Health Financia	al Systems	GOSHEN HOSP	I TAL	In Lie	u of Form CMS-25	552-10
	required by law (42 USC 1395) since the beginning of the co				FORM APPROVED OMB NO. 0938-00 EXPIRES 05-31-2	
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 15-00	From 01/01/2016	Worksheet S Parts I-III Date/Time Prepa 5/25/2017 4:26	
PART I - COST	REPORT STATUS					
Provi der use only	1. [X] Electronically filed 2. [] Manually submitted co 3. [0] If this is an amended 4. [F] Medicare Utilization.	st report report enter the number		Date: 5/25/20 ler resubmitted this o		26 pm
Contractor use only	 As Submitted Settled without Audit 	6. Date Received: 7. Contractor No. 8. [N] Initial Report fo 9. [N] Final Report for	or this Provider CCN this Provider CCN		or Code: Jumn 1 is 4: En nes reopened = 0	
PART II - CERT	I FI CATI ON					
	ION OR FALSIFICATION OF ANY I					
ADMI NI STRATI VE	ACTION FINE AND/OR IMPRISON	MENT UNDER FEDERAL LAW	FURTHERMORE LE SER	VICES IDENTIFIED IN 1	HIS REPORT WERE	

PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOSHEN HOSPITAL (15-0026) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	149, 463	-72, 699	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	149, 463	-72, 699	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.

Date

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Prov	ider CCN:	15-0026	Period: From 01/01		Works Part Date/	o <u>rm CMS</u> - heet S-2 I Time Pro 2017 2:4	2 epare
	1.00	2.00		3.00			4.00			-
00	Hospital and Hospital Health Care Co Street: 200 HIGH PARK AVENUE	PO Box:								1.
	City: GOSHEN	State: IN	Zip Co	ode: 46526	5 Cour	nty: ELKHART				2.
		Component Name	CCN	CBSA					stem (P,	
			Number	- Numbe	r Type	Certified		<u>, 0, o</u>		-
		1.00	2.00	3.00	4.00	5.00	V 6.00	XVII 0 7.00		-
	Hospital and Hospital-Based Componer		2.00	0.00	1.00	0.00	1 0. 00	5 7.00	/ 0.00	
00	Hospi tal	GOSHEN HOSPI TAL	150026	21140) 1	07/11/196	6 N	P	0	3.
0	Subprovider - IPF									4
0 0	Subprovider - IRF Subprovider - (Other)									5
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital -Based SNF									9
00 00	Hospital-Based NF Hospital-Based OLTC									10
00	Hospital -Based HHA	CARE AT HOME SERVICES	5 157174	21140)	04/17/198	6 N	P	N	12
	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce	CARE AT HOME HOSPICE	151527	21140)	04/17/198	6			14
00	Hospital-Based Health Clinic - RHC	SERVI CES								15
	Hospital -Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
00	Renal Dialysis Other									18
00	Jotnei					Fron	1:	Т	ō:	17
						1.0			. 00	
	Cost Reporting Period (mm/dd/yyyy)					01/01/	2016	12/3	1/2016	20
00	Type of Control (see instructions)					2				21
00	Does this facility qualify and is it	currently receiving	payments t	For dispr	oporti ona	te Y			N	22
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, er			§412.106(c) (2) (Pi cl	<le< td=""><td></td><td></td><td></td><td></td></le<>				
01	Did this hospital receive interim ur	3		this cost	reportino	a N			Y	22
	period? Enter in column 1, "Y" for y	ves or "N" for no for	the portio	on of the	cost					
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period occur	ring on or	arter u	ctoper I.					
02	Is this a newly merged hospital that	requires final uncom	pensated o	care paym	ents to be	e N			N	22
	determined at cost report settlement									
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for	1 31								
	or after October 1.	no, for the portroll c	in the cos	reporti	ng periou	OII				
03	Did this hospital receive a geograph								Ν	22
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for					er				
	prior to October 1. Enter in column					the				
	cost reporting period occurring on a									
	hospital contain at least 100 but no			ed in acc	ordance wi	th				
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			25 below	2 In colu	nn	1		Y	23
	1, enter 1 if date of admission, 2 i	f census days, or 3 i	f date of	di scharg	je. Is the					
	method of identifying the days in th									
	used in the prior cost reporting per			-State	Out-of		Medi ca	bid	Other	
				di cai d	State		HMO da		edi cai d	
		pai c	~	<u> </u>	Medi cai d	Medi cai d			days	
				npaid p days	aid days	el i gi bl e unpai d				
		1		2.00	3.00	4. 00	5.00)	6.00	-
00	lf this provider is an IPPS hospital		1, 414	0	0	0		318		0 24
	in-state Medicaid paid days in colum									
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c									
	out-of-state Medicaid eligible unpai									
	4, Medicaid HMO paid and eligible bu	ıt unpaid days in								
	column 5, and other Medicaid days ir				_					
~~	If this provider is an IRF, enter th Medicaid paid days in column 1, the		0	0	0	0		0		25
00	moundara para days in corumn i, the									
	Medicaid eligible unpaid davs in col	umn Z,	1							
	Medicaid eligible unpaid days in col out-of-state Medicaid days in columr	n 3, out-of-state								
		n 3, out-of-state umn 4, Medicaid								

	Financial Systems GOS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provider CC		eriod: rom 01/01/2016		
						5/25/2017 2:4 Date of Geogr	7 pm
					1.00	2.00	1
	Enter your standard geographic classification (not wa			ginning of the		1	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) st "2" f	atus at the en or rural. If a			1	27.00
5.00	enter the effective date of the geographic reclassifient of this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in	(D	35.00
					Begi nni ng:	Endi ng:	-
6.00	Enter applicable beginning and ending dates of SCH st	atus.	Subscript line	36 for number	1.00	2.00	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perio	ds MDH status	(D	37.00
	ls this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo						37.01
8. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of						38.00
	enter subsequent dates.				Y/N	Y/N	
0.00	Doos this facility qualify for the innationt besnital	n a) (m a	nt adjuctment :	For Low volumo	1.00 N	2.00 N	39.00
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ent uireme or "N"	er in column 1 nts in accorda for no. (see	"Y" for yes nce with 42 instructions)			
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1.	Enter "Y" for		N	N	40.00
					V 1.0		1
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for	di sproporti ona	te share in ac	cordance N	Y N	45.00
6.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N N	46.00
7.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals						47.00 48.00
	Is this a hospital involved in training residents in a or "N" for no.	approv	ed GME program	s? Enter "Y"	for yes N		56.00
7.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t ", com	r "N" for no i his cost repor plete Workshee	n column 1. lf ting period?	column 1 Enter "Y"		57.00
8.00	If line 56 is yes, did this facility elect cost reimb	urseme	nt for physicia	ans' services	as		58.00
1	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	•		Pt. I.	N		59.00
0.00	Are you claiming nursing school and/or allied health	costs	for a program	that meets the	Y		60.00
	provider-operated criteria under §413.85? Enter "Y"	for ye Y/N	s or "N" for n IME	<u>o. (see instru</u> Direct GME	ctions) IME	Direct GME	
	_	-					
1.00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	0.00	0.00		0.00	
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0. 00	0.00			61.01
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00			61.02
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00			61.03
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00			61.04
01. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.00			61.05

USITIAL A	nancial Systems AND HOSPITAL HEALTH CARE COMP		<u>SHEN HO:</u> ATA	Provi der CC		eri od:	u of Form CMS-2 Worksheet S-2	
					Fr Tc	com 01/01/2016 0 12/31/2016	Part I Date/Time Pre 5/25/2017 2:4	
			Y/N	IME	Direct GME	IME	Direct GME	
use	er the amount of ACA §5503 aw of for cap relief and/or FTEs re or general surgery. (see in	that are nonprimary	1.00	<u>2.00</u> 0.00	<u>3.00</u> 0.00	4.00	5.00	61.
	e or general surgery. (see th		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
spe for col pro unw FTE	the FTEs in line 61.05, speci scialty, if any, and the numbe each new program. (see instr umn 1, the program name, ente ogram code, enter in column 3, veighted count and enter in co	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME				0.00	0.00	
pro res i ns ent 3,	the FTEs in line 61.05, speci- ogram specialty, if any, and t sidents for each expanded prog structions) Enter in column 1, er in column 2, the program c the IME FTE unweighted count direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0.00	61.
							1.00	
2.00 Ent	A Provisions Affecting the Heater the number of FTE resident	s that your hospital	traineo			iod for which	0.00	62.
2.01 Ent dur	ur hospital received HRSA PCRE er the number of FTE resident ing in this cost reporting pe aching Hospitals that Claim Re	s that rotated from riod of HRSA THC pro	a Teachi gram. (s	<u>see instructio</u>		your hospital	0.00	62.
3.00 Has	s your facility trained reside for yes or "N" for no in col	nts in nonprovider s	ettings	during this co		period? Enter	Ν	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1. 00	2.00	3.00	
	tion 5504 of the ACA Base Yea iod that begins on or after J							
4.00 Ent in res set res	er in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro tings. Enter in column 2 the sident FTEs that trained in yo (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty train n-priman all non d non-pu n column	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	gram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Ent	erin column 1, ifline 63	1.00		2.00	3.00 0.00	4.00	5.00 0.000000	65
is tra yea ass FTE pro res the col unw	yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained sidents. Enter in column 2, e program code, enter in umn 3, the number of weighted primary care FTE sidents attributable to cations occurring in all -provider settings. Enter in umn 4, the number of							

