Project (§410A De	, , ,	e instructions)	0	
). 87	Demonstration payment adjustment amount before sequestra			0	
). 88). 89	SCH or MDH volume decrease adjustment (contractor use on Piopeer ACO demonstration payment adjustment amount (see			0	70 70
). 89). 90	Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instructio			0	
). 90	HSP bonus payment HRR adjustment amount (see instruction			0	
0. 92	Bundled Model 1 discount amount (see instructions)	-,		0	
J. 7Z				45, 855	
). 92). 93	(HVBP payment adjustment amount (see instructions)				
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)				70

	ON OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0065	Period: From 01/01/2021	Worksheet E Part A	
				To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
96 10	w volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0 2021	1.00 616,970	70
	e corresponding federal year for the period prior to 10/1)			2021	010, 770	/0.
	w volume adjustment for federal fiscal year (yyyy) (Enter i e corresponding federal year for the period ending on or af			2022	270, 362	70.
	w Volume Payment-3				0	
	C adjustment amount (see instructions)	(0 0 70)			0	
	ount due provider (line 67 minus lines 68 plus/minus lines questration adjustment (see instructions)	09 & 70)			8, 146, 253 0	
	monstration payment adjustment amount after sequestration				0	
	questration adjustment-PARHM pass-throughs				0	71.
	terim payments				7, 130, 128	
	terim payments-PARHM				1,100,120	72.
1	ntative settlement (for contractor use only)				0	73.
. 01 Te	ntative settlement-PARHM (for contractor use only)					73.
. 00 Ba	lance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			1, 016, 125	74.
73	·					
	lance due provider/program-PARHM (see instructions)					74.
	otested amounts (nonallowable cost report items) in accorda	nce with			141, 746	75.
	S Pub. 15-2, chapter 1, §115.2 BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					-
	erating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.
	us 2.04 (see instructions)				_	
00 Ca	pital outlier from Wkst. L, Pt. I, line 2				0	91.
	erating outlier reconciliation adjustment amount (see instr				0	92.
	pital outlier reconciliation adjustment amount (see instruc				0	
	e rate used to calculate the time value of money (see instr				0.00	
	me value of money for operating expenses (see instructions)				0	
5. 00 Ti	me value of money for capital related expenses (see instruc	tions)		Prior to 10/1	0 0n/After 10/1	96.
				1.00	2.00	
HSF	P Bonus Payment Amount					
	P bonus amount (see instructions)			0	0	100.
	3P Adjustment for HSP Bonus Payment					
	BP adjustment factor (see instructions)			0. 000000000		
2. 00 HV	BP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.
	R Adjustment for HSP Bonus Payment R adjustment factor (see instructions)			0,0000	0.0000	1102
	5			0.0000		
)		0	0	
4. 00 HR	R adjustment amount for HSP bonus payment (see instructions cal Community Hospital Demonstration Project (\$410A Demonst) ration) Adii	Istment	0	0	1104.
4. 00 HR Rur	ral Community Hospital Demonstration Project (§410A Demonst	ration) Adju		C		104. 200.
4. 00 HR Rur 0. 00 I s	R adjustment amount for HSP bonus payment (see instructions ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no.	ration) Adju		0		200.
1.00 HR Rur 0.00 I s Ce	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe	ration) Adju		0		
4.00 HR Rur 0.00 Is Ce Cos 1.00 Me	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ration) Adju riod under				200. 201.
1. 00 HR Rur 0. 00 I s Ce Cos . 00 Me 2. 00 Me	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions)	ration) Adju riod under				200 201 202
A. 00 HR Rur 0. 00 I s Ce Cos 00 Me 2. 00 Me 3. 00 Ca	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions)	ration) Adju riod under e 49)	the 21st			200 201 202
4. 00 HR Rur 0. 00 I s Cos 1. 00 Me 2. 00 Me 3. 00 Ca Cor	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in	ration) Adju riod under e 49)	the 21st			200 201 202
1. 00 HR Rur 0. 00 I s Cos 1. 00 Me 2. 00 Me 3. 00 Ca Cor per	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod)	ration) Adju riod under e 49)	the 21st		strati on	200 201 202 203
4. 00 HR Rur 0. 00 I s Cos 1. 00 Me 2. 00 Me 3. 00 Ca Cor per 4. 00 Me	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount	ration) Adju riod under e 49)	the 21st		strati on	200 201 202 203 203
A. 00 HR Rui D. 00 I s Cos Cos Cos Cos Cos Cos Cos Cos Cos Co	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204)	ration) Adju riod under e 49)	the 21st		stration	200 201 202 203 204 204
I. 00 HR Rui Rui 0. 00 I s Cos Cos . 00 Me 2. 00 Me 3. 00 Can Period Con 4. 00 Me 5. 00 Can 5. 00 Can	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205)	ration) Adju riod under e 49)	the 21st		stration	200
I. 00 HR Rur D. 00 I s Cos Cos Cos Cos Cos B. 00 Me B. 00 Ca Cor Per I. 00 Me 5. 00 Ca Cos Cos Cos Cos Cos Cos Cos Cos Cos Cos	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204)	ration) Adju riod under e 49) first year	the 21st		stration	200 201 202 203 204 204
I. 00 HR Rur Ce Cos Cos I. 00 I s Cos Cos I. 00 Me 3. 00 Ca B. 00 Ca For Cor per Con per Con 5. 00 Ca 6. 00 Me 7. 00 Pr	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) istment to Medicare Part A Inpatient Reimbursement	ration) Adju riod under e 49) first year ructions)	the 21st		strati on	200 201 202 203 204 205 206
I. 00 HR Rur Rur 0. 00 I s Ce Cos . 00 Me 2. 00 Me 3. 00 Can 6. 00 Can 6. 00 Can 6. 00 Can 6. 00 Can 7. 00 Per 3. 00 Me 7. 00 Per 3. 00 Me	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst	ration) Adju riod under e 49) first year ructions)	the 21st		stration	200 201 202 203 204 205 206 207 208
4. 00 HR Rur 2. 00 I s Cos 2. 00 Me 3. 00 Ca 6. 00 Me 5. 00 Ca 5. 00 Me Adj 7. 00 Pr 8. 00 Me 2. 00 Adj 2. 00 Adj 2. 00 Adj 2. 00 Ac	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A, justment to Medicare IPPS payments (see instructions)	ration) Adju riod under e 49) first year ructions)	the 21st		strati on	200 201 202 203 204 205 206 207 208 209 210
I. 00 HR Rur Rur 0. 00 I s Cos Cos 0. 00 Me 0. 00 Me 0. 00 Car 0. 00 Car 0. 00 Car 0. 00 Me 0. 00 Pri 3. 00 Me 0. 00 Re 0. 00 Re 0. 00 Re 0. 00 Ro	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) ustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A, justment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare IPPS payments (see instructions)	ration) Adju riod under e 49) first year ructions)	the 21st		strati on	200 201 202 203 204 205 206
4. 00 HR Rur D. 00 I s Ce Com 2. 00 Me 3. 00 Ca Com Per 4. 00 Me 5. 00 Ca 5. 00 Me 5. 00 Pr 3. 00 Me 7. 00 Pr 3. 00 Me 2. 00 Ad 0. 00 Re 1. 00 To 1. 00 To 1	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) iustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A, justment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare IPPS payments (see instructions) mparision of PPS versus Cost Reimbursement	ration) Adju riod under e 49) first year ructions) line 59)	the 21st		stration	200 201 202 203 204 205 206 207 208 207 208 209 210 211
4. 00 HR Rur Ce 0. 00 I s Cos Cos 1. 00 Me 2. 00 Me 3. 00 Ca 5. 00 Ca 6. 00 Ca 6. 00 Ca 7. 00 Pr 3. 00 Adj 0. 00 Re 1. 00 To 0. 00 Re 1. 00 To Car Car	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) iustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A, justment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare Part A IPPS payments (from line	ration) Adju riod under e 49) first year ructions) line 59)	the 21st		strati on	2001 2022 203 204 205 206 207 208 209 210 211
4. 00 HR Rur D. 00 I s Ce Cos Cos 2. 00 Me 2. 00 Me 3. 00 Ca 5. 00 Me 6. 00 Me 6. 00 Me 7. 00 Pr 3. 00 Pr 3. 00 Re 1. 00 Re 1. 00 Ca 5. 00 Re 2. 00 Re 2. 00 To Ca 5. 00 Ca 5. 00 Ca 5. 00 Ca 5. 00 Ca 5. 00 Ca 6. 00 Me 2. 00 To Ca 5. 00 Ca 5. 00 Ca 6. 00 Ca 6. 00 Ca 7. 00 Pr 3. 00 Ca 5. 00 Ca 6. 00 Ca 6. 00 Ca 6. 00 Ca 6. 00 Ca 7. 00 Pr 3. 00 Ca 5. 00 Ca 6. 00 Ca 7. 00 Pr 3. 00 Ca 6. 00 Ca 7. 00 Ca	ral Community Hospital Demonstration Project (§410A Demonst this the first year of the current 5-year demonstration pe ntury Cures Act? Enter "Y" for yes or "N" for no. st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, lin dicare discharges (see instructions) se-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) dicare target amount se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205) iustment to Medicare Part A Inpatient Reimbursement ogram reimbursement under the §410A Demonstration (see inst dicare Part A inpatient service costs (from Wkst. E, Pt. A, justment to Medicare IPPS payments (see instructions) served for future use tal adjustment to Medicare IPPS payments (see instructions) mparision of PPS versus Cost Reimbursement	ration) Adju riod under e 49) first year ructions) line 59) 211)	of the curre		strati on	200 201 202 203 204 205 206 207 208 207 208 209 210 211

I VC	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2021 To 12/31/2021		pare
				Title	e XVIII	Hospi tal	5/23/2022 3:0 PPS	s pili
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01		Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.
)1	payments DRG amounts other than outlier payments for discharges	1.01	3, 420, 056	0	3, 420, 05	6	3, 420, 056	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	1, 510, 454	0		1, 510, 454	1, 510, 454	1.
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0		0	0	1.
4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	O	0		0	0	1
0	October 1 Outlier payments for discharges (see instructions)	2.00						2
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	125, 034	0	125, 03	4	125, 034	2
3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	261, 000	0		261, 000	261, 000	2
0	Operating outlier reconciliation	2. 01	0	0		0 0	0	3
0	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0.00000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	
1	instructions) IME payment adjustment for managed care (see	22.01	О	0		0 0	0	6
	instructions)		a Add an East Co	ati an 100 af .				
0	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000	0. 000000		0.00000		7
0	(see instructions) IME adjustment (see	28.00	0.000000	0.000000		0 0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		0 0	0	8
0	instructions) Total IME payment (sum of	29.00	0	0		0 0	0	9
1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0		0 0	0	9
00	8.01) Disproportionate Share Adjustmo Allowable disproportionate	ent 33.00	0. 1200	0. 1200	0. 120	0 0. 1200		10
	share percentage (see i nstructi ons)						, .	
	Disproportionate share adjustment (see instructions) Uncompensated care payments	34.00 36.00	147, 916 1, 625, 031	0			147, 916 1, 625, 031	
00	Additional payment for high per Total ESRD additional payment					0 0		12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	7, 089, 491 0	0 0	4, 985, 59	3 2, 103, 898 0 0	7, 089, 491 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 089, 491	0	4, 985, 59	3 2, 103, 898	7, 089, 491	15

	Financial Systems		SCHNECK MEDI				u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prio to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	433, 998	0	282, 73	33 151, 265	433, 998	16.00
17.00	Special add-on payments for new technologies	54.00	192, 446	0	96, 63	31 95, 815	192, 446	
17.01	Net organ aquisition cost	(0.00						17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19.00	SUBTOTAL			0	5, 364, 9	57 2, 350, 978	7, 715, 935	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		371, 668 0	0		00 111, 568 0 0		
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	62, 330 0			33 39, 697 0 0		
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0			0 0	-	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0. 0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	-		0 0	_	
26.00	Total prospective capital payments (see instructions)	12.00 W/S E, Part A	433,998 (Amounts to	0	282, 73	33 151, 265	433, 998	26.00
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor Low volume adjustment	70, 96			0. 1150 616, 9			27.00 28.00
	(transfer amount to Wkst. E, Pt. A, line)							
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A. line)	70. 97				270, 362	270, 362	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

OSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	6 Provider CC	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021		pared
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	3, 420, 056			3, 420, 056	1.0 1.0
02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 510, 454		1, 510, 454	1, 510, 454	1.0
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.0
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. C
00	Outlier payments for discharges (see instructions)	2.00					2.0
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.0
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	125, 034	125, 03		125, 034	2.0
03	Outlier payments for discharges occurring on or after October 1 (see instructions) Operating outlier reconciliation	2. 04 2. 01	261, 000 0		261, 000 0 0	261, 000 0	2. C 3. C
00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0		0 0	0	
00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 000000	0. 00000	0.000000		5.0
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0 0		0 0 0 0	0 0	6. (6. (
	Indirect Medical Education Adjustment for the	Add-on for S	ection 422 of 1	he MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0. 000000		7.0
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0 0		0 0 0 0	0 0	8. (8. (
00 01	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00 29. 01	0		0 0	0	9. (9. (
01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29.01	0		0 0	0	9.
00		33.00	0. 1200	0. 120	0. 1200		10.
00	(see instructions) Disproportionate share adjustment (see	34.00	147, 916	102, 60		147, 916	
. 01	instructions) Uncompensated care payments	36.00	1, 625, 031	1, 337, 90	01 287, 130	1, 625, 031	11.
00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46.00	di scharges 0		0 0	0	12.
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	7, 089, 491 0	4, 985, 59	23 2, 103, 898 0 0	7, 089, 491 0	
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 089, 491	4, 985, 59	2, 103, 898	7, 089, 491	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	433, 998	282, 73	33 151, 265	433, 998	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	192, 446	96, 63		192, 446	17.
02 00	Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	68.00 93.00	0		0 0 0 0	0	17. 18.
00	amount (see instructions) SUBTOTAL	73.00		5, 364, 95			

Health Financial Systems	SCHNECK MEDI			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: Worksheet From 01/01/2021 Part A Exh To 12/31/2021 5/23/2022 5/23/2022		pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	371, 668	260, 10	00 111, 568	371, 668	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	62, 330	22, 63	33 39, 697	62, 330	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	1
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	433, 998	282, 73	33 151, 265	433, 998	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	616, 970	616, 9	70	616, 970	28.00
29.00 Low volume adjustment on or after October 1	70. 97	270, 362		270, 362	270, 362	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	45, 855	45, 85	55 0	45, 855	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	
31.00 HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	•
					(Amt. to Wkst. E, Pt.	
	0	1.00	2.00	3.00	A) 4.00	
32.00 HAC Reduction Program adjustment (see	70.99	1.00	2.00	0 0		32.00
instructions) 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.	5	Ν				100. 00

	Financial Systems SCHNECK MEDIC. ATION OF REIMBURSEMENT SETTLEMENT	AL CENTER Provider CCN: 15-0065	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10	
CALCUL	ATION OF REIMBORSEMENT SETTLEMENT	Provider CCN: 15-0065	From 01/01/2021 To 12/31/2021	Part B Date/Time Pre 5/23/2022 3:0	epared:	
		Title XVIII	Hospi tal	PPS		
				1.00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00		
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	uctions)		6, 498 15, 214, 874	2.00	
3.00 4.00	OPPS payments Outlier payment (see instructions)			14, 364, 662 271, 854	4.00	
4.01 5.00 6.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	ructions)		0 0. 000 0	5.00	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7.00	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	. IV, col. 13, line 200		0	9.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		6, 498			
	Reasonabl e charges					
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 60)		11, 612 0	12.00	
	Total reasonable charges (sum of lines 12 and 13) Customary charges			11, 612		
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable 1			0	1	
17.00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	3(e)	Ũ	0. 000000		
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds l	ine 11) (see	11, 612 5, 114	18.00 19.00	
20.00	instructions) Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds l	ine 18) (see	0	20.00	
21.00 22.00	instructions) Lesser of cost or charges (see instructions) Interns and residents (see instructions)			6, 498 0	1	
23.00 24.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 0 14, 636, 516	23.00	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT)		14, 030, 310	24.00	
25.00 26.00	00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)					
27.00 28.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions) Direct graduate medical education payments (from Wkst. E-4,		2 and 23] (see	12, 047, 413		
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36	<i>,</i>		0	29.00	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			12, 047, 413 12, 975		
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	// (ES)		12, 034, 438		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	VIGE3)		0	33.00	
34.00 35.00	Allowable bad debts (see instructions)			271,606		
36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	structions)		176, 544 97, 047		
37.00	Subtotal (see instructions)			12, 210, 982		
38.00	MSP-LCC reconciliation amount from PS&R			151		
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructio	one)		0	39.00 39.50	
	Demonstration payment adjustment amount before sequestration			0		
39. 98	Partial or full credits received from manufacturers for repl		ctions)	0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0		
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			12, 210, 831 0		
40.02	Demonstration payment adjustment amount after sequestration			0		
40.03	Sequestration adjustment-PARHM pass-throughs				40.03	
41.00	Interim payments			12, 029, 003		
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01	
	Tentative settlement-PARHM (for contractor use only)			0	42.00	
43.00	Balance due provider/program (see instructions)			181, 828		
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	2, 721, 590	43.01 44.00	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				1	
90.00	Original outlier amount (see instructions)			0	90.00	
	Outlier reconciliation adjustment amount (see instructions))		0		
92.00	The rate used to calculate the Time Value of Money				92.00	
93.00	Time Value of Money (see instructions)			0	93.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	pared
					5/23/2022 3:0	5 pm
			XVIII t Part A	Hospi tal	PPS T B	
		l	LPAILA	Pai	LD	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		7, 130, 1	28 0	12, 029, 003 0	1. (2. (
. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider					
. 01 . 02	ADJUSTMENTS TO PROVIDER			0	0	3. 3.
. 03 . 04				0	0	3. 3.
. 04 . 05				0	0	3.
	Provider to Program					0.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52 53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
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)		7, 130, 1	28	12, 029, 003	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	5
	Provider to Program					_
50 51	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0) 5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)		4 944 -			6
01	SETTLEMENT TO PROVIDER		1, 016, 1		181, 828	6
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		8, 146, 2	0 53	0 12, 210, 831	0
50			0, 140, 2	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0065 CCN: 15-U065	Period: From 01/01/20 To 12/31/20		epare
		Title	e XVIII	Swing Beds - S		
		I npati er	nt Part A	F	Part B	
		mm/dd/yyyy	Amount		Amount	-
		1.00	2.00	3.00	4.00	-
00	Total interim payments paid to provider	11.00	9,9		(0 1.
00	Interim payments payable on individual bills, either			0	() 2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	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					-
01	ADJUSTMENTS TO PROVIDER			0	(5 3
02				0		
03				0	0) 3
04				0	0) 3
05				0	(3 3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53				0	(
54				0	(
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0) 3
00	Total interim payments (sum of lines 1, 2, and 3.99)		9,9	00		2 4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		7,7	00		J 4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			1		
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1		-	
01 02	TENTATI VE TO PROVIDER			0		
02 03				0		
55	Provider to Program			0		4 3
50	TENTATIVE TO PROGRAM			0	(5 5
51				0		
52				0	0) 5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0) 5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
24	the cost report. (1)					
01	SETTLEMENT TO PROVIDER			0	0	
02	SETTLEMENT TO PROGRAM		9.8	1		
00	Total Medicare program liability (see instructions)		9,8	Contractor		<u>7 כ</u>
				Number	(Mo/Day/Yr)	
			0	1, 00	2.00	
00	Name of Contractor		-	1.00	2.00	8

Heal th	Financial Systems	SCHNECK MEDICAL CENTER		In Lie	u of Form CMS-:	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN:		Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Pre	pared:
		Title XV	/111	Hospi tal	5/23/2022 3:0 PPS	5 pm
				10301 tu	113	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD (COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION A					
1.00	Total hospital discharges as defined in AARA §4	4102 from Wkst. S-3, Pt. I co	I. 15 line	14		1.00
2.00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost					
	reporting periods beginning on or after 10/01/2					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col.					3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, reporting periods beginning on or after 10/01/2		gh 12, and	plus for cost		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col.					5.00
6.00	Total hospital charity care charges from Wkst.					6.00
7.00	CAH only - The reasonable cost incurred for the line 168	e purchase of certified HIT t	echnol ogy	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see i	nstructions)				8.00
9.00	Sequestration adjustment amount (see instruction	ons)				9.00
10.00	Calculation of the HIT incentive payment after	sequestration (see instructi	ons)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CA	λH				
30.00	Initial/interim HIT payment adjustment (see in:	structions)				30.00
31.00	Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10) minu:	s line 30 and line 31) (see i	nstruction	s)		32.00

LCULATION OF REIMBURSEMENT SETTLEMENT - SWI	G BEDS Provider CCN: 15-0065	Peri od:	Worksheet E-2	<u>2552-</u> 2
	Component CCN: 15-U065	From 01/01/2021 5 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
	Title XVIII	Swing Beds - SNF		
		Part A 1.00	Part B 2.00	
COMPUTATION OF NET COST OF COVERED SERVI	ES	1.00	2.00	
00 Inpatient routine services - swing bed-		10, 827	0	1.
00 Inpatient routine services - swing bed-				2.
	3, line 200, for Part A, and sum of Wkst.		0	3.
	B) (For CAH and swing-bed pass-through, s	iee		
instructions) 01 Nursing and allied health payment-PARHM	see instructions)			3.
00 Per diem cost for interns and residents			0.00	
instructions)				
00 Program days		28		
00 Interns and residents not in approved to		0	0	
00 Utilization review – physician compensa 00 Subtotal (sum of lines 1 through 3 plus		0 10, 827		7. 8.
00 Primary payer payments (see instruction:		10, 827	0	
.00 Subtotal (line 8 minus line 9)		10, 827		
.00 Deductibles billed to program patients	xclude amounts applicable to physician	0	0	11.
professional services)				
.00 Subtotal (line 10 minus line 11)		10, 827		
.00 Coinsurance billed to program patients for physician professional services)	rom provider records) (exclude coinsurance	928	0	13.
. 00 80% of Part B costs (line 12 x 80%)			0	14.
.00 Subtotal (see instructions)		9, 899	0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SI		0	0	1
.50 Pioneer ACO demonstration payment adjus				16.
. 55 Rural community hospital demonstration adjustment (see instructions)	oject (§410A Demonstration) payment	0		16.
. 99 Demonstration payment adjustment amount	efore sequestration	0	0	16.
. 00 Allowable bad debts (see instructions)		0		
.01 Adjusted reimbursable bad debts (see in		0	0	
.00 Allowable bad debts for dual eligible b	eficiaries (see instructions)	0		
. 00 Total (see instructions)	-)	9, 899		
.01 Sequestration adjustment (see instruction of the sequestration payment adjustment amount		0		
. 03 Sequestration adjustment-PARHM pass-thro		0		19.
. 25 Sequestration for non-claims based amou	5	0	0	
.00 Interim payments		9, 900	0	20.
.01 Interim payments-PARHM				20.
. 00 Tentative settlement (for contractor use		0	0	
.01 Tentative settlement-PARHM (for contrac .00 Balance due provider/program (line 19 m	us lines 19.01, 19.02, 19.25, 20, and 21)	-1	0	21.
. 01 Balance due provider/program-PARHM (see		- 1		22.
	rt items) in accordance with CMS Pub. 15-2	2, 0	0	
chapter 1, §115.2				
Rural Community Hospital Demonstration F			1	1000
0.00 Is this the first year of the current 5 Century Cures Act? Enter "Y" for yes or				200.
Cost Reimbursement			1	
1.00 Medicare swing-bed SNF inpatient routine	service costs (from Wkst. D-1, Pt. II, lin	ie		201.
66 (title XVIII hospital))				
2.00 Medicare swing-bed SNF inpatient ancilla 200 (title XVIII swing-bed SNF))	y service costs (from Wkst. D-3, col. 3, I	ine		202.
3.00 Total (sum of lines 201 and 202)				203.
4.00 Medicare swing-bed SNF discharges (see i	structions)			204.
	t Limitation (N/A in first year of the cur	rent 5-year demons	stration	1
period)				
5.00 Medicare swing-bed SNF target amount	cost can (line 205 times line 204)			205.
6.00 Medicare swing-bed SNF inpatient routine Adjustment to Medicare Part A Swing-Bed			I	206.
7.00 Program reimbursement under the §410A De				207.
8.00 Medicare swing-bed SNF inpatient service	· , ,	es 1		208.
and 3)				
9.00 Adjustment to Medicare swing-bed SNF PP	payments (see instructions)			209.
0.00 <u>Reserved for future use</u> Comparision of PPS versus Cost Reimburse	ent			210.
5.00 Total adjustment to Medicare swing-bed				215.