Health Financial Systems	GO	SHEN HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION D	ATA Provid		Period: From 01/01/2016 Fo 12/31/2016		pared:
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Se	1.00 etti ngsEffecti ve	2.00 for cost report	3.00 ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations	010 unweighted non-prima occurring in all nonp	ry care resident rovider settings	0.0	-		66.00
Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	tal. Enter in column	3 the ratio of				
	Program Name	Program Cod	e Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00 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 3 divided by (column 3 + column 4)). (see instructions)			0.0	0 0.00	0. 000000	67.00
		1		1.00	2.00 3.00	
Inpatient Psychiatric Facility					5 2.00 3.00	
70.00 Is this facility an Inpatient P Enter "Y" for yes or "N" for n		IPF), or does it	contain an IPF su	bprovider? N		70.00
71.00 If line 70 yes: Column 1: Did ti recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 C Column 3: If column 2 is Y, ind (see instructions)	he facility have an a before November 15, 2 Dlumn 2: Did this fac FR 412.424 (d)(1)(iii icate which program y	004? Enter "Y" ility train resi)(D)? Enter "Y"	for yes or "N" for dents in a new tea for yes or "N" for	no. (see chi ng no.	0	71.00
75.00 Is this facility an Inpatient R		v (IRF), or does	it contain an IRF	N		75.00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did ti recent cost reporting period en no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Enter	and "N" for no. he facility have an a ding on or before Nov train residents in a er "Y" for yes or "N"	pproved GME teac ember 15, 2004? new teaching pr for no. Column	hing program in th Enter "Y" for yes ogram in accordanc 3: If column 2 is	e most or "N" for e with 42 Y,	0	76.00
indicate which program year beg	<u>an during this cost r</u>	<u>eporting period.</u>	(see instructions)		
Long Term Care Hospital PPS					1.00	
80.00 Is this a long term care hospit. 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.				g period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 4286.00Did this facility establish a new \$413.40(f)(1)(ii)? Enter "Y" for	ew Other subprovider	(excluded unit)			N	85. 00 86. 00
87.00 Is this hospital a "subclause (86(d)(1)(B)(iv)(II)? Enter "Y"	Ν	87.00
for yes or "N" for no.				V 1.00	XI X 2.00	
Title V and XIX Services 90.00 Does this facility have title V	and/or XIX inpationt	hospital convic	es? Enter "V" for	N	Υ	90.00
yes or "N" for no in the applic	able column.					
91.00 Is this hospital reimbursed for full or in part? Enter "Y" for				N	N	91.00
92.00 Are title XIX NF patients occup instructions) Enter "Y" for yes	ying title XVIII SNF	beds (dual certi	fication)? (see		N	92.00
93.00 Does this facility operate an I "Y" for yes or "N" for no in the	CF/IID facility for p			Ν	N	93.00
94.00 Does title V or XIX reduce capi applicable column.		or yes, and "N"	for no in the	N	Ν	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PITAL Provider C	CN: 15-0026	Peri od:		Workshee		2552-1
			From 01/01/ To 12/31/		Part I Date/Tin 5/25/201		
			V		XI X		
			1.00		2.00		05.0
 P5.00 If line 94 is "Y", enter the reduction percentage in the appl Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. 			0.00 N		0. 00 N)	95.0 96.0
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	licable colum	nn.	0.00		0.00)	97.0
105.00 Does this hospital qualify as a critical access hospital (CAH 106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		thod of payme	nt N				105. 0 106. 0
 101 outpatient services? (see fistifications) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II. 	1. (see inst	tructions) If					107. 0
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edule? See 42					108. 0
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respira 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							109. 0
				-	1.00		-
10.00 Did this hospital participate in the Rural Community Hospital		on project (110A Demo)fo	or	N		110.0
the current cost reporting period? Enter "Y" for yes or "N" f	for no.						
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers 	lf column 2 t for long te	is "E", ente erm care (incl	rin column udes	N		0	115.0
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" f 17.00 s this facility legally-required to carry malpractice insura			r "N" for	N			116. C
no. 18.001s the malpractice insurance a claims-made or occurrence poli		5		1			118.0
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losse	s l	Insura	nce	
		1.00	2.00		3.00)	
18.01 List amounts of malpractice premiums and paid losses:			2.00		01.00		118. C
		1, 111, 4		5, 000	0.00	0	118.0
		1, 111, 4			2.00		118.0
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu		than the	93 2)	
 18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment 	ule listing of Harmless pro column 1, "Y alifies for 1	than the cost centers ovision in AC, (" for yes or the Outpatien	22 1.00 N)	118. (119. (
 18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implar 	ule listing of Harmless pro column 1, "Y alifies for t ts? (see inst	than the cost centers ovision in AC, (" for yes or the Outpatien tructions)	22 1.00 N		2.00)	118. (119. (120. (
 18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 	ule listing of Harmless pro column 1, "\ alifies for 1 ts? (see inst ntable devico Enter "Y" for	than the cost centers ovision in AC, (" for yes or the Outpatien tructions) es charged to - yes or "N"	93 2! 1.00 N A N t		2.00)	118. (119. (120. (121. (
 18. 02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendments? 21. 00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for 	ule listing of Harmless pro column 1, "Y alifies for 1 ts? (see inst ntable device Enter "Y" for e Worksheet A	than the cost centers ovision in AC/ (" for yes or the Outpatien tructions) es charged to a yes or "N" A line number	293 29 1.00 N A N t t		2.00)	118. (119. (120. (121. (122. (
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 18. 02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 27. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 28. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certif	than the cost centers ovision in AC/ (" for yes or the Outpatien tructions) es charged to r yes or "N" A line number for no. If fication date	23 22 1.00 N A N t Y N P		2.00		118. C 119. C 120. C 121. C 122. C 125. C 126. C 127. C 128. C
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 118. 02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119. 00 D0 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 qual Hold Harmless provision in ACA §3121 and applicable amendments. 121. 00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 	Harmless pro column 1, "Y alifies for 1 ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certif er the certifi enter the certifi enter the certifi enter the certifi	than the cost centers ovision in AC/ (" for yes or the Outpatien tructions) es charged to be charged	23 22 1.00 N A N t Y N P		2.00		118.0 118.0 119.0 120.0 121.0 122.0 125.0 126.0 127.0 128.0 129.0 130.0 131.0

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CC		Peri od:	Worksheet S-2	2
				From 01/01/2016 To 12/31/2016		enared
					5/25/2017 2:4	
				1.00	0.00	-
133.00 If this is a Medicare certified of	her transplant center en	ter the certif	ication date	1.00	2.00	133.00
in column 1 and termination date,			reaction date			
134.00 If this is an organ procurement or		he OPO number	in column 1			134.00
and termination date, if applicable All Providers	e, in column 2.					-
140.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-1.	Y	15H059	140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office costs	5		
are claimed, enter in column 2 the			tions)			<u> </u>
<u> </u>	2.0		ugh 143 the r	3.00	s of the home	-
office and enter the home office c			Jugii 143 the i		s of the nome	
141.00Name: IU HEALTH	Contractor's Name: WP		Contracto	or's Number: 081	01	141.00
142.00 Street: I 65 @ 21ST STREET	PO Box:					142.00
143.00 City: INDIANAPOLIS	State: IN		Zip Code:	462	02	143.00
					1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet .	A?			Y	144.00
145 00 f agoto fan ranal comui ago aro al	aimed on Wkat A line 74	and the east	o for	1.00 N	2.00 N	145.00
145.00 If costs for renal services are claring inpatient services only? Enter "Y"				IN	IN	145.00
no, does the dialysis facility inc	lude Medicare utilization					
period? Enter "Y" for yes or "N"			_			
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				- N		146.00
yes, enter the approval date (mm/d		15-2, chapter	40, 94020) 11			
					1.00	
147.00 Was there a change in the statistic 148.00 Was there a change in the order of					N	147.00 148.00
148.00 Was there a change to the simplifi				- no	N	148.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "						
155.00Hospital		N	N N	<u>(366 42 CIK 34</u> N	N	155.00
156.00 Subprovider - IPF		Ν	N	N	N	156.00
157.00 Subprovi der – IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	N	Ν	N	158.00 159.00
160.00HOME HEALTH AGENCY		N N	N N	N N	N	160.00
161. 00 CMHC			N	N	N	161.00
Multicampus					1.00	
165.00 Is this hospital part of a Multica	mpus hospital that has on	e or more camp	uses in diffe	erent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.						
_	Name	County		o Code CBSA	FTE/Campus	-
166.00 If line 165 is yes, for each	0	1.00	2.00 3	3.00 4.00	5.00	0166.00
campus enter the name in column					0.00	100.00
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)						
	1			I		
					1.00	
Heal th Information Technology (HIT				nt Act	Y	147 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under grooo(n)? Enter " 5 is "Y") and is a meaning	τ τοι yes or aful user (lin	וא וטר חט. ופ 167 is "Y")	. enter the		167.00
reasonable cost incurred for the H	IT assets (see instructio	ns)				
168.01 If this provider is a CAH and is not	ot a meaningful user, doe	s this provide	r qualify for	a hardship		168. 01
exception under §413.70(a)(6)(ii)? 169.00 f this provider is a meaningful u						9169.00
transition factor. (see instruction		IS NOT A CAR	(1116-100-15	in , enter the	7.9	103.00
•						

Health Financial Systems	GOSHEN HOSP	I TAL	In Lieu	」of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	NTIFICATION DATA	Provider CCN: 15-0026	Period: From 01/01/2016	Worksheet S-2 Part I	2
					epared: 47 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2013	09/30/2014	170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in			N		0171.00
section 1876 Medicare cost plans report "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in	lf column 1 is yes, e		on		