ALCULA		ovider CCN: 15-0065 aponent CCN: 15-U065	Period: From 01/01/2021 To 12/31/2021	Worksheet E- Date/Time Pr 5/23/2022 3:	repared:
		Title XIX	Swing Beds - NF	Cost	
			Part A 1.00	<u>Part B</u> 2.00	_
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		0		1.00
	npatient routine services - swing bed-NF (see instructions)		0		2.00
	ncillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b				3.00
	nstructions)	ieu pass-tili ougli, sei	5		
	lursing and allied health payment-PARHM (see instructions)				3.01
00 P	Per diem cost for interns and residents not in approved teaching	program (see	0.00		4.00
	nstructions)				
	Program days	weti enc)	0		5.00
	nterns and residents not in approved teaching program (see instr Itilization review - physician compensation - SNF optional methoc		0		6.00
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	i oni y	0		8.00
	Primary payer payments (see instructions)		0		9.00
	Subtotal (line 8 minus line 9)		0		10.00
1.00 D	Deductibles billed to program patients (exclude amounts applicabl	e to physician	0		11.00
	professional services)				
	Subtotal (line 10 minus line 11)		0		12.00
	coinsurance billed to program patients (from provider records) (e For physician professional services)	exclude col nsurance	0		13.00
	10% of Part B costs (line 12 x 80%)		0		14.00
	Subtotal (see instructions)		0		15.00
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
6.50 P	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
	Rural community hospital demonstration project (§410A Demonstrati	on) payment			16.55
	djustment (see instructions)				1.00
	Demonstration payment adjustment amount before sequestration		0		16.99
	llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions)		0		17.0
	Ilowable bad debts for dual eligible beneficiaries (see instruct	ions)	0		18.00
	otal (see instructions)		0		19.00
9.01 S	Sequestration adjustment (see instructions)		0		19.0
	Demonstration payment adjustment amount after sequestration)		0		19.02
	equestration adjustment-PARHM pass-throughs				19.03
	equestration for non-claims based amounts (see instructions)		0		19.25
	nterim payments nterim payments-PARHM		0		20.0
	entative settlement (for contractor use only)		0		21.00
	entative settlement-PARHM (for contractor use only)				21.0
2.00 B	alance due provider/program (line 19 minus lines 19.01, 19.02, 1	9.25, 20, and 21)	0		22.00
	alance due provider/program-PARHM (see instructions)				22.0
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0		23.00
	:hapter 1, §115.2 ural Community Hospital Demonstration Project (§410A Demonstrati	on) Adjustment			
	s this the first year of the current 5-year demonstration period				200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				
	ledicare swing-bed SNF inpatient routine service costs (from Wkst	. D-1, Pt. II, line			201.00
	ν6 (title XVIII hospital)) Nedicare swing-bed SNF inpatient ancillary service costs (from Wk	ct D 2 col 2 li	20		202.00
	200 (title XVIII swing-bed SNF))	St. D-3, COL. 3, TH	le		202.00
	otal (sum of lines 201 and 202)				203.00
	ledicare swing-bed SNF discharges (see instructions)				204.00
C	omputation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	ent 5-year demons	tration	
	eriod)				-
	ledicare swing-bed SNF target amount	1100 204)			205.00 206.00
	ledicare swing-bed SNF inpatient routine cost cap (line 205 times djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				206.00
	Program reimbursement under the §410A Demonstration (see instruct				207.00
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2, c		1		208.00
	ind 3)				
	djustment to Medicare swing-bed SNF PPS payments (see instruction	ins)			209.00
	Reserved for future use				210.00
	omparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 209	nluc line 210) (1		215 0
	nstructions)	prus rine ziu) (See			215.0

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet G Date/Time Pre 5/23/2022 3:0	
		General Fund	Speci fi c Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	82, 238, 600	0	0 0	0	1.0
00	Temporary investments	8, 000, 000	0	0 0	0	2.0
00	Notes receivable	0	0	0 0	0	3.0
00	Accounts receivable	113, 492, 504		-	0	
00	Other receivable	9, 540, 871	C	, united and a second s	0	
00	Allowances for uncollectible notes and accounts receivable			-	0	
00 00	Inventory Prepaid expenses	5, 810, 357		-	0	
00	Other current assets	1, 382, 451 74, 031, 830		-	0	
	Due from other funds	-1, 747, 100			0	
	Total current assets (sum of lines 1-10)	215, 729, 019			0	
	FIXED ASSETS		-	·1 -1	-	1
. 00	Land	10, 922, 437	0	0 0	0	12.
. 00	Land improvements	4, 853, 948	c	0 0	0	13.
. 00	Accumul ated depreciation	-3, 264, 435	0	0 0	0	14.
	Bui I di ngs	152, 748, 139			0	
	Accumulated depreciation	-65, 417, 150			0	
	Leasehold improvements	5, 300, 487			0	
	Accumulated depreciation	-94, 659			0	
	Fixed equipment Accumulated depreciation	8, 098, 161		-	0	
	Accumulated depreciation Automobiles and trucks	-5, 311, 109			0	
	Accumulated depreciation			-	0	
	Major movable equipment	61, 176, 989			0	
	Accumulated depreciation	-44, 450, 746			0	
	Minor equipment depreciable	4, 567, 899			0	
	Accumulated depreciation	-3, 884, 054			0	
	HIT designated Assets	0	0		0	
. 00	Accumulated depreciation	0	0	0 0	0	28
	Mi nor equi pment-nondepreci abl e	0	0	0 0	0	29
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	125, 245, 907		0 0	0	30.
. 00	Investments	9, 021, 979	0	0 0	0	31.
	Deposits on leases	0			0	
	Due from owners/officers	0	0	0 0	0	33
. 00	Other assets	167, 043, 843	c	0 0	0	34
	Total other assets (sum of lines 31-34)	176, 065, 822			0	
. 00	Total assets (sum of lines 11, 30, and 35)	517, 040, 748	C	0 0	0	36
	CURRENT LI ABI LI TI ES		-	-		
	Accounts payable	11, 903, 753			0	
	Salaries, wages, and fees payable	15, 714, 567			0	
	Payroll taxes payable Notes and Loans payable (short term)	15, 033			0	
	Deferred income				0	
	Accelerated payments			, J	0	42
	Due to other funds	0	0	0	0	
	Other current liabilities	1, 082	0	0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	27, 634, 435	0	0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0	C		0	
	Notes payable	28, 702, 516			0	
	Unsecured Loans	0	0		0	
	Other long term liabilities	15, 534, 545		-	0	
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	44, 237, 061 71, 871, 496			0	
00	CAPITAL ACCOUNTS	/1, 0/1, 490			0	1 51
00	General fund balance	445, 169, 252				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
_	replacement, and expansion					_
00 00	Total fund balances (sum of lines 52 thru 58)	445, 169, 252		0	0	
	Total liabilities and fund balances (sum of lines 51 and	517, 040, 748		0	0	60

Heal th	Financial Systems	SCHNECK MEDIC	AL CENTER		In L	ieu of Form CMS	-2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provider CO	CN: 15-0065	Period: From 01/01/20 To 12/31/20		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		405, 500, 047 39, 669, 205 445, 169, 252 0 445, 169, 252 0 445, 169, 252			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 0 11.00 0 11.00 0 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0 0 0 0 0 0		0 0		8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18.00 19.00

5/23/2022 3:05 pm

STATE	Financial Systems SCHNECK MEDICA	Provider C	CN: 15 0045	Peri od:	eu of Form CMS-2 Worksheet G-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider C	UN: 15-0065	From 01/01/202 To 12/31/202	1 Parts I & II	epared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services		1		-	
1.00	Hospi tal		13, 750, 3	33	13, 750, 333	
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.00
8.00 9.00	OTHER LONG TERM CARE					9.00
9.00	Total general inpatient care services (sum of lines 1-9)		13, 750, 3	22	13, 750, 333	
10.00	Intensive Care Type Inpatient Hospital Services		13,750,3	33	15,750,355	10.00
11.00	INTENSIVE CARE UNIT		12, 086, 7	14	12, 086, 714	11.00
12.00	CORONARY CARE UNIT		12,000,7	14	12,000,714	12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
	Total intensive care type inpatient hospital services (sum o	flines	12, 086, 7	14	12, 086, 714	
.0.00	11-15)		12,000,1		12/000///11	10100
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	25, 837, 0	47	25, 837, 047	17.00
18.00	Ancillary services	,	59, 881, 0	53 341, 884, 83	4 401, 765, 887	18.00
19.00	Outpati ent servi ces		7, 200, 4	30 42, 687, 43	1 49, 887, 861	19.00
20.00	RURAL HEALTH CLINIC			0	o o	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	21.00
22.00	HOME HEALTH AGENCY			2, 716, 05	1 2, 716, 051	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE			0 2, 752, 35		
27.00	OTHER OUTPATIENT		24, 2			
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	92, 942, 7	43 391, 972, 59	7 484, 915, 340	28.00
	G-3, line 1)					-
20.00	PART II - OPERATING EXPENSES		1	1(0 741 00		1 20 00
29.00	Operating expenses (per Wkst. A, column 3, line 200)			169, 741, 28	B	29.00
30.00 31.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
34.00				0		34.00
34.00				0		34.00
36.00	Total additions (sum of lines 30-35)			-	b	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			-	b	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		169, 741, 28	-	43.00
	to Wkst. G-3, line 4)	, , , , , , , , , , , , , , , , , , , ,	1	. , , 20	1	1

Health Financial Systems	SCHNECK MEDI CAL	CENTER	In Lie	u of Form CMS-2	2552-10			
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Pre 5/23/2022 3:0	pared:			
				1.00				
1.00 Total patient revenues (from Wkst. G	-2, Part I, column 3, lin	e 28)		484, 915, 340	1.00			
2.00 Less contractual allowances and disc				296, 917, 638				
3.00 Net patient revenues (line 1 minus l	ne 2)			187, 997, 702	3.00			
4.00 Less total operating expenses (from	00 Less total operating expenses (from Wkst. G-2, Part II, line 43)							
5.00 Net income from service to patients		18, 256, 414	5.00					
OTHER INCOME								
6.00 Contributions, donations, bequests,	etc			308, 700	6.00			
7.00 Income from investments				11, 447, 169	7.00			
8.00 Revenues from telephone and other mi	scellaneous communication	servi ces		1, 318	8.00			
9.00 Revenue from tel evision and radio se	rvi ce			0	9.00			
10.00 Purchase di scounts				68, 126	10.00			
11.00 Rebates and refunds of expenses				0	11.00			
12.00 Parking lot receipts				0	12.00			
13.00 Revenue from Laundry and Linen servi				0	13.00			
14.00 Revenue from meals sold to employees				387, 538				
15.00 Revenue from rental of living quarte				548, 432				
16.00 Revenue from sale of medical and sur		nan patients		0	16.00			
17.00 Revenue from sale of drugs to other				221, 018				
18.00 Revenue from sale of medical records				12, 567				
19.00 Tuition (fees, sale of textbooks, un					19.00			
20.00 Revenue from gifts, flowers, coffee	shops, and canteen			302	20.00			
21.00 Rental of vending machines				0	21.00			
22.00 Rental of hospital space				74, 590				
23.00 Governmental appropriations				0	23.00			
24.00 CONTRACT REVENUE				1, 489, 880				
24.01 GRANT REVENUE				807, 678				
24.02 MI SCELLANEOUS I NCOME				-1, 791, 134				
24.03 UNREALIZED GAIN/LOSS				95, 579				
24.50 COVID-19 PHE Funding				7, 735, 828				
25.00 Total other income (sum of lines 6-2	4)			21, 412, 791				
26.00 Total (line 5 plus line 25)				39, 669, 205				
27.00 OTHER EXPENSES (SPECIFY)				0	27.00			
28.00 Total other expenses (sum of line 27				0	28.00			
29.00 Net income (or loss) for the period	(line 26 minus line 28)			39, 669, 205	29.00			

NALYS	Financial Systems ISTS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS	SCHNECK MEDI	Provider C		eriod:	u of Form CMS-: Worksheet H	2552-
				HHA CCN:	15-7155 F	rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared
							5/23/2022 3:0)5 pm
						Home Health Agency I	PPS	
		Sal ari es			Contracted/Pu	Other Costs	Total (sum of	
			Benefits	n (see instructions)	rchased Servi ces		cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0		0	0	1 1 0
. 00	Fixtures			0		0	U	1.0
. 00	Capital Related - Movable Equipment			0		0	C	2.0
. 00	Plant Operation & Maintenance	0	0	0	0	0	0	3.0
. 00 . 00	Transportation Administrative and General	0 263, 867	0	0 456	0 10, 217	0 106, 212	0 380, 752	
. 00	HHA REIMBURSABLE SERVICES	203,007	0	430	10,217	100, 212	500, 752	. 5.0
. 00	Skilled Nursing Care	700, 731	0	0		-		
. 00 . 00	Physical Therapy Occupational Therapy	333, 820 223, 135		0		0	333, 820 223, 135	
. 00	Speech Pathology	14, 705	0	0	0	0	14, 705	
0.00	Medical Social Services	0	0	0	0	0	0	
1. 00	Home Health Aide	46, 961	0	0	0	0	46, 961	
2.00	Supplies (see instructions)	0	0	0	0	7, 288	7, 288	
3.00 4.00	Drugs DME	0	0	0	0	0	0	
00	HHA NONREI MBURSABLE SERVI CES	0	0	0	0	0	0	
5.00	Home Dialysis Aide Services	0	0	0	0	0	0	
5.00	Respiratory Therapy	0	0	0	0	0	0	
7.00	Private Duty Nursing Clinic	0	0	0	0	0	0	
<i>9.</i> 00	Health Promotion Activities	0	0	0	0	0	0	
. 00	Day Care Program	0	0	0	0	0	0	
. 00	Home Delivered Meals Program	0	0	0	0	0	0	21.
		0	0	0	0	0	0	
3.00 3.50	All Others (specify) Telemedicine	0	0	0	0	0	0	
	Total (sum of lines 1-23)	1, 583, 219	0	456	10, 217	113, 500		
		Recl assi fi cat		Adjustments	Net Expenses			
		i on	Trial Balance		for			
			(col. 6 + col.7)		Allocation (col. 8 +			
					col. 9)			
		7.00	8.00	9.00	10.00			
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0	0			1 1.0
00	Fixtures	0	0	0	0			'.`
00	Capital Related - Movable Equipment	0	0	0	0			2.0
00	Plant Operation & Maintenance	0	0	0	0			3.
00	Transportati on	0 0 -162 707	0 0 218 045	0 0	-			4.
00		0 0 -162, 707	0 0 218, 045	0 0 0	-			4.
00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	0 0 -162, 707 0	700, 731	0	218, 045 700, 731			4. 5. 6.
00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy		700, 731 333, 820	0	218, 045 700, 731 333, 820			4. 5. 6. 7.
00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	0 0 0	700, 731 333, 820 223, 135	0	218, 045 700, 731 333, 820 223, 135			4. 5. 6. 7. 8.
00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	0	700, 731 333, 820	0	218, 045 700, 731 333, 820			4. 5. 6. 7. 8. 9.
00 00 00 00 00 00 00 . 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 0	700, 731 333, 820 223, 135 14, 705	0	218, 045 700, 731 333, 820 223, 135 14, 705			4. 5. 6. 7. 8. 9. 10. 11.
00 00 00 00 00 00 . 00 . 00 . 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288	0	218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288			4. 5. 7. 8. 9. 10. 11. 12.
00 00 00 00 00 . 00 . 00 . 00 . 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 554 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0			4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 00 . 00 . 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288	0	218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0			4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 . 00 . 00 . 00 . 00 . 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 554 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0			4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0			4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
00 00 00 00 00 00 00 00 00 00 00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 554 0 0 0 0 0	700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0		218, 045 700, 731 333, 820 223, 135 14, 705 554 46, 961 7, 288 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 5/23/2022 3:05 pm