	Financial Systems GOSHEN HO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0026	Peri od:	u of Form CMS Worksheet S	
103F11	AL AND HUSFFTAL HEALTH GAKE KETMBURSEMENT QUESTIONNALKE	FIOVIDEI C	CN. 15-0020	From 01/01/2016 To 12/31/2016	Part II	repare
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	lforall NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the east	N		1
. 00	reporting period? If yes, enter the date of the change in c	column 2 (see	instruction			1.
	Treporting period. In yes, enter the date of the endinge in e	501 Gillin 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of 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 relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	Y	A	03/23/2017	4.
6. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements?		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
o. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider	is N		6.
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.YWere nursing school and/or allied health programs approved and/or renewed during theN					7. 8.
9. 00	cost reporting period? If yes, see instructions. 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 of cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.
					Y/N 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 p period? If yes, submit copy.			cost reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see i	nstructions.	N	14.
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1	yes, see in t A	structions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data		05 (00 (05)	,	05 (00 (00))	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/02/2017	7 Y	05/02/2017	16.
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Ν		Ν		17.
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

iospi i	Financial Systems GOSHEN HO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN:	15-0026	Period: From 01/01/2016 To 12/31/2016	u of Form CM Worksheet S Part II Date/Time P 5/25/2017 2	-2 repared:
		Descript	i on	Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				-	1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HOS	PLTALS)	I	1.00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.00
3.00	Have changes occurred in the Medicare depreciation expense		s made dur	ing the cost	N	23.00
	reporting period? If yes, see instructions.	· · · · · · · · · · · · · · ·		5		
4.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during th	nis cost re	porting period?	Ν	24.00
5.00	Have there been new capitalized leases entered into during	the cost reporti	ng period?	'lfyes, see	N	25.00
	instructions.	•		-		
6.00	Were assets subject to Sec.2314 of DEFRA acquired during th	e cost reporting] period?	f yes, see	N	26.00
	instructions.					
7.00	Has the provider's capitalization policy changed during the	e cost reporting	period? If	yes, submit	N	27.00
	copy. Interest Expense					_
8.00	Were new Loans, mortgage agreements or letters of credit en	torod into durir	a the cost	roporting	N	28.00
0.00	period? If yes, see instructions.		ig the cost	reporting	IN	20.00
9.00	Did the provider have a funded depreciation account and/or	bond funds (Debt	t Sarvica E	Pasarva Fund)	Ν	29.00
9.00	treated as a funded depreciation account? If yes, see instr		. Service in		IN	27.00
0.00	Has existing debt been replaced prior to its scheduled matu		ht? If ves	SEE	Ν	30.00
0.00	instructions.	in the new de	<i>, b c</i> . 11 <i>y c c</i>	, 300		00.00
31.00	Has debt been recalled before scheduled maturity without is	suance of new de	ebt? If ves	s, see	Ν	31.00
	instructions.		2			
	Purchased Services					
2.00	Have changes or new agreements occurred in patient care ser		through co	ontractual	N	32.00
	arrangements with suppliers of services? If yes, see instru					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertaining	to competi	tive bidding? If	N	33.00
	no, see instructions.					_
4 00	Provider-Based Physicians	rongoment with r		and physicians?	Y	- 24.00
4.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with p	ovi dei -ba	ised physicians?	ř	34.00
85 00	If line 34 is yes, were there new agreements or amended exi	sting agreements	s with the	nrovi der_based	Ν	35.00
5.00	physicians during the cost reporting period? If yes, see in		, wi th the	provider based	i N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
6.00	Were home office costs claimed on the cost report?			Y		36.00
7.00	If line 36 is yes, has a home office cost statement been pr	epared by the ho	ome office?	P Y		37.00
	lf yes, see instructions.					
8.00	If line 36 is yes, was the fiscal year end of the home off			Γ N		38.00
0 00	the provider? If yes, enter in column 2 the fiscal year end					
9.00	If line 36 is yes, did the provider render services to othe	er chain componer	its? If yes	5, N		39.00
0 00	see instructions. If line 36 is yes, did the provider render services to the	home office? If	E NOS COS	Ν		40.00
0.00	instructions.	nome office? If	yes, see	IN		40.00
		2.0	00			
		1.00				
	Cost Report Preparer Contact Information					
1. 00		MI KE		NI CHOLS		41.00
1. 00		MI KE		NI CHOLS		41.00
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			NI CHOLS		41.00
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	ni ke RSM		NI CHOLS		
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.			NI CHOLS		41.00

Health Financial Systems GC	SHEN HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	RE Provi der CCN: 15-0026	Period: From 01/01/2016	Worksheet S-2	
			Date/Time Pre 5/25/2017 2:4	pared: 7 pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/positi	on PARTNER			41.00
held by the cost report preparer in columns 1, 2, and	id 3,			
respectively.				
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	cost			43.00
report preparer in columns 1 and 2, respectively.				

	Financial Systems	GOSHEN HO				u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period:	Worksheet S-3	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	5/25/2017 2:4	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	competient	Line Number	101 01 2000	Avai I abl e	or an ender of		
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	111	40, 62	6 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		111	40, 62	6 0.00	-	7.00
7.00	beds) (see instructions)			40,02	0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00	12	4, 39	2 0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0		0.00	-	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0.00	-	10.00
11.00		34.00	0			0	10.00
	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0.00	0	
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00
13.00	NURSERY	43.00	100	45.04		0	13.00
14.00	Total (see instructions)		123	45, 01	8 0.00		14.00
15.00	CAH visits		-			0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.00
18.00	SUBPROVIDER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.00
20.00	NURSING FACILITY	45.00	0		0	0	20.00
21.00	OTHER LONG TERM CARE	46.00	0		0		21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.00
24.00	HOSPI CE	116.00	0		0		24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		123				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0				32.00
52.01	outpatient days (see instructions)						52.01
33 00	LTCH non-covered days						33.00
55.00	Eron non-covered days	I		I	1	I	I 33.00

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	<u>5/25/2017_2:4</u> Equi val ents	/ pm
	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	6, 615	1, 081	17, 48			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2,670	3, 318				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0				5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	6, 615	1, 081	17, 48			6.00 7.00
7.00	beds) (see instructions)	0,015	1,001	17,403			7.00
8.00	INTENSIVE CARE UNIT	1, 045	182	2, 939			8.00
9.00	CORONARY CARE UNIT	1, 045	102		2		9.00
10.00	BURN I NTENSI VE CARE UNI T	0	0				10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	0	0	(-		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	0	0	· · · · · ·			12.00
13.00			151	2, 448	3		13.00
14.00	Total (see instructions)	7,660	1, 414	22, 872		1, 024. 81	
15.00	. ,	0	0)	.,	15.00
16.00	SUBPROVIDER - IPF	o	ō	(0.00	0.00	
17.00	SUBPROVIDER - IRF	0	0	(0.00	1
18.00	SUBPROVIDER		0	(0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	19.00
20.00	NURSING FACILITY		0	(0.00	0.00	20.00
21.00	OTHER LONG TERM CARE			(0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	5, 941	0	10, 463	0.00	23.97	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23.00
24.00	HOSPI CE	0	0	(0.00	17.37	24.00
24.10	HOSPICE (non-distinct part)	0	0	(0		24.10
25.00	CMHC - CMHC	0	0	(0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	0	0	(0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(01.00		26.25
27.00					0.00	1, 066. 15	
28.00	5		400	2, 73	7		28.00
29.00		0					29.00
30.00				(30.00
31.00				(31.00
32.00	5 5 5 7	0	82	235			32.00
32.01	Total ancillary labor & delivery room			(ן		32.01
22.00	outpatient days (see instructions)						00.00
33. UU	LTCH non-covered days	0			1		33.00

IOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016		pared
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		O	1, 7	12 1, 839	6, 721	1.0
2. 00 5. 00 5. 00 5. 00 5. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			50	53 0 0 0		2.0 3.0 4.0 5.0 6.0
3.00 9.00 0.00 1.00 2.00 3.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 0 9. 0 10. 0 11. 0 12. 0 13. 0
4.00	Total (see instructions) CAH visits	0.00	C	1, 7	12 1, 839	6, 721	13. 14. 15.
6.00 7.00 8.00 9.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY	0.00 0.00 0.00 0.00	0 0 0		0 0 0 0 0	0 0 0	16. 17. 18. 19.
0.00 1.00 2.00 3.00 4.00	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	0.00 0.00 0.00 0.00 0.00 0.00				0	20.0 21.0 22.0 23.0 24.0
4. 10 5. 00 6. 00 6. 25	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00 0. 00					24. 25. 26. 26.
7.00 8.00 9.00 0.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0.00					27.0 28.0 29.0 30.0
1.00 2.00 2.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						31. 32. 32. 33.

SPI TA	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 01/01/2016 To 12/31/2016		epare
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet 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							-
-	Total salaries (see	200.00	69, 851, 354	0	69, 851, 354	2, 243, 353. 00	31.14	1.
	instructions) Non-physician anesthetist Part		0	0	C	0.00	0.00	2.
	A		Ũ	-				
00	Non-physician anesthetist Part B		0	0	C	0.00	0.00	3.
	Physician-Part A -		896, 836	0	896, 836	6, 442. 00	139. 22	4
	Administrative Physicians - Part A - Teaching		0	0	C	0. 00	0.00	4
	Physician and Non Physician-Part B		6, 336, 538	0	6, 336, 538	28, 323. 00	223. 72	5
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	С	0.00	0.00	6
00	Interns & residents (in an	21.00	0	0	C	0. 00	0.00	7
	approved program) Contracted interns and		0	0	(0. 00	0.00	7
	residents (in an approved programs)		0			,	0.00	
	Home office and/or related organization personnel		0	0	C	0.00	0.00	8
00	SNF	44.00	0	0	C	0.00		
	Excluded area salaries (see instructions) DTHER WAGES & RELATED COSTS		5, 412, 512	753, 825	6, 166, 337	217, 342. 00	28.37	10
	Contract Labor: Direct Patient		2, 815, 324	0	2, 815, 324	29, 669. 00	94.89	11
	Care Contract Labor: Top Level		0	0	C	0. 00	0.00	12
	management and other management and administrative services		0	0		0.00	0.00	
00	Contract Labor: Physician-Part		699, 793	0	699, 793	1, 555. 00	450.03	13
	A - Administrative Home office and/or related		0	o	c c	0. 00	0.00	14
	orgainzation salaries and		-					
	wage-related costs Home office salaries		5,007,398	0	5, 007, 398	97, 540. 00	51.34	14
02	Related organization salaries		0	0	C	0. 00		
	Home office: Physician Part A - Administrative		0	0	C	0.00	0.00	15
	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	C	0.00	0.00	16
00	Wage-related costs (core) (see		21, 394, 831	0	21, 394, 831			17
	instructions) Wage-related costs (other)		0	0	0			18
	(see instructions) Excluded areas		1 33E E00		0 00E E00			19
	Excluded areas Non-physician anesthetist Part		2, 335, 508 0	0	2, 335, 508 C			20
00	A Non-physician anesthetist Part		0	0	C			21
00	B Physician Part A -		80, 388	0	80, 388	3		22
	Administrative Physician Part A – Teaching		Ω	0	C			22
00	Physician Part B		353, 460	0	353, 460			23
00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0 0	0)		24 25
50 51	Home office wage-related Related orgainzation		732, 696 0	0	732, 696 C			25 25
52	wage-related Home office: Physician Part A - Administrative -		0	0	C			25
. 53	- Administrative - wage-related Home office & Contract Physicians Part A - Teaching -		0	0	C			25