Heal th	Financial Systems		SCHNECK MEDIC	AL CENTER		Inlie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0065	Period: From 01/01/2021	Worksheet H-1	
				HHA CCN:	15-7155	To 12/31/2021	Date/Time Pre 5/23/2022 3:0	epared:
						Home Health	PPS	<u>13 pili</u>
			Capital Rela	ated Costs		Agency I		
		Not Exponsos	BIdgs &	Movabl e	Plant	Trancportatio	Subtotal	-
		Net Expenses for Cost	Fixtures	Equi pment	Operation &	Transportati o n	(col s. 0-4)	
		Allocation (from Wkst.			Maintenance			
		H, col. 10)	1.00				14.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	0		0			C	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	C	3.00
4.00	Transportation Administrative and General	0	0	0		0 0 0 0	210 045	4.00
5.00	HHA REIMBURSABLE SERVICES	218, 045	0	0		0 0	218, 045	5.00
6.00 7.00	Skilled Nursing Care Physical Therapy	700, 731 333, 820	0	0		0 0 0 0	700, 731 333, 820	
8.00	Occupational Therapy	223, 135	0	0		0 0	223, 135	8.00
9.00 10.00	Speech Pathology Medical Social Services	14, 705 554	0	0		0 0 0 0	14, 705 554	1
11. 00 12. 00	Home Health Aide	46, 961	0	0		0 0	46, 961	
12.00	Supplies (see instructions) Drugs	7, 288 0	0	0 0		0 0 0	7, 288 0	1
14.00	DME HHA NONREIMBURSABLE SERVICES	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	0 0		0 0 0 0		
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		0 0 0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	1
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23.50 24.00	Telemedicine Total (sum of lines 1–23)	0 1, 545, 239	0	0 0		0 0 0 0	0 1, 545, 239	23.50 24.00
		Administrativ e & General	Total (cols. 4A + 5)					
	r	5.00	6.00					
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related – Movable Equipment							2.00
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General	218, 045						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	115, 124	815, 855					6.00
7.00 8.00	Physical Therapy Occupational Therapy	54, 843 36, 659	388, 663 259, 794					7.00 8.00
9.00	Speech Pathology	2, 416	17, 121					9.00
10.00 11.00	Medical Social Services Home Health Aide	91 7, 715	645 54, 676					10.00
12.00	Supplies (see instructions)	1, 197	8, 485					12.00
13.00 14.00	Drugs DME	0	0 0					13.00 14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic	0	0 0					17.00 18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.50	Tel emedi ci ne	0	0					23.50
∠4.UU	Total (sum of lines 1-23)	I I	1, 545, 239					24.00

	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0065 15-7155	Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
						Home Health	5/23/2022 3:0 PPS	5 pm
						Agency I	110	
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE)	(SQUARE FEET)	4.00	54.00		
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5A. 00	5.00	
1.00	Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures	Ū				0		1.00
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0		0		4.00
5.00	Administrative and General	0	0	0		0 -218,045	1, 327, 194	5.00
5.00	HHA REIMBURSABLE SERVICES	U 0	0	0	I	210,043	1, 527, 174	0.00
6.00	Skilled Nursing Care	0	0	0		0 0	700, 731	6.00
7.00	Physi cal Therapy	0	0	0		0 0	333, 820	7.00
8.00	Occupational Therapy	0	0	0		0 0	223, 135	
9.00	Speech Pathology	0	0	0		0 0	14, 705	
10.00	Medical Social Services Home Health Aide	0	0	0		0 0	554	
11.00 12.00	Supplies (see instructions)	0	0	0		0 0	46, 961	12.00
13.00		0	0	0		0	0	
14.00	DME	0	0	0		0 0	-	
	HHA NONREI MBURSABLE SERVI CES							1
15.00	Home Dialysis Aide Services	0	0	0		0 0	-	
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0		
20.00		0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00	All Others (specify)	0	0	0		0 0	0	20.00
23.50		0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	0		0 -218, 045		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		U	218, 045	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	00	0. 164290	26.00
20.00		0.00000	0.00000	0.00000	0.00000		1 0.101270	1 20.

LOCATION OF GENERAL SE	RVICE COSTS	TO HHA COST CEN	SCHNECK MEDI	Provider C		Period:	u of Form CMS-2 Worksheet H-2	
				HHA CCN:		From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/23/2022 3:0	par 5 p
						Home Health	PPS	
			CAPI TAL REL	ATED COSTS		Agency I		
								1
Cost Center	Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
00 Administrative an	d General	0	29, 946	522	75, 15	4 105, 622		1
00 Skilled Nursing C	are	815, 855		0	199, 58			
0 Physical Therapy	2014	388, 663	0	0	95,07			
00 Occupational Ther 00 Speech Pathology	ару	259, 794 17, 121	0	0	63, 55 4, 18			
00 Medical Social Se	rvi ces	645	0	0	4, 18			
00 Home Heal th Ai de		54, 676	0	0	13, 37			
00 Supplies (see ins	tructions)	8, 485	0	0		0 8, 485		
00 Drugs		0	0	0		0 0	0	9
OO DME	<i>.</i>	0	0	0		0 0	-	
00 Home Dialysis Aid		0	0	0		0 0	0	
00 Respiratory Thera 00 Private Duty Nurs		0	0	0		0 0 0 0	-	
00 Clinic	ing		0	0		0 0	-	
00 Health Promotion	Acti vi ti es	0	0	0		0 0	0	15
00 Day Care Program		0	0	0		0 0	0	16
00 Home Delivered Me	als Program	0	0	0		0 0	0	17
00 Homemaker Service		0	0	0		0 0	0	
00 All Others (speci	fy)	0	0	0		0 0	0	
50 Telemedicine 00 Total (sum of lin	ac (1, 10) (2)	0 1, 545, 239	0 29, 946	0 522		0 0	0 421, 091	
.00 Unit Cost Multipl		1, 545, 239	29, 940	522	451, 08	7 2, 026, 794 0. 000000		21
26, line 1 divide						0.000000		21
of column 26, lin								
column 26, line 1	, rounded to							
6 decimal places.	Deserietien						NUDCLNC	
Cost Center	Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
			EINER OENTOE				N	
		7.00	8.00	9.00	10.00	11.00	13.00	
00 Administrative an 00 Skilled Nursing C		32, 701 0	0	10, 640 0		0 0 0 0	-	
0 Physical Therapy	are	0	0	0		0 0	0	
00 Occupational Ther	apv	0	0	0		0 0		
00 Speech Pathology		0	0	0		0 0	0	
00 Medical Social Se	rvi ces	0	0	0		0 0	0	
00 Home Health Aide		0	0	0		0 0	0	
0 Supplies (see ins	tructions)	0	0	0		0 0	-	
			0	0		0 0	0	
			0	0		0 0	0	
OO DME	e Services					0	, i i i i i i i i i i i i i i i i i i i	
00 DME 00 Home Dialysis Aid		0	-	0		0 0	0	
00 DME00 Home Dialysis Aid00 Respiratory Thera	ру		0	-		0 0 0 0	0	13
00 DME 00 Home Dialysis Aid 00 Respiratory Thera 00 Private Duty Nurs 00 Clinic	py i ng		0	0		-		
00 DME 00 Home Dialysis Aid 00 Respiratory Thera 00 Private Duty Nurs 00 Clinic 00 Health Promotion	py i ng		0	0		0 0	0 0 0	14 15
00 DME 00 Home Dialysis Aid 00 Respiratory Thera 00 Private Duty Nurs 00 Clinic 00 Health Promotion 00 Day Care Program	py ing Activities	0 0 0 0	0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0	0 0 0	14 15 16
 00 DME 00 Home Dialysis Aid 00 Respiratory Thera 00 Private Duty Nurs 00 Clinic 00 Health Promotion 00 Day Care Program 00 Home Delivered Me 	py ing Activities als Program		0 0 0	0 0 0		0 0 0 0	0 0 0 0	14 15 16 17
 .00 DME .00 Home Dialysis Aid .00 Respiratory Thera .00 Private Duty Nurs .00 Clinic .00 Health Promotion .00 Day Care Program .00 Home Delivered Me .00 Homemaker Service 	py ing Activities als Program	0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	14 15 16 17 18
.00DME.00Home Dialysis Aid.00Respiratory Thera.00Private Duty Nurs.00Clinic.00Health Promotion.00Day Care Program.00Home Delivered Me.00Homemaker Service.00All Others (speci	py ing Activities als Program	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0 0 0	14 15 16 17 18 19
 .00 DME .00 Home Dialysis Aid .00 Respiratory Thera .00 Private Duty Nurs .00 Clinic .00 Health Promotion .00 Day Care Program .00 Home Delivered Me .00 Homemaker Service .00 All Others (speci .50 Telemedicine 	py ing Activities als Program fy)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	14 15 16 17 18 19
 .00 DME .00 Home Dialysis Aid .00 Respiratory Thera .00 Private Duty Nurs .00 Clinic .00 Health Promotion .00 Day Care Program .00 Home Delivered Me .00 Homemaker Service .00 All Others (speci .50 Telemedicine .00 Total (sum of lin 	py ing Activities als Program fy) es 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14 15 16 17 18 19 19
.00DME.00Home Dialysis Aid.00Respiratory Thera.00Private Duty Nurs.00Clinic.00Health Promotion.00Day Care Program.00Home Delivered Me.00Homemaker Service.00All Others (speci.50Telemedicine.00Total (sum of lin.00Unit Cost Multipl.26Line 1 divide	py ing Activities als Program fy) es 1–19) (2) ier: column d by the sum	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14 15 16 17 18 19 19 20
 .00 DME .00 Home Dialysis Aid .00 Respiratory Thera .00 Private Duty Nurs .00 Clinic .00 Health Promotion .00 Day Care Program .00 Home Delivered Me .00 Homemaker Service .00 All Others (speci .50 Telemedicine .00 Total (sum of lin .00 Unit Cost Multipl 	py ing Activities als Program fy) es 1–19) (2) ier: column d by the sum e 20 minus	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14 15 16 17 18 19 19 20

ALLOC	ATION OF GENERAL SERVICE COSTS T	TO HHA COST CEN	TERS	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet H-2 Part I Date/Time Pre	
				HHA CCN:	10-7100		5/23/2022 3:0	5 pm
						Home Health Agency I	PPS	
					OTHER GENERA			
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVI CE PHYSI CI AN PRI VATE PRACTI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	
		14.00	15.00	16.00	18.00	19.00	24.00	
1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Home Delivered Meals Program Homemaker Service All Others (specify)	14.00 0 0 0 0 33,591 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	24, 00 183, 018 1, 226, 406 584, 244 390, 526 25, 736 970 82, 189 43, 839 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 15. 00 19. 00 19. 00 20. 00 21. 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine		183, 018 1, 226, 406 584, 244 390, 526 970 82, 189 43, 839 0 0 0 0 0 0 0 0 0 0 0 0 0	95, 353 45, 426 30, 364 2, 001 75 6, 390 3, 409 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	629, 67 420, 89 27, 73 1, 04 88, 57 47, 24 2, 536, 92	r0 20 77 55 99 88 00 00 00 00 00 00 00 00 00 00 00 00		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00

Heal th Financial			SCHNECK MEDIC				u of Form CMS-2	
ALLOCATION OF GEN BASIS	IERAL SERVI CE COSTS	IO HHA COSI CEN	TERS STATISTICA	AL Provider C HHA CCN:	CN: 15-0065 15-7155	Period: From 01/01/2021 To 12/31/2021	Worksheet H-2 Part II Date/Time Pre 5/23/2022 3:0	pared:
						Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS			Agency I		
Cost	Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati n	o ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	1.00
2.00 Skilled Nu 3.00 Physical TI 4.00 Occupation 5.00 Speech Pati 6.00 Medical So 7.00 Home Heal ti 8.00 Supplies (: 9.00 Drugs 10.00 DME 11.00 Home Dial y: 12.00 Respirator: 13.00 Private Du 14.00 Clinic 15.00 Heal th Proi 16.00 Day Care P 17.00 Home Deliv 18.00 Homemaker S 19.00 All Others 19.50 Tel emedici	herapy al Therapy hology cial Services h Aide see instructions) sis Aide Services y Therapy ty Nursing motion Activities rogram ered Meals Program Service (specify) ne	1, 579 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	510 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	263, 867 700, 731 333, 820 223, 135 14, 705 554 46, 961 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{array}{cccccccccccccccccccccccccccccccccccc$		2.00 3.00 4.00 5.00 6.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
21.00 Total cost	of lines 1-19) to be allocated	1, 579 29, 946	510 522	1, 583, 773 451, 087		2, 026, 794 421, 091	32, 701	21.00
22.00 Unit cost	Center Description	18. 965168 LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	1. 023529 HOUSEKEEPI NG (SQUARE FEET)	0. 284818 DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	0. 207762 NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	22.00
1 00 Administra	tive and Conoral	8.00	9.00	10.00	11.00	13.00	14.00	1.00
2.00 Skilled Nu 3.00 Physical TI 4.00 Occupation 5.00 Speech Patt 6.00 Medical So 7.00 Home Healt 8.00 Supplies (19) 9.00 Drugs 10.00 DME 11.00 Home Dialy: 12.00 Respirator; 13.00 Private Du 14.00 Clinic 15.00 Health Pro 16.00 Day Care P 17.00 Home maker 3 19.00 All Others 19.00 Tel emedici 20.00 Total (sum	herapy al Therapy hology cial Services h Aide see instructions) sis Aide Services y Therapy ty Nursing motion Activities rogram ered Meals Program Service (specify)		1, 579 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