Heal th	Financial Systems		GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2016 To 12/31/2016		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	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	682, 308		682, 30	8 19, 884. 00	34.31	26.00
27.00	Administrative & General	5.00	12, 001, 336	-753, 825	11, 247, 51	1 318, 750. 00	35.29	27.00
28.00	Administrative & General under		275, 815	0	275, 81	5 992.00	278.04	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	757, 969	0	757, 96	9 33, 133. 00	22.88	30.00
31.00	Laundry & Linen Service	8.00	39, 199	0	39, 19	9 3, 219. 00	12. 18	31.00
32.00	Housekeepi ng	9.00	965, 186	0	965, 18	6 66, 826. 00	14.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	779, 957	-537, 648	242, 30	9 18, 357. 00	13. 20	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	537, 648	537,64	8 40, 725. 00	13. 20	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 628, 591	0	1, 628, 59	1 46, 786. 00	34.81	38.00
39.00	Central Services and Supply	14.00	231, 212	0	231, 21	2 14, 204. 00	16. 28	39.00
40.00	Pharmacy	15.00	1, 777, 921	0	1, 777, 92	1 40, 158. 00	44.27	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	1, 491, 807	0	1, 491, 80			
42.00	Social Service	17.00	797, 545	0	797, 54	5 28, 312. 00	28. 17	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2016 To 12/31/2016		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		63, 790, 631	0	63, 790, 63	1 2, 216, 022. 00	28.79	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 412, 512	753, 825	6, 166, 33	7 217, 342. 00	28.37	2.00
	instructions)							
3.00	Subtotal salaries (line 1		58, 378, 119	-753, 825	57, 624, 29	4 1, 998, 680. 00	28.83	3.00
	minus line 2)							
4.00	Subtotal other wages & related		8, 522, 515	0	8, 522, 51	5 128, 764. 00	66.19	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		22, 207, 915	0	22, 207, 91	5 0.00	38.54	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		89, 108, 549	-753, 825	88, 354, 72	4 2, 127, 444. 00	41.53	6.00
7.00	Total overhead cost (see		21, 428, 846	-753, 825	20, 675, 02	1 688, 827.00	30. 01	7.00
	instructions)							
								•

Heal th	Financial Systems GOS	SHEN HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS	Provi der CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016		pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			1, 757, 426	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instruct	i ons)		1, 992, 282	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions	s)		0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organizat	tion)			
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			14, 941, 840	8.00
8.01	Health Insurance (Self Funded without a Third Party			0	8.01
8.02	Health Insurance (Self Funded with a Third Party Admi	inistrator)		0	8.02
8.03	Health Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			420, 217	
11.00	Life Insurance (If employee is owner or beneficiary)			160, 013	
12.00	Accident Insurance (If employee is owner or beneficia			0	
13.00	Disability Insurance (If employee is owner or benefic			201, 498	
14.00	Long-Term Care Insurance (If employee is owner or be	nefi ci ary)		2, 219	
15.00	'Workers' Compensation Insurance			533, 791	
16.00	Retirement Health Care Cost (Only current year, not	the extraordinary accrual requi	red by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			3, 916, 492	17.00
17.00	Medicare Taxes - Employers Portion Only			3, 910, 492	17.00
19.00	Unemployment Insurance			42, 186	
20.00	State or Federal Unemployment Taxes			42, 100	
20.00	OTHER			0	20.00
21.00	Executive Deferred Compensation (Other Than Retirement instructions))	nt Cost Reported on lines 1 thr	ough 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			583	22.00
23.00	Tui ti on Rei mbursement			195, 640	
24.00	Total Wage Related cost (Sum of lines 1 -23)			24, 164, 187	
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	GOSHEN HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI 1	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0026	Period: From 01/01/2016	Worksheet S-3 Part V	
			To 12/31/2016		pared:
				5/25/2017 2:4	7 pm
	Cost Center Description		Contract	Benefit Cost	
			Labor	0.00	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost	14			
1 00	Hospital and Hospital-Based Component Identificat		0.015.004	04 4/4 407	1 00
1.00	Total facility's contract labor and benefit cost		2, 815, 324		1.00
2.00	Hospi tal		2, 815, 324		2.00
3.00	Subprovider - IPF		0	0	3.00 4.00
4.00	Subprovider - IRF		0	0	4.00 5.00
5.00	Subprovider - (Other)		0	-	5.00 6.00
6.00	Swing Beds - SNF		0	0	8.00 7.00
7.00 8.00	Swing Beds - NF		0	0	7.00 8.00
8.00 9.00	Hospital -Based SNF		0	0	8.00 9.00
9.00 10.00	Hospi tal -Based NF Hospi tal -Based OLTC		0	0	9.00 10.00
10.00	Hospital-Based HHA		0	0	10.00
12.00	Separately Certified ASC		0	0	12.00
12.00	Hospi tal -Based Hospi ce		0	0	12.00
14.00	Hospital -Based Health Clinic RHC		0	0	13.00
15.00	Hospital -Based Health Clinic FQHC		0	0	14.00
16.00	Hospital -Based-CMHC		0	0	16.00
17.00	Renal Dialysis		0	0	17.00
	Other		0	0	17.00
10.00			l U	0	10.00

	Financial Systems HEALTH AGENCY STATISTICAL DATA	GOSHEN HOS		CN: 15-0026	In Lie Period:	u of Form CMS-2 Worksheet S-4	
	TEALTH AGENCE STATISTICAL DATA				From 01/01/2016 To 12/31/2016		
			•		Home Health	5/25/2017 2:4 PPS	
					Agency I		
0.00	County				1. ELKHART	00	0.00
0.00		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	0.00
	HOME HEALTH AGENCY STATISTICAL DATA			1			
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0.00	946 339.00	33.0	0 217 0 304.00 I oyees (Ful I Ti	676.00	
		Enter the number your normal		Staff	Contract	Total	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
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	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service Physical Therapy Supervisor Occupational Therapy Supervisor Speech Pathology Service Speech Pathology Supervisor Medical Social Service Medical Social Service Supervisor Home Health Aide		40. 00	0 0 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	7 0.00 6 0.00 5 0.00 6 0.00 6 0.00 6 0.00 0 0.00 0 0.00 0 0.00 0 0.00 7 0.00 0 0.00 6 0.00 0 0.00 0 0.00 0 0.00 0 0.00	0. 17 0. 86 1. 40 1. 05 0. 46 0. 00 0. 28 0. 00 0. 07 0. 00 0. 16 0. 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
17.00 18.00 19.00	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost			0.0			17.00 18.00 19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			21140			20.00
20. 01 20. 02 20. 03 20. 04 20. 05				99915 23060 43780 50031 50032			20.01 20.02 20.03 20.04 20.05
		Without W Outliers		LUPA Epi sodes	Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges	3, 060 471, 510 1, 122 190, 230 521 87, 210 44 7, 920	155 24, 025 3 510 9 1, 530 0 0	28, 05 1 2, 21 34	5 2, 480 3 10 0 1, 700 3 10 0 1, 700 1 0	526, 070 1, 148 194, 650 543	22.00 23.00 24.00 25.00 26.00 27.00
29.00 30.00 31.00 32.00 33.00	Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	120 25, 660 608 48, 640 5, 475	10 2, 150 37 2, 960 214	64 40	3 2 5 430 5 5 0 400	135 28, 885 655 52, 400	29.00 30.00 31.00 32.00
34.00 35.00	29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0 831, 170	0 31, 175		0 0 0 6, 710	Ŭ Ŭ	
36.00	Total Number of Episodes (standard/non outlier)	396		6	8 2	466	36.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	70, 615	6 5, 559	8, 08	0 0		

	Financial Systems		GOSHEN H				u of Form CMS-2	
10SPI TA	L-BASED HOSPICE IDENTIFICATION	DATA		Provider CO Hospice CCI	CN: 15-0026 N: 15-1527	Period: From 01/01/2016 To 12/31/2016	Worksheet S-9 PARTS I THROU Date/Time Pre 5/25/2017 2:4	GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	DST REPORTING	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015			
2.00 3.00 4.00 5.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days							1.00 2.00 3.00 4.00 5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBEN	<u> 1, 2015</u>			
. 00	Number of patients receiving hospice care Total number of unduplicated Continuous Care hours billable to Medicare							6.0 7.0
3. 00 J	Average Length of Stay (line 5 / line 6)							8.0
9.00	Unduplicated census count							9.00
OTE: P	arts 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 cols. 1 through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1			
1.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care			0 16, 815 84		0 0 0 4, 436 0 8	0 21, 251 92	
3.00 4.00	Hospice General Inpatient Care Total Hospice Days PART IV - CONTRACTED STATISTIC/			299 17, 198		0 145 0 4, 589	444 21, 787	13.0
	Hospice Inpatient Respite Care	L DATA FOR CO.	ST KEFUKTING P	O	IN ON AFTE	0 0		15.0
	Hospice General Inpatient Care			0		0 0		