Heal th	Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTIC	AL Provider C	CN: 15-0065	Period:	Worksheet H-2	
BASI S				HHA CCN:	15-7155	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/23/2022 3:0	
-						Home Health	PPS	
						Agency I		
				OTHER GENERAL				
		DUADNAOV		SERVI CE				-
	Cost Center Description	PHARMACY	MEDI CAL	PHYSI CI AN	NONPHYSI CI A			
		(COSTED REQUIS.)	RECORDS & LI BRARY	PRI VATE PRACTI CE	ANESTHETI ST (ASSI GNED	>		
		REQUIS.)	(GROSS	(TIME	TI ME)			
			CHARGES)	SPENT)				
		15.00	16.00	18.00	19.00			1
1.00	Administrative and General	0	2, 716, 051	0		0		1.00
2.00	Skilled Nursing Care	0	0	0		0		2.00
3.00	Physical Therapy	0	0	0		0		3.00
4.00	Occupational Therapy	0	0	0		0		4.00
5.00	Speech Pathology	0	0	0		0		5.00
6.00	Medical Social Services	0	0	0		0		6.00
7.00	Home Health Aide	0	0	0		0		7.00
8.00	Supplies (see instructions)	0	0	0		0		8.00
9.00	Drugs	0	0	0		0		9.00
10.00	DME	0	0	0		0		10.00
11.00 12.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0		12.00
12.00	Private Duty Nursing	0	0	0		0		12.00
	Clinic	0	0			0		14.00
	Health Promotion Activities	0	0	0		0		15.00
	Day Care Program	0	0	0		0		16.00
	Home Delivered Meals Program	0	0	0		0		17.00
	Homemaker Service	0	0	0		0		18.00
19.00	All Others (specify)	0	0	0		0		19.00
19.50	Tel emedi ci ne	0	0	0		0		19.50
20.00	Total (sum of lines 1-19)	0	2, 716, 051	0		0		20.00
	Total cost to be allocated	0	12, 111			0		21.00
22.00	Unit cost multiplier	0. 000000	0. 004459	0. 000000	0.0000	00		22.00

DDODT	Financial Systems	T.C.	SCHNECK MEDI		01 45 00/5		u of Form CMS-2	
PPORI	IONMENT OF PATIENT SERVICE COS	15		Provider C HHA CCN:	CN: 15-0065 15-7155	Period: From 01/01/2021 To 12/31/2021	Worksheet H-3 Part I Date/Time Prep	pared
				Ti +L c	× XVIII	Home Health	5/23/2022 3: 05 PPS	5 pm
						Agency I		
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (col s		Per Visit	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
	Cost Per Visit Computation							
. 00	Skilled Nursing Care	2.00			1, 321, 7			
. 00	Physical Therapy	3.00	629, 670	0			211.87	2.
. 00	Occupational Therapy	4.00		0			269.80	
. 00	Speech Pathology	5.00 6.00		0	27, 7:			
. 00 . 00	Medical Social Services Home Health Aide	7.00	1,045		88, 5		52. 25 168. 08	
. 00	Total (sum of lines 1-6)	7.00	88, 579 2, 489, 680	0				0. 7.
. 00	Total (suil of Triles 1-6)		2, 469, 060	0	Program Visi			7.
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es			
		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	
. 00	Skilled Nursing Care		18020	0		17		8.0
. 01	Skilled Nursing Care		31140	0		22		8.
. 02	Skilled Nursing Care		50002	0		67		8.0
. 03	Skilled Nursing Care		99915	0	1, 40	61		8.0
. 00	Physical Therapy		18020	0		20		9.
. 01	Physical Therapy		31140	0		29		9.0
. 02	Physical Therapy		50002	0		59		9.
. 03	Physical Therapy		99915	0	1, 1			9.
0.00	Occupational Therapy		18020	0		8 10		10. 10.
0. 01 0. 02	Occupational Therapy Occupational Therapy		31140 50002	0		45		10.
0.02	Occupational Therapy		99915	0		77		10.
1.00	Speech Pathology		18020	0		0		11.
1.01	Speech Pathology		31140	0		0		11.
1.02	Speech Pathology		50002	0		0		11.
1.03	Speech Pathology		99915	0		14		11.
2.00	Medical Social Services		18020	0		1		12.
2.01	Medical Social Services		31140	0		0		12.
2. 02	Medical Social Services		50002	0		0		12.
2.03	Medical Social Services		99915	0		5		12.
3.00	Home Health Aide		18020	0		0		13.
3. 01	Home Health Aide		31140	0		0		13.
3. 02	Home Health Aide		50002	0		0		13.
3.03	Home Health Aide		99915	0		56		13.
4.00		East Miles	E a a l d d d	0	3, 8		Datia (1 2	14.
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges		
		H-2 Part I, col. 28, line	Costs (from	Ancillary Costs (from	Costs (cols 1 + 2)	. (from HHA Records)	÷ col. 4)	
		201. 20, 11/10	Wkst. H-2, Part I)	Part II)	1 + 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput Cost of Medical Supplies			0	1			

	Financial Systems TIONMENT OF PATIENT SERVICE COST	c	SCHNECK MEDI	Provider C	N. 15 0045	Peri od:	u of Form CMS-2 Worksheet H-3	
PURI	TONMENT OF PATIENT SERVICE COST	3		HHA CCN:	15-7155	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	eparec
				Title	XVIII	Home Health	5/23/2022 3:0 PPS	ing ci
			Program Visits		Cost of	Agency I		
					Servi ces			L
	Cost Conton Decorintion	Dort A	Part		Dort A	Part B	Subi oot to	
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles &	Part A	Not Subject to	Subject to Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM L	IMITATION COST, C	OR BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							-
00	Skilled Nursing Care	C	1, 567			0 572, 942		1.
00	Physical Therapy	C				0 267, 592		2.
00	Occupational Therapy	C	740			0 199, 652		3.
00	Speech Pathology	C				0 5, 884		4.
00	Medical Social Services	C				0 314		5.
00	Home Health Aide	C				0 43,028		6.
00	Total (sum of lines 1-6) Cost Center Description	C	3, 846			0 1, 089, 412		7.
	cost center bescription	6. 00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03 00	Skilled Nursing Care Physical Therapy							8.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physi cal Therapy							9.
. 00	Occupational Therapy							10.
). 01	Occupational Therapy							10.
). 02	Occupational Therapy							10.
0. 03 . 00	Occupational Therapy Speech Pathology							10.
. 00	Speech Pathology							11.
. 02	Speech Pathology							11.
. 03	Speech Pathology							11.
. 00	Medical Social Services							12.
. 01	Medical Social Services							12.
. 02	Medical Social Services							12.
. 03 . 00	Medical Social Services Home Health Aide							12.
. 00	Home Health Aide							13.
. 01	Home Heal th Aide							13.
	Home Health Aide							13.
	Total (sum of lines 8-13)							14.
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
			Part	В		Part B		-
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		(Coi nsurance	0.00	0.00	Coi nsurance	11.00	-
	Supplies and Drugs Cost Computa	6.00	7.00	8.00	9.00	10.00	11.00	-
. 00	Cost of Medical Supplies	C	28, 487	28, 487		0 23, 307	23, 307	15
	Cost of Drugs		0	0		0		16.

APPORTIONMENT OF PATIENT SERVICE COSTS Provider CN: 15-0065 Period 1/20221 Dirth Provider 1-3 HHA CON: 15-7155 To 12/31/2021 To 12/31/2021 To 12/31/2021 Period 1/3/31/2021 Cost Center Description Total Program Cost (sum of cols. 9-10) Total Program Cost (sum of cols. 9-10) Period 1/20221 Period 1/2021 Period 1/20221 Period 1/2021 Period 1		Financial Systems		SCHNECK MEDI CAL			u of Form CMS-2	
HHA CCI: 15-7155 To 12/21/2021 Date Time Prepared: 5/22/2022 Science Title XVIII Home Heal th Agency, I PPS Cost Center Description Total Program Cost (sum of cols, 9-10) Image: Cost Center Description Total Program Cost (sum of cols, 9-10) PPS PART I - COMPUTATION OF LESSER OF AGGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY Cost LimitATION 2 0 Cost Center Description 5/22,942 2 0 0 0 1:00 Skilled Mursing Care 5/22,942 2 0 <t< td=""><td>APPORT</td><td>IONMENT OF PATIENT SERVICE COST</td><td>ſS</td><td></td><td>Provider CCN: 15-0065</td><td>Peri od:</td><td></td><td></td></t<>	APPORT	IONMENT OF PATIENT SERVICE COST	ſS		Provider CCN: 15-0065	Peri od:		
Title XVIII Home Heal th Agency I PPS Cost Center Description Total Program Image: Cost Center Description Total Argency I PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Image: Cost Center Description 1.00 1.00 Skilled Nursing Care 52, 542 2.00 2.00 Physical Therapy 267, 592 3.00 3.00 Speech Pathology 5, 884 4.00 3.00 Goographic Center Description 5.00 6.00 Cost Center Description 1.009, 1.00 1.009, 4.02 7.00 Cost Center Description 1.009, 4.12 7.00 7.00 Cost Center Description 1.00 8.00 8.00 8.00 8.00 Skilled Nursing Care 8.00 8.00 8.00 8.00 9.01 Physical Therapy 9.00 9.00 9.00 9.00 9.00 9.02 Physical Therapy 9.03 9.03 9.00 9.01 9.03 9.03 9.03 9.03 <td< td=""><td></td><td></td><td></td><td></td><td>HHA CCN: 15-7155</td><td></td><td>Date/Time Pre</td><td></td></td<>					HHA CCN: 15-7155		Date/Time Pre	
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^{5/23/2022 3:05} pm

Health Financial Systems		SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0065	Peri od:	Worksheet H-3	
			HHA CCN:	15-7155	From 01/01/2021 To 12/31/2021	Part II	norod.
			HHA CCN:	15-7155	To 12/31/2021	Date/Time Pre 5/23/2022 3:0	5 pm
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	1			TAL DEPARTME			
1.00 Physical Therapy	66.00				0 col. 2, line 2		1.00
2.00 Occupational Therapy	67.00				0 col. 2, line 3		2.00
3.00 Speech Pathology	68.00	0. 293551	(D	0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	1. 112624	(D	0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 559605	(0 col. 2, line 1	6.00	5.00

^{5/23/2022 3:05} pm

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0065	Peri od:	Worksheet H-4	1
	HHA CCN:	15-7155	From 01/01/2021 To 12/31/2021		
	Title	XVIII	Home Health	PPS	<u>, , , , , , , , , , , , , , , , , , , </u>
			Agency I		
				t B	_
		Part A	Not Subject to	Subject to Deductibles &	
			Deductibles &	Coi nsurance	
			Coi nsurance		
	-	1.00	2.00	3.00	-
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGE	S			
Reasonable Cost of Part A & Part B Services					
Reasonable cost of services (see instructions)			0 0		
) Total charges			0 0	0	2
Customary Charges					
 Amount actually collected from patients liable for payment for on a charge basis (from your records) 	r services		0 0	0	3
Amount that would have been realized from patients liable for	navmont		0 0	0	4
for services on a charge basis had such payment been made in a			0		1
with 42 CFR §413.13(b)					1
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5
Total customary charges (see instructions)			0 0	0	$ \epsilon$
Excess of total customary charges over total reasonable cost	(complete		0 0	0	1
only if line 6 exceeds line 1)					
Excess of reasonable cost over customary charges (complete on	lyifline		0 0	0	8
1 exceeds line 6) Primary payer amounts			0 0	0	ģ
) Primary payer amounts			Part A	Part B	<u> </u>
			Services	Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00 Total reasonable cost (see instructions)			0		10
00 Total PPS Reimbursement - Full Episodes without Outliers			0	,	
0 Total PPS Reimbursement - Full Episodes with Outliers			0	12, 387	
0 Total PPS Reimbursement - LUPA Episodes			0	24, 553	
00 Total PPS Reimbursement - PEP Episodes 00 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	6, 281 1, 065	
0 Total PPS Outlier Reimbursement - PEP Episodes with outliers			0	I, 005	
0 Total Other Payments			0	0	
00 DME Payments			0	0	
00 Oxygen Payments			0	0	
0 Prosthetic and Orthotic Payments			0	0	20
00 Part B deductibles billed to Medicare patients (exclude coins	urance)			0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)			0	958, 956	
00 Excess reasonable cost (from line 8)			0	0	
00 Subtotal (line 22 minus line 23)			0	958, 956	
			_		
0 Coinsurance billed to program patients (from your records)			0		
00 Coinsurance billed to program patients (from your records) 00 Net cost (line 24 minus line 25)			~	0	
00 Coinsurance billed to program patients (from your records) 00 Net cost (line 24 minus line 25) 00 Reimbursable bad debts (from your records)	actruction (0	-	
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in 			0	0	
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) 			Ű.	0 958, 956	29
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 	e 27)		0 0 0	0 958, 956 0	29 30
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions) 	e 27)		0	0 958, 956 0 0	29 30 30
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration 	e 27)		0 0 0 0	0 958, 956 0 0 0	29 30 30 30
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Subtotal (see instructions) 	e 27)			0 958, 956 0 0 0	29 30 30 30 30 31
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Subtotal (see instructions) 	e 27)			0 958, 956 0 0 0 958, 956	29 30 30 30 30 31 31
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Dustotal (see instructions) Sequestration adjustment (see instructions) 	e 27) s)			0 958, 956 0 0 0 958, 956 0	29 30 30 30 31 31 31
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Dustotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration 	e 27) s)			0 958, 956 0 0 958, 956 958, 956 0 0	29 30 30 30 31 31 31 31 31
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only) 	e 27) 5) structions)			0 958, 956 0 0 958, 956 0 0 0 958, 957	29 30 30 30 31 31 31 31 31 32 33
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Pioneer ACO demonstration payment adjustment (see instructions) Demonstration adjustment (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see instructions) Interim payments (see instructions) 	e 27) s) structions) and 33)			0 958, 956 0 0 958, 956 0 0 0 958, 957 0	29 30 30 30 31 31 31 31 32 33 34

	GIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0065		eriod:	Worksheet H-5	
) PR(DGRAM BENEFI CI ARI ES	HHA CCN:	15-7155	Fr To	om 01/01/2021 12/31/2021	Date/Time Prep	pareo
					Home Health	5/23/2022 3: 05 PPS	s pm
		Inpatien	it Part A		Agency I Par	t B	
	-	mm/dd/yyyy	Amount	_	mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0		958, 957 0	1.(2.(
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3. (
01				0		0	3.
02				0		0	3.
03				0		0	3.
04				0		0	3.
05	Dravidar to Dragram			0		0	3.
50	Provider to Program		1	0		0	3.
50 51				0		0	3.
52				0		0	3.
53				0		0	3
54				0		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)			0		958, 957	4.
00	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		936, 937	4
	TO BE COMPLETED BY CONTRACTOR			- 1	1		
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider		1				
D1				0		0	5
)2)3				0 0		0	5 5
55	Provider to Program			0		0	5
50				0		0	5
51				0		0	5
52				0		0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER			0		0	6
02	SETTLEMENT TO PROGRAM			0		1	6
00	Total Medicare program liability (see instructions)			0	0	958, 956	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
			C		1, 00	(MO/Day/Yr) 2.00	

NALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CO Hospice CCI	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet O Date/Time Pre	pared
			· ·		Hospi ce I	5/23/2022 3:0	
		SALARI ES	OTHER	SUBTOTAL (col. 1 pl us col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			1			
. 00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	
. 00	CAP REL COSTS-MVBLE EQUIP* EMPLOYEE BENEFITS DEPARTMENT*	0	9, 695	9, 695	0	9, 695 0	2. C 3. C
. 00	ADMI NI STRATI VE & GENERAL*	73, 958	48, 111	122, 069	0	122, 069	4.0
. 00	PLANT OPERATION & MAINTENANCE*	0	959	959	0	959	5.0
. 00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.0
. 00	HOUSEKEEPI NG*	0	0	0	0	0	7.0
. 00	DI ETARY*	0	0	0 750	0	0	8.0
. 00 0. 00	NURSI NG ADMI NI STRATI ON* ROUTI NE MEDI CAL SUPPLI ES*	88, 750	0 5, 629	88, 750 5, 629	0	88, 750 5, 629	
1.00	MEDICAL RECORDS*	0	5,029	0 3,029	0	5,029	
2.00	STAFF TRANSPORTATION*	0	0	0	0	0	
3.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	3, 493	3, 493	
4.00	PHARMACY*	0	1, 125	1, 125	0	1, 125	14.0
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.0
6.00	OTHER GENERAL SERVICE*	0	5, 049	5, 049	0	5, 049	
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES DI RECT PATI ENT CARE SERVI CE COST CENTERS						17.0
5.00	INPATIENT CARE-CONTRACTED**	1	0	0	0	0	25.0
6.00	PHYSICIAN SERVICES**	55, 603	0	55, 603	0	55, 603	
7.00	NURSE PRACTI TI ONER**	0	0	0	0	00,000	27.0
3. 00	REGI STERED NURSE**	424, 384	0	424, 384	0	424, 384	28.
9.00	LPN/LVN**	0	0	0	0	0	29.0
0.00	PHYSI CAL THERAPY**	0	0	0	0	0	
1.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	
2.00 3.00	SPEECH/LANGUAGE PATHOLOGY** MEDI CAL SOCI AL SERVI CES**	0	0	0	0 41, 688	0 41, 688	
4.00	SPIRITUAL COUNSELING**	83, 532	0	83, 532	-45, 181	38, 351	
5.00	DI ETARY COUNSELI NG**	00,002	0	00,002	0	00,001	
6.00	COUNSELING - OTHER**	0	0	0	0	0	
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	104, 477	0	104, 477	0	104, 477	37.0
8.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	62, 709	62, 709	0	62, 709	38.0
9.00	PATIENT TRANSPORTATION**	0	6, 936	6, 936	0	6, 936	
0.00	I MAGI NG SERVI CES**	0	0	0	0	0	
1.00 2.00	LABS & DI AGNOSTI CS** MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0 3, 250	3, 250	0	0 3, 250	
2.50	DRUGS CHARGED TO PATIENTS**	0	3, 200	3,230	0	3, 230	
3.00	OUTPATI ENT SERVICES**	0	0	0	0	0	
4.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.0
5.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.0
6.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.0
	NONREI MBURSABLE COST CENTERS	-		-	-		
	BEREAVEMENT PROGRAM *	0	0	0	-	0	
1.00 2.00	VOLUNTEER PROGRAM * FUNDRAI SI NG*	0	0	0	0	0	
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	
4.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	
	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	
5.00	RESIDENTIAL CARE*	0	0	0	0	0	
7.00	ADVERTI SI NG*	0	0	0	0	0	67.
3. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	
	THRI FT STORE*	0	0	0	0	0	
	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	
	OTHER NONREI MBURSABLE (SPECI FY) *	0	142 442		0	074 167	
JU. UL	TOTAL	830, 704	143, 463	974, 167	0	974, 167	1100.

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

	Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	SCHNECK MEDIC	Provider CCN	: 15-0065	Peri od:	u of Form CM Worksheet (
					From 01/01/2021		
			Hospi ce CCN:	15-1529	To 12/31/2021	Date/Time F 5/23/2022 3	
		ADJUSTMENTS 1	OTAL (col. 5		Hospi ce I		
		ADJUSTMENTS	± col. 6)				
		6.00	7.00				
00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	0	0				1
00	CAP REL COSTS-BLDG & FIXT	0	9, 695				
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
00	ADMI NI STRATI VE & GENERAL*	0	122, 069				4
00	PLANT OPERATION & MAINTENANCE*	0	959				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	o				7
00	DI ETARY*	0	o				6
00	NURSI NG ADMI NI STRATI ON*	0	88, 750				9
00	ROUTINE MEDICAL SUPPLIES*	0	5, 629				10
00	MEDI CAL RECORDS*	0	0				11
00	STAFF TRANSPORTATION*	0	0				12
00	VOLUNTEER SERVICE COORDINATION*	0	3, 493				13
00	PHARMACY*	0	1, 125				14
00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15
00	OTHER GENERAL SERVICE*	0	5, 049				16
00	PATI ENT/RESI DENTI AL CARE SERVI CES						17
	DIRECT PATIENT CARE SERVICE COST CENTERS						_
	INPATIENT CARE-CONTRACTED**	0	0				25
00	PHYSI CI AN SERVI CES**	-1	55, 602				26
00	NURSE PRACTITIONER**	0	0				27
00	REGI STERED NURSE**	0	424, 384				28
00		0	0				29
00 00	PHYSI CAL THERAPY** OCCUPATI ONAL THERAPY**	0	0				30
00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
00	MEDI CAL SOCI AL SERVI CES**	0	41, 688				33
00	SPIRITUAL COUNSELING**	0	38, 351				34
00	DI ETARY COUNSELI NG**	0	0				35
00	COUNSELING - OTHER**	0	o				36
00	HOSPICE AIDE & HOMEMAKER SERVICES**	-2	104, 475				3
00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	62, 709				38
00	PATI ENT TRANSPORTATI ON**	0	6, 936				39
00	I MAGI NG SERVI CES**	0	o				40
00	LABS & DI AGNOSTI CS**	0	o				4
00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	3, 250				42
50	DRUGS CHARGED TO PATIENTS**	0	0				42
00	OUTPATIENT SERVICES**	0	0				43
00	PALLIATIVE RADIATION THERAPY**	0	0				44
00	PALLIATIVE CHEMOTHERAPY**	0	0				45
00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
~ ~	NONREI MBURSABLE COST CENTERS						
00	BEREAVEMENT PROGRAM *	0	0				60
00	VOLUNTEER PROGRAM *	0	0				61
00 00		0	0				62
00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
00	PALLIATIVE CARE PROGRAM* OTHER PHYSICIAN SERVICES*	0	0				64
00	RESIDENTIAL CARE*		0				65
	ADVERTI SI NG*	0	0				66
00 00	TELEHEALTH/TELEMONI TORI NG*	0					68
	THRIFT STORE*	0					69
	NURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREIMBURSABLE (SPECIFY)*	0					71
	· · · ·	_ 2	974 164				100
0. 00)TOTAL sfer the amounts in column 7 to Wkst. 0-5, c	-3	974, 164				10

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

	Financial Systems	SCHNECK MEDIC				u of Form CMS-2	
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provider C	CN: 15-0065	Peri od:	Worksheet 0-2	
CARE			Hospi ce. CCI	N: 15-1529	From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
			1030100 001	1. 10 1027	10 12/01/2021	5/23/2022 3:0	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
	PHYSI CI AN SERVI CES	54, 869	0	54, 86	59 0	54, 869	26.0
	NURSE PRACTITIONER	0	0		0 0	0	
28.00	REGI STERED NURSE	418, 786	0	418, 78	36 0	418, 786	28.0
29.00	LPN/LVN	0	0		0 0	0	29.0
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.0
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.0
33.00	MEDICAL SOCIAL SERVICES	0	0		0 41, 138	41, 138	33.0
34.00	SPI RI TUAL COUNSELI NG	82, 430	0	82, 43	-44, 585	37, 845	34.0
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.0
36.00	COUNSELING - OTHER	0	0		0 0	0	36.0
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	103, 099	0	103, 09	99 0	103, 099	37.0
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	62, 709	62, 70	0	62, 709	38.0
39.00	PATI ENT TRANSPORTATI ON	0	6, 845	6, 84	15 0	6, 845	39.0
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.0
41.00	LABS & DIAGNOSTICS	0	0		0 0	0	41.0
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	3, 207	3, 20	07 0	3, 207	42.0
42 50	DRUGS CHARGED TO PATLENTS	0	0		0 0	0	42 5

121 00 111		0	0/20/	0,20,		0,20,	1 121 00		
42.50 DI	RUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50		
43.00 0	UTPATI ENT SERVI CES	0	0	0	0	0	43.00		
44.00 P	ALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00		
45.00 P	ALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00		
46.00 0	THER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00		
100. 00 T	OTAL *	659, 184	72, 761	731, 945	-3, 447	728, 498	100.00		
* Transf	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.								