Heal th Fi	nancial Systems	GOSHEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI TAL	UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0026	Period:	Worksheet S-1	0
				From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10 12/01/2010	5/25/2017 2:4	7 pm
					1.00	
	compensated and indigent care cost computation				0.010054	1 00
	ost to charge ratio (Worksheet C, Part I line 20 dicaid (see instructions for each line)	12 column 3 alvidea by I	The 202 colum	n 8)	0. 310054	1.00
	et revenue from Medicaid				4, 339, 744	2.00
	d you receive DSH or supplemental payments from	Medicaid?			4, 559, 744 Y	3.00
	fline 3 is "yes", does line 2 include all DSH o		from Medicai	d?	Ŷ	4.00
	fline 4 is "no", then enter DSH or supplemental				. 0	5.00
	edicaid charges				54, 338, 156	6.00
7.00 Me	edicaid cost (line 1 times line 6)				16, 847, 763	7.00
8.00 Di	fference between net revenue and costs for Medi	caid program (line 7 mi	nus sum of li	nes 2 and 5; if	12, 508, 019	8.00
	zero then enter zero)					
	ildren's Health Insurance Program (CHIP) (see i	nstructions for each li	ne)			
	et revenue from stand-alone CHIP				0	9.00
	tand-alone CHIP charges				0	10.00
	tand-alone CHIP cost (line 1 times line 10)	d along CIUD (Ling 11 m	inus line O	if , zoro then	0	11.00 12.00
	fference between net revenue and costs for stan nter zero)	id-alone CHIP (IThe IT m	inus ine 9;	ir < zero then	0	12.00
	her state or local government indigent care pro	aram (see instructions	for each line	<u></u>		
	et revenue from state or local indigent care pro				0	13.00
	narges for patients covered under state or local				0	14.00
10	0	····· g···· · · · · · · · · · · · ·	(-	
15.00 St	tate or local indigent care program cost (line 1	times line 14)			0	15.00
16.00 Di	fference between net revenue and costs for stat	e or local indigent car	re program (li	ne 15 minus line	0	16.00
	3; if < zero then enter zero)					
	compensated care (see instructions for each lin					
	ivate grants, donations, or endowment income re				0	17.00
	overnment grants, appropriations or transfers font otal unreimbursed cost for Medicaid , CHIP and s			c (cum of lines	0 12, 508, 019	18.00 19.00
	12 and 16)	tate and rocar rhorgent	care program	is (sum of fines	12, 508, 019	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
	narity care charges for the entire facility (see			0 0	0	20.00
	ost of patients approved for charity care (line			0 0	0	21.00
	artial payment by patients approved for charity	care		0 0	0	22.00
23.00 Cc	ost of charity care (line 21 minus line 22)			0 0	0	23.00
					1.00	
24.00 Do	pes the amount in line 20 column 2 include charg	es for natient days be	ond a length	of stay limit	1.00	24.00
	posed on patients covered by Medicaid or other		ond a rength	or stay rimit		24.00
	fline 24 is "yes," charges for patient days be		rogram's lend	th of stav limit	0	25.00
	otal bad debt expense for the entire hospital co			, ,	0	26.00
	edicare bad debts for the entire hospital comple				168, 540	27.00
	on-Medicare and non-reimbursable Medicare bad de				-168, 540	28.00
	ost of non-Medicare and non-reimbursable Medicar		ne 1 times lir	ne 28)	-52, 257	
20 00 00	est of uncomponented care (line 22 column 2 plus	lino 20)			52 257	20 00

 30.00
 Cost of uncompensated care (line 23 column 3 plus line 29)
 -52, 257
 30.00

 31.00
 Total unreimbursed and uncompensated care cost (line 19 plus line 30)
 12, 455, 762
 31.00

RECLAS	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		PITAL Provider C		eriod:	u of Form CMS-2 Worksheet A	2332-10
				T	rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		12, 478, 819	12, 478, 819	-6, 908, 799	5, 570, 020	1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT		12, 478, 819			6, 701, 791	2.00
3.00	00300 OTHER CAP REL COSTS	(00.000)	0	0	0	0	3.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	682, 308 934, 257	21, 535, 403 1, 068, 036		576, 237 0	22, 793, 948 2, 002, 293	
5.02	00590 OTHER ADMIN & GENERAL	11, 067, 079	32, 641, 717			44, 039, 887	5.02
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 757, 969	0 2, 241, 842	0 2, 999, 811	0	0 2, 999, 811	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	39, 199	593, 367	632, 566	0	632, 566	
9.00	00900 HOUSEKEEPI NG	965, 186	516, 438			1, 481, 592	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	779, 957	798, 294 0	1, 578, 251 0	-1, 087, 936 1, 087, 936	490, 315 1, 087, 936	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00		1, 628, 591	451, 537	2, 080, 128		2, 079, 180	
14.00 15.00	01500 PHARMACY	231, 212 1, 777, 921	381, 501 8, 711, 183	612, 713 10, 489, 104		612, 507 2, 020, 582	
16.00		1, 491, 807	2, 237, 614	3, 729, 421	-43	3, 729, 378	
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	797, 545	20, 247	817, 792	-277	817, 515 0	17.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00		0	0	0	0	0	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0	0	0	0 245, 472	0 245, 472	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			-			20.00
30.00 31.00		6, 885, 110 1, 752, 257	2, 074, 001 710, 980	8, 959, 111	1, 288, 363		30.00
32.00	03200 CORONARY CARE UNIT	1, 752, 257	/10, 980 0	2, 463, 237 0	-116, 191 0	2, 347, 046 0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	0	0	0	34.00 40.00
40.00	04000 SUBPROVIDER - IRF	0	0	0	0	0	40.00
42.00		0	0	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	2, 902, 934	1, 251, 671	4, 154, 605	-3, 533, 451	621, 154 0	43.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00		4, 749, 344	11, 720, 787	16, 470, 131	-7, 082, 022	9, 388, 109	50.00
51.00		553, 319	135, 815				
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	1, 928, 425 0		52.00 53.00
53.01	05301 PALN MANAGEMENT	696, 063	951, 518		-67	1, 647, 514	53.01
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	14, 603, 941 368, 756	27, 042, 854 39, 670			24, 172, 956 407, 763	
56.00	05600 RADI OLOGI - MERAPLOTI C	0	39, 070 0	408, 420	-003	407,703	56.00
56.01	05601 CARDI AC CATH LAB	965, 126	3, 555, 016	4, 520, 142	-2, 990, 541	1, 529, 601	56.01
57.00 58.00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	2, 814, 337	4, 150, 073	6, 964, 410	-1, 422, 665	5, 541, 745	60.00
60.01 61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
64.00 65.00	06500 RESPIRATORY THERAPY	1, 168, 676	0 231, 252	0 1, 399, 928	-24, 634	1, 375, 294	
66.00	06600 PHYSI CAL THERAPY	1, 870, 418	401, 099	2, 271, 517	-8, 147	2, 263, 370	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	604, 169 375, 888	13, 067 15, 162	617, 236 391, 050		614, 057 390, 049	67.00 68.00
69. 00		0	90, 152	90, 152	-381	89, 771	•
70.00		0	0	0	0	0	70.00
71.00 72.00			0	0	7, 597, 988 5, 723, 399	7, 597, 988 5, 723, 399	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	24, 909, 575	24, 909, 575	
74.00		0	0	0	0	0	
75.00	07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 241, 057	0 124, 177	0 365, 234	0 -1, 947	0 363, 287	89.00 90.00
90.00				105 /34			

Health Financial Systems	GOSHEN HOS	PI TAL		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CC		Period:	Worksheet A	
				rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared [.]
					5/25/2017 2:4	
Cost Center Description	Sal ari es	Other		Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
90. 03 09003 MOBILE CLINIC	0	0	(0.00	90.03
91. 00 09100 EMERGENCY	2, 733, 274	903, 353	3, 636, 627	-106, 753	3, 529, 874	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,		-, , -		-, - ,	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	(0 0	0	99.00
101.0010100 HOME HEALTH AGENCY	1, 941, 933	255, 779	2, 197, 712	-5, 266	2, 192, 446	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		1, 187, 449	1, 187, 449	-1, 187, 449		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0)	0		115.00
116.00 11600 HOSPI CE	856, 427	806, 492				
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	67, 237, 202	141, 363, 146	208, 600, 348	-804, 451	207, 795, 897	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 321, 461	716, 271	2,037,732	-30, 341	2,007,391	100 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	208, 123	8, 395	2,037,732		2,007,391	
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	200, 120	0, 373	210, 310			190.02
190. 03 19003 LI FELI NE	0	0	(0		190.03
190. 04 19004 COMMUNITY RELATIONS	501, 615	4, 505, 261	5,006,876	834, 792		
190. 05 19005 PRI VATE DUTY	0	0	(0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	12, 771	1, 519, 163	1, 531, 934	0	1, 531, 934	190.06
190. 07 19007 FOUNDTI ON	0	35	35	0	35	190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	(0 0		190.08
191. 00 19100 RESEARCH	570, 182	280, 742	850, 924	0	850, 924	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0		192.00
193.00 19300 NONPAI D WORKERS	0	0	(0		193.00
200.00 TOTAL (SUM OF LINES 118-199)	69, 851, 354	148, 393, 013	218, 244, 367	' O	218, 244, 367	200.00