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7.00		
	DI RECT PATI ENT CARE SERVI CE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	-1	54, 868		26.00
27.00	NURSE PRACTI TI ONER	0	0		27.00
28.00	REGI STERED NURSE	0	418, 786		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	41, 138		33.00
34.00	SPI RI TUAL COUNSELI NG	0	37, 845		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	-2	103, 097		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	62, 709		38.00
39.00	PATI ENT TRANSPORTATI ON	0	6, 845		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	3, 207		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	-3	728, 495	1	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51			

Health Financial Systems	SCHNECK MEDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CCN		Period:	Worksheet 0-3	
RESPITE CARE		Hospice CCN:		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	pared: 5 pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATIONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVI CE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26.00 PHYSICIAN SERVICES	483	0	48	0	483	
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	3, 684	0	3, 68	34 0	3, 684	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		0 362	362	33.00
34.00 SPI RI TUAL COUNSELI NG	725	0	72	-392	333	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	907	0	90	07 0	907	37.00
38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	60	6	0 0	60	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 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	28	2	.8 0	28	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 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	5, 799	88	5, 88	-30	5, 857	100.00

 40.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 5,799

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

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	<u>± col. 6)</u> 7.00	
DIF	RECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25.00 I NI	PATIENT CARE-CONTRACTED	0	0	25.00
26.00 PH	YSI CI AN SERVI CES	0	483	26.00
27.00 NUI	RSE PRACTITIONER	0	0	27.00
28.00 RE	GI STERED NURSE	0	3, 684	28.00
29.00 LPI	N/LVN	0	0	29.00
	YSI CAL THERAPY	0	0	30.00
31.00 OC	CUPATI ONAL THERAPY	0	0	31.00
	EECH/LANGUAGE PATHOLOGY	0	0	32.00
	DI CAL SOCI AL SERVI CES	0	362	33.00
	IRITUAL COUNSELING	0	333	34.00
	ETARY COUNSELING	0	0	35.00
	UNSELING - OTHER	0	0	36.00
	SPICE AIDE & HOMEMAKER SERVICES	0	907	37.00
	RABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
	TI ENT TRANSPORTATI ON	0	60	39.00
	AGI NG SERVI CES	0	0	40.00
	BS & DI AGNOSTI CS	0	0	41.00
	DI CAL SUPPLI ES-NON-ROUTI NE	0	28	42.00
	UGS CHARGED TO PATIENTS	0	0	42.50
	TPATI ENT SERVI CES	0	0	43.00
	LLIATIVE RADIATION THERAPY	0	0	44.00
	LLI ATI VE CHEMOTHERAPY	0	0	45.00
	HER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00 T0	TAL *	0	5, 857	100.00
* Transfe	er the amount in column 7 to Wkst. 0-5, col	umn 1, line 52		

Health Financial Systems	SCHNECK MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E GENERAL	Provider CC		Period:	Worksheet 0-4	
I NPATI ENT CARE		Hospi ce CCN		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATIONS		
	1 00	0.00	<u>col. 2)</u>	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVI CE COST CENTERS 25. 00 I NPATI ENT CARE-CONTRACTED		0			0	25.00
26. 00 PHYSI CI AN SERVI CES	251	0	25	0 0	251	25.00
27. 00 NURSE PRACTITIONER	231	0		0 0	231	20.00
28. 00 REGI STERED NURSE	1, 914	0	1, 91	-	1, 914	
29.00 LPN/LVN	0	0	1, 71	0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	0	0		0 188	188	33.00
34.00 SPIRITUAL COUNSELING	377	0	37	7 -204	173	34.00
35. 00 DI ETARY COUNSELI NG	0	0		o o	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	471	0	47	1 0	471	37.00
38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	0		0 0	0	38.00
39. 00 PATI ENT TRANSPORTATI ON	0	31	3	1 0	31	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 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	15	1	5 0	15	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATI ENT SERVI CES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	3, 013	46	3, 05	9 -16	3, 043	100.00

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 3,013

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

		ADJUSTMENTS	TOTAL (col. 5									
		6,00	± col. 6) 7.00									
	DIRECT PATIENT CARE SERVICE COST CENTERS											
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25.00							
26.00	PHYSI CI AN SERVI CES	0	251		26.00							
27.00	NURSE PRACTI TI ONER	0	0		27.00							
28.00	REGI STERED NURSE	0	1, 914		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	188		33.00							
34.00	SPI RI TUAL COUNSELI NG	0	173		34.00							
35.00	DI ETARY COUNSELI NG	0	0		35.00							
36.00	COUNSELING - OTHER	0	0		36.00							
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	471		37.00							
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00							
39.00	PATIENT TRANSPORTATION	0	31		39.00							
40.00	I MAGI NG SERVI CES	0	0		40.00							
41.00	LABS & DIAGNOSTICS	0	0		41.00							
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	15		42.00							
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50							
43.00	OUTPATI ENT SERVI CES	0	0		43.00							
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00							
	PALLIATIVE CHEMOTHERAPY	0	0		45.00							
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00							
100.00	TOTAL *	0	3, 043	1	00.00							
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53			* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.							

Health Financial Systems SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0065	Peri od:	Worksheet 0-5	
EXPENSES FOR ALLOCATION			From 01/01/2021		
	Hospi ce CC	N: 15-1529	To 12/31/2021	Date/Time Pre	
				5/23/2022 3:0	5 pm
			Hospi ce I	TOTAL	
Descriptions		HOSPI CE	GENERAL	TOTAL	
		DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES FROM	of cols. 1 +	
		TINSTRUCTIONS	WKST B PART I	2)	
			(see		
		1.00	i nstructi ons) 2.00	3.00	
GENERAL SERVICE COST CENTERS		1.00	2.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT			0 29, 946	29, 946	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP		9,69			2.00
3. 00 EMPLOYEE BENEFITS DEPARTMENT			0 189, 687	189, 687	3.00
4. 00 ADMI NI STRATI VE & GENERAL		122, 06			4.00
5. 00 PLANT OPERATION & MAINTENANCE		95		33, 660	5.00
6.00 LAUNDRY & LINEN SERVICE			0 0		6.00
7.00 HOUSEKEEPING			0 10, 640	-	7.00
8.00 DI ETARY			0 10, 840		8.00
			0	-	9.00
		88, 75			
10. 00 ROUTINE MEDICAL SUPPLIES		5, 62		30, 296	10.00
11.00 MEDICAL RECORDS			0 12, 273		11.00
12.00 STAFF TRANSPORTATION			0	0	12.00
13. 00 VOLUNTEER SERVICE COORDINATION		3, 49		3, 493	
14.00 PHARMACY		1, 12			14.00
15. 00 PHYSI CLAN ADMINI STRATI VE SERVI CES			0	0	15.00
16. 00 OTHER GENERAL SERVICE		5, 04			16.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
		T		0	
50.00 HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE		728, 49		728, 495	
52. 00 HOSPICE INPATIENT RESPITE CARE		5,85		5, 857	52.00
53.00 HOSPICE GENERAL INPATIENT CARE		3, 04	3	3, 043	53.00
				0	60.00
60.00 BEREAVEMENT PROGRAM 61.00 VOLUNTEER PROGRAM			0	0	61.00
			0	-	
62.00 FUNDRALSING			0	0	62.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS			-	0	63.00
64. 00 PALLIATIVE CARE PROGRAM			0	0	64.00
65. 00 OTHER PHYSICIAN SERVICES			0	0	65.00
66. 00 RESIDENTIAL CARE			0	0	66.00
67. 00 ADVERTI SI NG			0	0	67.00
68. 00 TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00 THRIFT STORE			0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00 OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99. 00 NEGATIVE COST CENTER			0	0	99.00
100. 00 TOTAL		974, 16	4 547,940	1, 522, 104	1100.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part I Date/Time Pre 5/23/2022 3:0	pared:
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBL EQUI P	E EMPLOYEE BENEFI TS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
-	GENERAL SERVICE COST CENTERS			•			
1.00	CAP REL COSTS-BLDG & FIXT	29, 946	29, 946				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 695		9,6	95		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	189, 687	0	., -	0 189, 687		3.00
4.00	ADMI NI STRATI VE & GENERAL	370, 095	5,624	9.6		402, 302	4.00
5.00	PLANT OPERATION & MAINTENANCE	33, 660	0,021	,,0	0 0	33, 660	5.00
6.00	LAUNDRY & LINEN SERVICE	000	0		0 0	0 000	6.00
7.00	HOUSEKEEPING	10, 640	0		0 0	10, 640	
8.00	DI ETARY	10, 040	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	00 750	1 052		0 20, 266	-	9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES	88, 750 30, 296	1, 853 777		0 20, 200	110, 869 31, 073	
					0		
11.00	MEDICAL RECORDS	12, 273	0		0 0	12, 273	
12.00	STAFF TRANSPORTATION	0	0		0 0	0	
13.00	VOLUNTEER SERVICE COORDINATION	3, 493	0		0 0	3, 493	
14.00	PHARMACY	1, 125	0		0 0	1, 125	
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	8, 099		0 0	8, 099	
16.00	OTHER GENERAL SERVICE	5, 049	3, 706		0 0	8, 755	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		2, 760		0	2, 760	17.00
	LEVEL OF CARE	,		1		I	
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	728, 495			150, 521	879, 016	
52.00	HOSPICE INPATIENT RESPITE CARE	5, 857	0		0 1, 324	7, 181	
53.00	HOSPICE GENERAL INPATIENT CARE	3, 043	0		0 688	3, 731	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	7, 127		0 0	7, 127	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0	0	70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0	Ω		0 0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0 0		99.00
	TOTAL	1, 522, 104	29, 946	9,6	95 189, 687	1, 522, 104	
	-1	1 ., 022, 104	27,740	,,0	107,007	1 ., 022, 104	1.00.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER			In Lieu	u of Form CMS	-25	552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS		CN: 15-0065 N: 15-1529			Worksheet O- Part I Date/Time Pr 5/23/2022 3:	∼ер	
						Hospi ce I			
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
-	GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMI NI STRATI VE & GENERAL	402, 302							4.00
5.00	PLANT OPERATION & MAINTENANCE	12, 093	45, 753						5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0				6.00
7.00	HOUSEKEEPING	3, 823	O			14, 463			7.00
8.00	DIETARY	0	0			0		ol	8.00
9.00	NURSI NG ADMI NI STRATI ON	39, 831	3, 486			1, 102			9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	11, 163	1, 463			462			10.00
11.00	MEDI CAL RECORDS	4, 409	0			0			11.00
12.00	STAFF TRANSPORTATION	0	0			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	1, 255	0			0			13.00
14.00	PHARMACY	404	0			0			14.00
15.00	PHYSICIAN ADMINI STRATI VE SERVICES	2, 910	15, 234			4, 816			15.00
16.00	OTHER GENERAL SERVICE	3, 145	6, 971			2, 204			16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	992	5, 192			1,641			17.00
	LEVEL OF CARE		0,172			.,			
50.00	HOSPICE CONTINUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	315, 797							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2, 580	O		0	0			52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 340	0		õ	0			53.00
00.00	NONREI MBURSABLE COST CENTERS	1,010		1		0		-	00.00
60.00	BEREAVEMENT PROGRAM	2, 560	13, 407	1		4, 238			60.00
61.00	VOLUNTEER PROGRAM	0	0			0			61.00
62.00	FUNDRALSING	0	0	1		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0			64.00
65.00	OTHER PHYSI CI AN SERVICES	0	0			0			65.00
66.00	RESI DENTI AL CARE	0	0		0	0		0	66.00
67.00	ADVERTI SI NG	0	0		Ŭ	0		Ĭ	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0			0			68.00
	THRI FT STORE	0	0			0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			0			70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0	0			71.00
99.00	NEGATI VE COST CENTER	0	0		0	0			99.00
	TOTAL	402, 302	45, 753		0	14, 463			00.00
	-1		, , , , , , , , , , , , , , , , , ,	1	~	, 100		-1,	

Heal th	n Financial Systems	SCHNECK MEDIC	AL CENTER		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL		Provider CO Hospice CCI		Period: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part I Date/Time Pre	pared:
					Hospice I	5/23/2022 3:0	5 pm
	Descriptions	NURSI NG ADMI NI STRATI O N	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	TRANSPORTATI O N	VOLUNTEER SERVI CE COORDI NATI ON	
		9,00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	155, 288 0 0 0 0 0 0 0	44, 161	16, 6	82 0 0 0 0 0 0	4, 748 0 0 4, 748	14.00 15.00
17.00		0			0	4,740	17.00
	LEVEL OF CARE						
50.00 51.00 52.00 53.00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0 46, 587 46, 586 46, 586	0 43, 579 383 199	16, 4 1	0 0 62 0 45 0 75 0	0	50.00 51.00 52.00 53.00
60.00 61.00 62.00 63.00 64.00 65.00 67.00 68.00 68.00 69.00 70.00 71.00 99.00 100.0	VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD OTHER NONREI MBURSABLE (SPECI FY)	15, 529 0 0 0 0 0 0 0 0 0 0 0 0 0 0 155, 288	0 44, 161	16, 6	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		60.00 61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		Inlie	u of Form CMS-	2552-10
	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE		Provi der Ci Hospi ce CCi		Period: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part I Date/Time Pre 5/23/2022 3:0	epared:
					Hospi ce I	0/20/2022 0.0	
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE		TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	1, 529					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	31, 059				15.00
16.00	OTHER GENERAL SERVICE	1, 529		27, 35			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				10, 585		17.00
	LEVEL OF CARE		-		-	-	
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	
51.00	HOSPICE ROUTINE HOME CARE	0	30, 649			1, 359, 082	1
52.00	HOSPICE INPATIENT RESPITE CARE	0	270			64, 348	
53.00	HOSPICE GENERAL INPATIENT CARE	0	140	12	3 3, 619	55, 813	53.00
(0.00	NONREI MBURSABLE COST CENTERS			1		42.0/1	
60.00	BEREAVEMENT PROGRAM	0			0	42, 861	1
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00		0			0	0	1
63.00 64.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		1
65.00	PALLIATIVE CARE PROGRAM	0			0		
	OTHER PHYSICIAN SERVICES	0	0		0 0		
66.00	RESIDENTIAL CARE	0	0		0	0	
67.00	ADVERTI SI NG	0			0		
68.00 69.00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE	0			0		
		0			0	0	1
70.00 71.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)		0		0 0		1
99.00	NEGATIVE COST CENTER	0	0		0 0		
	TOTAL	1, 529	31, 059	27, 35	0	1, 522, 104	
100.00		1, 527	51,007	27,30	- 10, 303	1, 522, 104	1.00.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0065	Period:	Worksheet 0-6	
STATI S	TI CAL BASI S		Hospi ce CCI	N: 15-1529	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
			nospi ce co	N. 1J-1J27	10 12/31/2021	5/23/2022 3:0	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCILIATIO	ADMI NI STRATI V	
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
		1.00	0.00	SALARIES)		4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
1.00	CAP REL COSTS-BLDG & FIXT	2, 311	1				1.00
2.00	CAP REL COSTS BEDG & TTXT	2,311	100				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0			14		3.00
4.00	ADMI NI STRATI VE & GENERAL	434	-			1, 119, 802	4.00
5.00	PLANT OPERATION & MAINTENANCE	0			0 0	33, 660	5.00
6.00	LAUNDRY & LI NEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	10, 640	7.00
8.00	DIETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	143	0	88, 75	50 0	110, 869	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60			0 0	31,073	10.00
11.00	MEDI CAL RECORDS	0			0 0	12, 273	
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	3, 493	13.00
14.00	PHARMACY	0	0		0 0	1, 125	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	625	0		0 0	8, 099	15.00
16.00	OTHER GENERAL SERVICE	286	0		0 0	8, 755	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	213	0		0	2, 760	17.00
	LEVEL OF CARE	-			_		
50.00	HOSPICE CONTINUOUS HOME CARE				0 0		50.00
51.00	HOSPICE ROUTINE HOME CARE			659, 18			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0				7, 181	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	3, 01	3 0	3, 731	53.00
(0.00	NONREI MBURSABLE COST CENTERS	550				7 407	1 / 0 . 00
60.00	BEREAVEMENT PROGRAM	550			0 0		60.00
61.00	VOLUNTEER PROGRAM	0			0 0 0 0		61.00
62.00	FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0	0		0 0	0	62.00
63.00 64.00	PALLIATIVE CARE PROGRAM	0	0		0 0		63.00 64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0		66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0		0 0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0 0	0	70.00
70.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	70.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	29, 946	9, 695	189, 68	37	402, 302	
	UNIT COST MULTIPLIER	12. 958027				0. 359262	
					I.		