	TION AND ADJUSTMENTS OF TRIAL BALANCE	-	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pro	epare
	Cost Center Description	Adjustments	Net Expenses			5/25/2017 2:	47 pm
		(See A-8)	For				
		(Allocation				
GENERA	L SERVICE COST CENTERS	6.00	7.00	<u> </u>			
	CAP REL COSTS-BLDG & FIXT	-1, 239, 544	4, 330, 476				1.
1 1	CAP REL COSTS-MVBLE EQUIP	-1, 236, 008		1			2.
	OTHER CAP REL COSTS	0		1			3.
	EMPLOYEE BENEFITS DEPARTMENT	0		1			4.
	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMIN & GENERAL	0 -13, 496, 614		1			5.
	MAINTENANCE & REPAIRS	-13, 490, 014	0 30, 543, 273	1			6
	OPERATION OF PLANT	-136		1			7
	LAUNDRY & LINEN SERVICE	0	632, 566				8
	HOUSEKEEPI NG	0					9
	DIETARY	0					10
	CAFETERIA MAINTENANCE OF PERSONNEL	-609, 960 0					11
	NURSING ADMINISTRATION	0					13
	CENTRAL SERVICES & SUPPLY	0		1			14
. 00 01500	PHARMACY	0	2, 020, 582				15
	MEDICAL RECORDS & LIBRARY	-53, 221	3, 676, 157	1			16
	SOCIAL SERVICE	0	817, 515	1			17
	NONPHYSI CI AN ANESTHETI STS NURSI NG SCHOOL	0		1			19
	I &R SERVICES-SALARY & FRINGES APPRV						20
	I&R SERVICES-OTHER PRGM COSTS APPRV	0		1			22
	PARAMED ED PRGM	-71, 250	174, 222				23
	ENT ROUTINE SERVICE COST CENTERS	1	1				
1 1	ADULTS & PEDIATRICS	0		1			30
1 1	INTENSIVE CARE UNIT	0		1			31
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			1			32
	SURGI CAL I NTENSI VE CARE UNI T	0					34
	SUBPROVIDER - IPF	0	0	1			40
	SUBPROVI DER – I RF	0	0	1			41
	SUBPROVI DER	0	0	1			42
	NURSERY SKILLED NURSING FACILITY	0	621, 154 0				43
	NURSING FACILITY	0					44
	OTHER LONG TERM CARE	0					46
	ARY SERVICE COST CENTERS						
	OPERATING ROOM	-4	9, 388, 105				50
1 1	RECOVERY ROOM	0		1			51
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0		1			52 53
	PALN MANAGEMENT	-1, 282, 531	364, 983				53
	RADI OLOGY-DI AGNOSTI C	-8,041,410					54
00 05500	RADI OLOGY-THERAPEUTI C	0	407, 763				55
	RADI OI SOTOPE	0	0				56
	CARDIAC CATH LAB	0	1, 529, 601				56
00 05700		0					57
	CARDI AC CATHETERI ZATI ON	0					59
	LABORATORY	-984, 801	4, 556, 944				60
01 06001	BLOOD LABORATORY	0	0				60
1 1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61
	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62
	BLOOD STORI NG, PROCESSI NG & TRANS. I NTRAVENOUS THERAPY						63 64
	RESPIRATORY THERAPY	-9, 182	1, 366, 112				64
	PHYSICAL THERAPY	-7, 102	2, 263, 370				66
	OCCUPATIONAL THERAPY	0	614, 057				67
	SPEECH PATHOLOGY	0	390, 049				68
	ELECTROCARDI OLOGY	0	89, 771				69
	ELECTROENCEPHALOGRAPHY	0					70
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS		7, 597, 988 5, 723, 399				71
	DRUGS CHARGED TO PATIENTS	0					73
	RENAL DI ALYSI S	0		1			74
00 07500	ASC (NON-DISTINCT PART)	0	0	1			75
	IENT SERVICE COST CENTERS						4
	RURAL HEALTH CLINIC	0		1			88
00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0 363 287	1			89
	WOUND CLINIC	0		1			90
J2 10/002	MOBILE CLINIC	0		1			90

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lieu	」 of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CC	CN: 15-0026	Period: From 01/01/2016	Worksheet A
				To 12/31/2016	Date/Time Prepared: 5/25/2017 2:47 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
	6.00	7.00			
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-108, 780	3, 421, 094			91.00 92.00
OTHER REIMBURSABLE COST CENTERS					
99.00 09900 CMHC 101.00 10100 HOME HEALTH AGENCY	0	0 2, 192, 446			99.00 101.00
SPECIAL PURPOSE COST CENTERS	T				
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			113.00 114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0			115.00
116. 00 11600 HOSPI CE	0	1, 436, 819			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-27, 133, 441				118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,007,391			190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	216, 518			190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0			190.02
190. 03 19003 LI FELI NE	0	0			190.03
190. 04 19004 COMMUNI TY RELATI ONS	0	5, 841, 668			190.04
190. 05 19005 PRI VATE DUTY	0	0			190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	1, 531, 934			190.06
190. 07 19007 FOUNDTI ON	0	35			190.07
190.08 19008 GOSHEN GACC CLINIC	0	0			190.08
191. 00 19100 RESEARCH	0	850, 924			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
193.00 19300 NONPALD WORKERS	0	0			193.00
200.00 TOTAL (SUM OF LINES 118-199)	-27, 133, 441	191, 110, 926			200.00

	Financial Systems		GOSHEN HOS		CN: 15-0026	In Lie Period:	u of Form CMS Worksheet A-	
						From 01/01/2016 To 12/31/2016		
		Increases					5/25/2017 2:	
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
1.00	A - SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	7, 680, 007				1.00
	PATI ENT		_					
2.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	5, 723, 399				2.00
3.00	FAITENTS	0.00	О	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0 0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9. 00 10. 00		0.00 0.00	0	0 0				9.00 10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00 14.00		0.00 0.00	0	0 0				13.00 14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00 18.00		0.00 0.00	0	0 0				17.00 18.00
19.00		0.00	Ö	0				19.00
20.00		0.00	0	0				20.00
21.00 22.00		0.00 0.00	0	0 0				21.00 22.00
23.00		0.00	Ö	0				23.00
24.00		0.00	0	0				24.00
25.00 26.00		0.00 0.00	0	0 0				25.00 26.00
27.00		0.00	0	0				27.00
28.00 29.00		0.00 0.00	0	0 0				28.00 29.00
29.00	0	0.00	0	13, 403, 406				29.00
1 00	B - PHARMACY	72.00		24 011 250				1 00
1.00 2.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	24, 911, 250 0				1.00
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0	0 0				4.00 5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00 9.00		0.00 0.00	0	0 0				8.00 9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00 13.00		0.00 0.00	0	0 0				12.00 13.00
14.00		0.00	Ö	0				14.00
15.00 16.00		0.00 0.00	0	0				15.00 16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19. 00 20. 00		0.00 0.00	0	0 0				19.00 20.00
20.00	o		<u>_</u>	24,911,250				20100
1.00	C – DI ETARY CAFETERI A	11.00	537, 648	550, 288				1.00
1.00			537, 648	<u>550, 288</u>				1.00
1 00	D - CAPITAL INSURANCE							1.00
1.00 2.00	OTHER ADMIN & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5.02 4.00	0	133, 815 627, 019				1.00
3.00	OTHER ADMIN & GENERAL	5.02	Ö	978, 453				3.00
4.00 5.00	CAP REL COSTS-MVBLE EQUIP OTHER ADMIN & GENERAL	2.00 5.02	0	4, 604 217, 818				4.00 5.00
5.00	0	<u> </u>	0	1, 961, 709				5.00
1 00	E - CAPITAL INTEREST	1 00						1
1.00	CAP_REL_COSTS_BLDG_&_FLXT		0	<u>1, 187, 449</u> 1, 187, 449				1.00
	F - CAPITAL DEPRECIATION							
1.00 2.00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0	6, 697, 187 0				1.00 2.00
	$\overline{\circ} = = = = = +$		- — — <u>ö</u>	6, 697, 187				

Heal th	Financial Systems		GOSHEN HC	SPI TAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider C	CCN: 15-0026	Peri od:	Worksheet A-	6
						From 01/01/2016 To 12/31/2016	Date/Time Pr 5/25/2017 2:	epared: 47 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	G - CIRCLE OF CARE							
1.00	ADULTS & PEDIATRICS	30.00	1, 145, 788	346, 369				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 480, 787	447,638				2.00
	0 — — — — — — —		2, 626, 575	794,007				
	H - COMMUNITY HEALTH							
1.00	COMMUNITY RELATIONS	190. 04	753, 825	327,070				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
	0		753, 825	327,070				
	I – EMT							
1.00	PARAMED ED PRGM	23.00	139, 378	106, 094				1.00
	0		139, 378	106, 094				
500.00	Grand Total: Increases		4, 057, 426	49, 938, 460				500.00

	Financial Systems		GOSHEN HC		CCN: 15-0026		of Form CMS-255 Worksheet A-6
RECLAS	STELCATIONS			Provider (1	rom 01/01/2016	
		-					Date/Time Prepa 5/25/2017 2:47
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
	A - SUPPLIES	4.00		0			
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMIN & GENERAL	4.00 5.02	0	9 83			
3.00	HOUSEKEEPING	9.00	0	32			
1.00	NURSI NG ADMI NI STRATI ON	13.00	0	948			
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	206			
o. 00	PHARMACY	15.00	0	5, 790	0		
. 00	MEDICAL RECORDS & LIBRARY	16.00	0	43			
3. 00	SOCI AL SERVI CE	17.00	0	277	0		
9.00	ADULTS & PEDIATRICS	30.00	0	203, 517			
0.00 1.00	INTENSIVE CARE UNIT NURSERY	31.00 43.00	0	115, 992 112, 819	-		1
2.00	OPERATI NG ROOM	50.00	0	7,079,490	-		1
3.00	RECOVERY ROOM	51.00	0	41, 143	-		1
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	750, 050			1
5.00	RADI OLOGY-THERAPEUTI C	55.00	0	663	0		1
6.00	CARDIAC CATH LAB	56.01	0	2, 988, 719			1
7.00	LABORATORY	60.00	0	1, 422, 506			1
8.00	RESPI RATORY THERAPY	65.00	0	24, 549			1
9.00	PHYSICAL THERAPY	66.00	0	8, 101	0		1
20.00 21.00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0	2, 161 977			2
2.00	ELECTROCARDI OLOGY	69.00	0	381			2
3.00	CLINIC	90.00	0	1, 947	0		2
4.00	WOUND CLINIC	90.02	0	488, 036	-		2
5.00	EMERGENCY	91.00	0	106, 018			2
6.00	HOME HEALTH AGENCY	101.00	0	3, 713	0		2
7.00	HOSPI CE	116.00	0	44, 476	0		2
8.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	129	0		2
	CANTEEN	100.04					
9.00	COMMUNITY_RELATIONS	<u> </u>	<u>0</u>	<u>631</u> 13, 403, 406	<u>0</u>		2
	B - PHARMACY	L		107 1007 100	1	1	
I. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	50, 773	0		
. 00	OTHER ADMIN & GENERAL	5.02	0	1, 711	0		
. 00	PHARMACY	15.00	0	8, 462, 732			
. 00	ADULTS & PEDIATRICS	30.00	0	277	0		
5.00 5.00	INTENSIVE CARE UNIT NURSERY	31.00 43.00	0	199 50			
. 00	OPERATING ROOM	43.00 50.00	0	2, 532			
. 00	PALN MANAGEMENT	53.01	0	67	0		
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 161, 141	0		
0. 00	CARDIAC CATH LAB	56.01	0	1, 822	0		1
1.00	LABORATORY	60.00	0	159	0		1
2.00	RESPI RATORY THERAPY	65.00	0	85			1
3.00	PHYSI CAL THERAPY	66.00	0	46			1
4.00	OCCUPATIONAL THERAPY	67.00	0	1,018			1
5.00	SPEECH PATHOLOGY	68.00	0	24			1
6.00 7.00	WOUND CLINIC EMERGENCY	90. 02 91. 00	0	14, 490 735			1
8.00	HOME HEALTH AGENCY	101.00	0	1, 553			1
9.00	HOSPI CE	116.00	0	181,624			1
0.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	30, 212			2
	CANTEEN						
			0	24, 911, 250			
. 00	C – DI ETARY DI ETARY	10.00	537, 648	550, 288	0		
	0		537, 648	550, 288		-	
	D - CAPITAL INSURANCE						
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	133, 815			
. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	627,019			
. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	978, 453			
. 00 . 00	CAP REL COSTS-BLDG & FIXT	1.00 0.00	0	222, 422	12 0		
			— — — d	1, 961, 709		-	
	E - CAPITAL INTEREST		<u>ଁ</u>	,,,,,	L	1	
. 00	INTEREST EXPENSE	1 <u>13.</u> 00	0	1, 187, 449			
	O F - CAPITAL DEPRECIATION		0	1, 187, 449			
. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	6, 268, 354	9		
2.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	428, 833			