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C	CN: 15-0065	Peri od:	Worksheet 0-6	
STATI S	ITI CAL BASI S				From 01/01/2021	Part II	
			Hospi ce CC	N: 15-1529	To 12/31/2021		
					lleent ee l	5/23/2022 3:0	5 pm
	Cont Conton Departingtions						
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N		NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET		ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		5.00	6.00	7.00	0.00	HRS.) 9.00	
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1			1.00
2.00							2.00
	CAP REL COSTS-MVBLE EQUIP						
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL	4 077					4.00
5.00	PLANT OPERATION & MAINTENANCE	1, 877					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1, 8			7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON	143			43	100	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60			60	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			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625		6	25	0	15.00
16.00	OTHER GENERAL SERVICE	286		2	86	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	213		2	13		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					30	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	30	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	30	53.00
	NONREIMBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	550		5	50	10	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	-		0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	Ū			0		70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	45, 753	0	14, 4	43 N	155, 288	
	UNIT COST MULTIPLIER	24. 375599					
101.00		27. 575577	0.00000	1 1.1033	0.00000	1, 332. 333000	1.51.00

Heal th	Financial Systems	SCHNECK MEDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part II	
			110001 00 00	10 1027	10 12/01/2021	5/23/2022 3:0	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS (PATI ENT	STAFF TRANSPORTATI N	0 SERVI CE COORDI NATI ON	PHARMACY (CHARGES)	
		(PATI ENT DAYS)	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 & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	11, 750					10.00
11.00	MEDI CAL RECORDS		11, 750				11.00
12.00	STAFF TRANSPORTATION				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 100		13.00
14.00	PHARMACY				0 0	100	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16.00	OTHER GENERAL SERVICE				0 100	100	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	11, 595	11, 595		0 0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	102	102		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	53	53		0 0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM				0 0	-	
61.00	VOLUNTEER PROGRAM				0 0	-	61.00
62.00	FUNDRAI SI NG				0 0	-	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	-	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	-	64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	0	65.00
66.00	RESI DENTI AL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	68.00
69.00	THRI FT STORE				0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)				0 0	0	
99.00	NEGATI VE COST CENTER				_		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	44, 161	16, 682		0 4,748		100.00
101.00	UNIT COST MULTIPLIER	3. 758383	1. 419745	0.0000	47. 480000	15. 290000	101.00

	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	DVICE COSTS					
STATI S		ERVICE CUSIS	Provider C	CN: 15-0065	Period:	Worksheet 0-	6
	TI CAL BASI S		Hospi ce CC	N: 15-1529	From 01/01/2021 To 12/31/2021	Part II Date/Time Pr	epared:
						5/23/2022 3:	05 pm
	Cost Costos Decesistions				Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN C ADMI NI STRATI V	SERVI CE	PATI ENT/ RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATIENT	BASIS)	(IN-FACILIT			
		DAYS)	DASI 5)	DAYS)	1		
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS	10100	10100	17100			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	11, 750					15.00
16.00	OTHER GENERAL SERVICE		11, 750				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1	55		17.00
I	LEVEL OF CARE	·					
50.00	HOSPI CE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	11, 595	11, 595				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	102	102		02		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	53	53		53		53.00
	NONREI MBURSABLE COST CENTERS	1		1			
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAL SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00 69.00	TELEHEALTH/TELEMONI TORI NG		0				68.00 69.00
69.00 70.00	THRIFT STORE NURSING FACILITY ROOM & BOARD		0				70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		70.00
	NEGATIVE COST CENTER		0		0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	31, 059	27, 352	10, 5	85		100.00
()() ()()	per most. 0-0, fait f)	51,007	21, 332	10,5	23		1.00.00

Heal th	Financial Systems	SCHNECK MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SER OF CARE	VICE COSTS BY	Provider C	CN: 15-0065	Period: From 01/01/2021	Worksheet 0-7	
			Hospi ce CC	N: 15-1529	To 12/31/2021	Date/Time Pre 5/23/2022 3:0	
					Hospice I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00	0. 422432		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0. 222132		0 0	0	
3.00	SPEECH PATHOLOGY	68.00	0. 293551		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 559605		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0 17017/				5.00
6.00	LABORATORY	60.00	0. 179176	1	0 0	0	
7.00 8.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS BEHAVI ORAL HEALTH	71.00 93.00	1. 112624 2. 379061		0 0	0	
8.00 9.00	RADI OLOGY-THERAPEUTI C	93.00 55.00	2.379001		0 0	0	9.00
9.00 10.00	WOUND CARE (DI ABETES CENTER)	76.00	0. 415128		0 0	0	
10.00	OTHER ANCI LLARY CMS LINE	76.01	0. 000000		0 0	0	
10.02	CASE MANAGEMENT	76.02	0. 000000		0 0	0	
10.02	PALN MANAGEMENT	76.03	0. 598519		0 0	0	
10.04	SLEEP LAB	76.04	0. 189523		0 0	0	
10.05	ONCOLOGY	76.05	0. 348028		0 0	0	10.05
10.97	CARDI AC REHABI LI TATI ON	76.97	1. 593748		0 0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
		Charges by		Shared Servi	ce Costs by LOC		
		LOC (from					
		Provi der					
	Cost Center Descriptions	Records) HGI P	HCHC (col. 1	HRHC (col.	1 HIRC (col. 1	HGIP (col. 1	
	cost center bescriptions	norr	x col 2)	x col. 3)	x col. 4)	x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0)	0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0		0 0	0	2.00
3.00	SPEECH PATHOLOGY	0	0		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0		0 0	0	
7.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	
8.00	BEHAVI ORAL HEALTH	0	0		0 0	0	
9.00 10.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	9.00 10.00
10.00	WOUND CARE (DIABETES CENTER) OTHER ANCILLARY CMS LINE	0	0		0 0	0	
10.02	CASE MANAGEMENT	0	0		0 0	0	
10.02	PAIN MANAGEMENT	0	0		0 0	0	
10.00	SLEEP LAB	0	0		0 0	0	
10.05	ONCOLOGY	0	0		0 0	0	
10.97	CARDI AC REHABI LI TATI ON	0	0		0 0	0	
11.00	Totals (sum of lines 1–11)		0		0 0	0	11.00

ealth Financial Systems	SCHNECK MEDICA				u of Form CMS-2	
ALCULATION OF HOSPITAL-BASED HOSPICE PER D	IEM COST	Provider C	CN: 15-0065	Period: From 01/01/2021	Worksheet 0-8	
		Hospi ce CC	N: 15-1529	To 12/31/2021	Date/Time Pre	nared
		110001 00 00	10 1027	10 12/01/2021	5/23/2022 3:0	
				Hospi ce I		
			TITLE XVIII		TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE			1			
.00 Total cost (Wkst. 0-6, Part I, col.	18, line 50 plus Wkst. O	-7, col. 6,			0	1.00
line 11)						
.00 Total unduplicated days (Wkst. S-9, o					0	2.00
.00 Total average cost per diem (line 1 c		10)			0.00	3.00
.00 Unduplicated program days (Wkst. S-9	col. as appropriate, li	ne 10)		0 0		4.00
. 00 Program cost (line 3 times line 4)				0 0		5.0
HOSPICE ROUTINE HOME CARE	0 Line F1 alve Whet 0	7 7	1		1 250 002	
.00 Total cost (Wkst. 0-6, Part I, col. 7 line 11)	18, line 51 plus Wkst. U	-/, COI. /,			1, 359, 082	6.0
.00 Total unduplicated days (Wkst. S-9, o					11 505	7.0
.00 Total average cost per diem (line 6 d					11, 595 117. 21	7.0 8.0
.00 Unduplicated program days (Wkst. S-9,		(no. 11)	10, 7	63 461		9.0
0.00 Program cost (line 8 times line 9)	cor. as appropriate, r	ine in)	1, 261, 5			10.00
HOSPICE INPATIENT RESPITE CARE			1, 201, 5	51 54,034		10.0
1.00 Total cost (Wkst. 0-6, Part I, col. 1	8 line 52 plus Wkst 0	-7 col 8	1		64, 348	111 0
line 11)		-7, COL. 0,			04, 540	11.0
2.00 Total unduplicated days (Wkst. S-9, o	col 4 line 12)				102	12.00
3.00 Total average cost per diem (line 11					630, 86	
4.00 Unduplicated program days (Wkst. S-9,		ine 12)	1	02 0		14.0
5.00 Program cost (line 13 times line 14)			64, 3			15.0
HOSPICE GENERAL INPATIENT CARE			0170			
6.00 Total cost (Wkst. 0-6, Part I, col.	8. line 53 plus Wkst. 0	-7, col, 9,			55, 813	16.0
line 11)		,				
7.00 Total unduplicated days (Wkst. S-9, o	col. 4, line 13)				53	17.0
8.00 Total average cost per diem (line 16	divided by line 17)				1, 053. 08	18.0
9.00 Unduplicated program days (Wkst. S-9,	col. as appropriate, l	ine 13)		48 5		19.0
0.00 Program cost (line 18 times line 19)	•••••	-	50, 5	48 5, 265		20.0
TOTAL HOSPICE CARE						
1.00 Total cost (sum of line 1 + line 6 +	line 11 + line 16)				1, 479, 243	21.0
2.00 Total unduplicated days (Wkst. S-9, o					11, 750	
3.00 Average cost per diem (line 21 divide	ed by line 22)				125.89	23 00

	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0065	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre	pare
				5/23/2022 3:0	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
	Capital DRG other than outlier			371, 668	
	Model 4 BPCI Capital DRG other than outlier			0	
	Capital DRG outlier payments			62, 330	
	Model 4 BPCI Capital DRG outlier payments	ot conarting pariod (and inc	tructions)	0	
00	Total inpatient days divided by number of days in the co	st reporting period (see ins	tructions)	26. 41 0. 00	
	Number of interns & residents (see instructions)			0.00	
00	Indirect medical education percentage (see instructions)		1 columns 1 and	0.00	
00	Indirect medical education adjustment (multiply line 5 b 1.01)(see instructions)	by the sum of times I and 1.0	r, corumns r and	0	0
00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	rt A patient days (Worksheet	E, part A line	0.00	7
00	Percentage of Medicaid patient days to total days (see i	nstructions)		0,00	8
	Sum of lines 7 and 8			0.00	9
	Allowable disproportionate share percentage (see instruc	ctions)		0.00	10
. 00	Disproportionate share adjustment (see instructions)			0	11
. 00	Total prospective capital payments (see instructions)			433, 998	12
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
	Program inpatient routine capital cost (see instructions	5)		0	1 1
	Program inpatient ancillary capital cost (see instruction			0	
	Total inpatient program capital cost (line 1 plus line 2			0	
	Capital cost payment factor (see instructions)	,		0	4
	Total inpatient program capital cost (line 3 x line 4)			0	
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	
	Program inpatient capital costs for extraordinary circum			0	
	Net program inpatient capital costs (line 1 minus line 2	2)		0	
	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line 4			0	
00	Percentage adjustment for extraordinary circumstances (s			0.00	
	Adjustment to capital minimum payment level for extraord	linary circumstances (line 2	x line 6)	0	
	Capital minimum payment level (line 5 plus line 7)			0	
	Current year capital payments (from Part I, line 12, as			0	
	Current year comparison of capital minimum payment level			0	
. 00	Carryover of accumulated capital minimum payment level of Worksheet L, Part III, line 14)		5	0	
	Net comparison of capital minimum payment level to capit			0	
	Current year exception payment (if line 12 is positive,	enter the amount on this line	· ·	0	
. 00				A	14
. 00 . 00	Carryover of accumulated capital minimum payment level of (if line 12 is negative, enter the amount on this line)		following period	0	
. 00 . 00 . 00	Carryover of accumulated capital minimum payment level o	ee instructions)	following period	0	15