000

54.00

6, 697, 187

428, 833

0

2.00

Health Financial Systems RECLASSIFICATIONS

RADI OLOGY-DI AGNOSTI C

2.00

Heal th	Financial Systems		GOSHEN HO	SPI TAL		In Lieu	u of Form CMS	6-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-0026	Period:	Worksheet A	-6
						From 01/01/2016 To 12/31/2016	Date/Time P 5/25/2017 2	repared: :47 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·.		
	6.00	7.00	8.00	9.00	10.00			
	G - CIRCLE OF CARE							
1.00	NURSERY	43.00	2, 626, 575	794, 007		0		1.00
2.00		0.00	0	0		0		2.00
	0		2, 626, 575	794,007				
	H - COMMUNITY HEALTH							
1.00	OTHER ADMIN & GENERAL	5.02	753, 825	243, 376		0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 675		0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	82, 019		0		3.00
	PATI ENT							
	0		753, 825	327,070				
	I – EMT							
1.00	COMMUNI TY RELATIONS	<u> </u>	<u>139, 3</u> 78	<u>106, 0</u> 94		Q		1.00
	0		139, 378	106, 094				
500.00	Grand Total: Decreases		4,057,426	49, 938, 460				500.00

	Financial Systems	GOSHEN HO	SPI TAL			In Lie	u of Form CMS-2	2552-10
RECON	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Froi To	iod: m 01/01/2016 12/31/2016		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							
1.00	Land	3, 884, 037	143, 430		0	143, 430	0	1.00
2.00	Land Improvements	2, 988, 795			0	0	0	2.00
3.00	Buildings and Fixtures	100, 003, 897	8, 607, 780		0	8, 607, 780	0	3.00
4.00	Building Improvements	113, 748	0		0	0	0	4.00
5.00	Fixed Equipment	13, 704, 628	3, 419, 240		0	3, 419, 240	11, 626	5.00
6.00	Movable Equipment	103, 810, 261	6, 160, 172		0	6, 160, 172	1, 517, 382	
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	224, 505, 366	18, 330, 622		0	18, 330, 622	1, 529, 008	
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	224, 505, 366	18, 330, 622		0	18, 330, 622	1, 529, 008	10.00
		Endi ng	Fully					
		Bal ance	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	4,027,467	0					1.00
2.00	Land Improvements	2, 988, 795	0					2.00
3.00	Buildings and Fixtures	108, 611, 677	0					3.00
4.00	Building Improvements	113, 748	0					4.00
5.00	Fixed Equipment	17, 112, 242	0					5.00
6.00	Movable Equipment	108, 453, 051	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	241, 306, 980	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	241, 306, 980	0					10.00

Heal th	Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0026	Period: From 01/01/2016	Worksheet A-7 Part II	,
					To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	WN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	12, 478, 819	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)	12, 478, 819			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	WN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	12, 478, 819				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	12, 478, 819	1			3.00

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Pre 5/25/2017 2:4	pared:
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		-				
1.00 CAP REL COSTS-BLDG & FIXT	132, 853, 929		132, 853, 929			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	108, 453, 051		108, 453, 051			2.00
3.00 Total (sum of lines 1-2)	241, 306, 980		241, 306, 980			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital -Relat	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	5, 058, 343		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(7, 160, 430		2.00
3.00 Total (sum of lines 1-2)	0	0	(12, 218, 773	0	3.00
		SL	IMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•			
1.00 CAP REL COSTS-BLDG & FIXT	1, 100, 027	-1, 827, 894	(0 0	4, 330, 476	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	-1, 699, 251		0	0 0	5, 465, 783	2.00
3.00 Total (sum of lines 1-2)	-599, 224			0 0	9, 796, 259	3.00
	•	•				

ealth Financial Systems DJUSTMENTS TO EXPENSES		GOSHEN H	Provider CCN: 15-0026	Peri od:	u of Form CMS-2 Worksheet A-8	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	parec
			Expense Classification of To/From Which the Amount is		072072017 2.1	
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	
00 Investment income - CAP REL	B		CAP REL COSTS-BLDG & FIXT	1.00	11	1.
COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-1, 699, 251	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.
COSTS-MVBLE EQUIP (chapter 2) 00 Investment income - other		l c		0.00	0	3.
(chapter 2)	P	E0.000				
00 Trade, quantity, and time discounts (chapter 8)	В		OTHER ADMIN & GENERAL	5.02	0	
00 Refunds and rebates of expenses (chapter 8)	В	-781, 254	OTHER ADMIN & GENERAL	5.02	0	5.
00 Rental of provider space by suppliers (chapter 8)	В	-1, 152, 122	CAP REL COSTS-BLDG & FIXT	1.00	9	6.
00 Tel ephone servi ces (pay		C		0.00	0	7.
stations excluded) (chapter 21)						
00 Television and radio service (chapter 21)		C		0.00	0	8.
00 Parking lot (chapter 21)		0 101 520		0.00	0	
D. 00 Provider-based physician adjustment	A-8-2	-9, 181, 530			0	
00 Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
. 00 Related organization transactions (chapter 10)	A-8-1	16, 716, 668	3		0	12.
.00 Laundry and Linen service		C		0.00	0	
00 Cafeteria-employees and guests 000 Rental of quarters to employee		-609, 960	CAFETERIA	11.00 0.00	0	
and others b. 00 Sale of medical and surgical				0.00	0	
supplies to other than				0.00	0	10.
patients 7.00 Sale of drugs to other than		C)	0.00	0	17.
patients 3.00 Sale of medical records and	В	-53 221	MEDICAL RECORDS & LIBRARY	16.00	0	18.
abstracts	U					
0.00 Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.
0.00 Vending machines 1.00 Income from imposition of	В	-306_186	OTHER ADMIN & GENERAL	0.00 5.02	0	
interest, finance or penalty				0.02	0	
charges (chapter 21) 2.00 Interest expense on Medicare		C		0.00	0	22.
overpayments and borrowings to repay Medicare overpayments						
3.00 Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
therapy costs in excess of limitation (chapter 14)						
Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
Limitation (chapter 14) 5.00 Utilization review -		C	UTILIZATION REVIEW-SNF	114.00		25.
physicians' compensation			OTTELZATION REVIEW-SNI	114.00		25.
(chapter 21) 0.00 Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
COSTS-BLDG & FIXT 2.00 Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
COSTS-MVBLE EQUIP					0	
8.00 Non-physician Anesthetist 9.00 Physicians' assistant			NONPHYSICIAN ANESTHETISTS	19.00 0.00	0	28. 29.
0.00 Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.
therapy costs in excess of limitation (chapter 14)						
D. 99 Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30.
1.00 Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.
limitation (chapter 14)						

Health Financial Systems		GOSHEN H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES		1	Provider CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Date/Time Pre 5/25/2017 2:4	pared:
			Expense Classification of To/From Which the Amount i			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33.00
33. 01 EMT CLASS TUITION	В	-71, 250	PARAMED ED PRGM	23.00	0	33.01
33. 02 MISC RADIOLOGY REV	В	-1, 650, 618	RADI OLOGY-DI AGNOSTI C	54.00	0	33.02
33.03 MISC A&G REVENUE	В	-202, 794	OTHER ADMIN & GENERAL	5.02	0	33.03
33.04 PERSONAL AUTO USAGE	A	-36, 581	OTHER ADMIN & GENERAL	5.02	0	33.04
33.05 ALCOHOLIC BEVERAGE	A	-622	OTHER ADMIN & GENERAL	5.02	0	33.05
33.06 LOBBYING EXPENSE	A	-78, 936	OTHER ADMIN & GENERAL	5.02	0	33.06
33.07 SHARED A&G EXPENSE	A	-1, 406, 344	OTHER ADMIN & GENERAL	5.02	0	33.07
33.08 PRI MECARE ASSESSMENT (PHYSI CI ANS)	A	-19, 352, 372	OTHER ADMIN & GENERAL	5.02	0	33.08
33. 09 PHYSI CLANS RECRUIMENT	A	5,000	OTHER ADMIN & GENERAL	5.02	0	33.09
33.10 MISC LAB REV	В	-801	LABORATORY	60.00	0	33.10
33.12 HAF OFFSET	A	-5, 130, 379	OTHER ADMIN & GENERAL	5.02	0	33.12
33.13 MISC OPERATING ROOM REVENUE	В	-4	OPERATING ROOM	50.00	0	33.13
33.14 MISC PLANT OPERATIONS REVENUE	В	-136	OPERATION OF PLANT	7.00	0	33.14
33. 15 MI SC RESPI RATORY THERAPY REVENUE	В	-9, 182	RESPI RATORY THERAPY	65.00	0	33. 15
50.00 TOTAL (sum of lines 1 thru 49 (Transfer to Worksheet A, column 6, line 200.)		-27, 133, 441				50.00

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

Heal th	ealth Financial Systems GOSHEN HOSPITAL In Lieu of Form (eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0026	Period: From 01/01/2016	Worksheet A-8	3-1
OFFI CE				To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1, 994, 144	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	463, 243	0	2.00
3.00	5.02	OTHER ADMIN & GENERAL	HOME OFFICE ALLOCATION	14, 259, 281	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			16, 716, 668	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which not been nosted to Worksheet A columns 1 and/or 2 the amount allowable should be indicated in column A thic nor

nas not	been posted to worksheet A,	corumns r and/or 2,	the amount a	riowable sn	nould be indicated in co	brumn 4 of this part	
					Related Organization(s)	and/or Home Office	
				_			
	Symbol (1)	Name	Perc	centage of	Name	Percentage of	
			Ov	wnershi p		Ownershi p	
	1.00	2.00		3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

6.00 B	0.00 I U HEALTH	0.00 6.0					
7.00	0.00	0.00 7.0					
8.00	0.00	0.00 8.0					
9.00	0.00	0.00 9.0					
10.00	0.00	0.00 10.0					
100.00 G. Other (financial or		100.0					
non-financial) specify:							

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

С Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems	GOSHEN HOSP	I TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-0026	Period: From 01/01/2016	Worksheet A-8-1
UFFICE CUSIS				Date/Time Prepared:

								10	12/ 51/ 20			
										5/23	5/2017 2:	47 pm
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6.00	7.00										
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT	OF TRANS	ACTI ONS	WITH RELATED	ORGA	NI ZATI ONS	OR CLAI	MED HOME	
	OFFICE COSTS:											
1.00	1, 994, 144	11										1.00
2.00	463, 243	9										2.00
3.00	14, 259, 281	0										3.00
4.00	0	0										4.00
5.00	16, 716, 668											5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nac	100	been posted to worksheet A,	cordinate and of 2, the amount arrowable should be that cated the cordinate of this part.	
		Related Organization(s)		
		and/or Home Office		
		Type of Business		
		51		
		6.00		
		B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming

rei mou	rsement under title XVIII.	
	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th	Financial Syste	ems	GOSHEN H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 01/01/2016 To 12/31/2016		narod.
						10 12/31/2010	5/25/2017 2:4	17 pm
	Wkst. A Line #	Cost Center/Physician	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	5. 02	OTHER ADMIN & GENERAL	592, 362	16, 669	575, 693			1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	113, 078	0	113, 078	179,000	1, 594	2.00
3.00		PAIN MANAGEMENT	1, 309, 553					3.00
4.00		RADI OLOGY-DI AGNOSTI C	6, 762, 040		720, 607			4.00
5.00		LABORATORY	1, 009, 000		25,000			5.00
6.00		EMERGENCY	126, 250	0	126, 250	179, 000		6.00
7.00	0. 00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			9, 912, 283		1, 596, 628			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OTHER ADMIN & GENERAL	176, 935		C	-		1.00
2.00		MEDICAL RECORDS & LIBRARY	137, 176		C			2.00
3.00		PAIN MANAGEMENT	27, 022		C	-	-	3.00
4.00		RADI OLOGY-DI AGNOSTI C	371, 248		C	-	-	4.00
5.00		LABORATORY	117, 159		C	0	0	5.00
6.00		EMERGENCY	17, 470		C	0	-	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	U U	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			847,010		C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	10.00		
1 00	1.00 E.02	2.00 OTHER ADMIN & GENERAL	15.00	16.00 176,935	17.00 398,758	18.00 415,427		1.00
1.00 2.00		MEDICAL RECORDS & LIBRARY			398, 758	415, 427		1.00 2.00
2.00		PAIN MANAGEMENT			8, 978			2.00
3.00 4.00		RADI OLOGY-DI AGNOSTI C		,				3.00 4.00
4.00 5.00		LABORATORY			349, 359	6, 390, 792 984, 000		4.00 5.00
5.00 6.00		EMERGENCY		,	108, 780			5.00 6.00
8.00 7.00	0.00			,	100, 780			8.00 7.00
7.00 8.00	0.00			-		0		7.00 8.00
8.00 9.00	0.00			°		0		8.00 9.00
9.00 10.00	0.00			-				9.00 10.00
200.00	0.00				865, 875	, s		200.00
200.00	I		1 0	047,010	000, 070	⁷ , 101, 330	I	200.00

	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	GOSHEN HO	Provider C	F	rom 01/01/2016 o 12/31/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/25/2017 2:4	pared:
			CAPI TAL REL	ATED COSTS		072072017 2.4	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	CASHI ERI NG/AC COUNTS RECEI VABLE	
	1	0	1.00	2.00	4.00	5. 01	
1.00 2.00 4.00 5.01 5.02 6.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS	4, 330, 476 5, 465, 783 22, 793, 948 2, 002, 293 30, 543, 273 0	51, 959 74, 680 357, 367 0	5, 465, 783 1, 333 5, 871 1, 751, 113 0	22, 847, 240 308, 594 3, 406, 571 0	2, 391, 438 0 0	1.00 2.00 4.00 5.01 5.02 6.00
7.00 8.00 9.00 10.00 11.00 12.00 13.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	2, 999, 675 632, 566 1, 481, 592 490, 315 477, 976 0 2, 079, 180	346, 787 21, 194 5, 497 28, 493 59, 739 0 17, 396	1, 299 3, 282 4, 213 8, 834 0	12, 948 318, 811 80, 037 177, 591 0	0 0 0 0 0 0 0 0 0	7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00 23.00		612, 507 2, 020, 582 3, 676, 157 817, 515 0 0 0 0 174, 222	29, 548 24, 373 51, 236 7, 401 0 0 0 0 0 2, 582	73, 466 7, 778	76, 372 587, 265 492, 759 263, 437 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	14.00 15.00 16.00 17.00 20.00 21.00 22.00 23.00
30.00 31.00 32.00 33.00 34.00 40.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	10, 247, 474 2, 347, 046 0 0 0 0 0	428, 318 114, 291 0 0 0 0 0	125, 350 0 0 0 0 0	578, 788	224, 820 54, 363 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00
41.00 42.00 43.00 44.00 45.00 46.00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE	0 0 621, 154 0 0 0	0 0 14, 837 0 0 0	0 0 9, 786 0 0 0	91, 284 0 0	0 0 9, 486 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	9, 388, 105	527, 795	1, 232, 408	1, 568, 756	263, 465	50.00
51.00 52.00 53.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	647, 991 1, 928, 425 0	36, 376 79, 511 0		182, 767 489, 119	22, 469 34, 216 0	51.00
53.01 54.00 55.00 56.00	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	364, 983 16, 131, 546 407, 763 0	0 864, 770 9, 800 0		4, 823, 837 121, 804	5, 121 437, 226 5, 680 0	53.01 54.00
56.01 57.00 58.00 59.00	05601 CARDIAC CATH LAB 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION	1, 529, 601 0 0 0	31, 533 0 0 0	0 0 0	0 0 0	89, 687 0 0 0	56.01 57.00 58.00 59.00
60.00 60.01 61.00 62.00 63.00 64.00	06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	4, 556, 944 0 0 0 0 0 0 0	71, 409 0 0 0 0 0	85, 737 0 0 0 0 0 0	929, 604 0 0 0 0 0	164, 366 0 0 0 0	60.00 60.01 61.00 62.00 63.00 64.00
65.00 66.00 67.00 68.00 69.00 70.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 366, 112 2, 263, 370 614, 057 390, 049 89, 771 0	25, 371 207, 125 0 84, 961 0	21, 110 274 0 17, 320 0	617, 818 199, 563 124, 160 0 0	31, 519 26, 583 11, 705 6, 599 19, 327 0	65.00 66.00 67.00 68.00 69.00 70.00
71.00 72.00 73.00 74.00 75.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	7, 597, 988 5, 723, 399 24, 909, 575 0 0	0 0 0 0	0 0 0 0	0 0 0	36, 267 65, 849 715, 140 0 0	73.00 74.00
88. 00 89. 00	OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	000				0	88.00 89.00

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016		pared: 7 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	CASHI ERI NG/AC COUNTS RECEI VABLE	
	0	1.00	2.00	4.00	5. 01	
90. 00 09000 CLINIC	363, 287	22, 721	16, 37			90.00
90. 02 09002 WOUND CLINIC	1, 525, 397	224, 613	4, 61			
90. 03 09003 MOBILE CLINIC	0	0		0 0	0	90.03
91. 00 09100 EMERGENCY	3, 421, 094	234, 527	91, 97	5 902, 828	116, 207	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS				T	-	
99.00 09900 CMHC	0	0		0 0	0	99.00
101.0010100 HOME HEALTH AGENCY	2, 192, 446	58, 810	22, 47	641, 440	7,470	101.00
SPECIAL PURPOSE COST CENTERS	1			-	-	
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	1, 436, 819	0		0 282, 886		
118.00 SUBTOTALS (SUM OF LINES 1-117)	180, 662, 456	4, 115, 020	5, 411, 90	1 21, 780, 802	2, 391, 438	118.00
NONREI MBURSABLE COST CENTERS				-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 007, 391	128, 716	39, 92			190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	216, 518	52, 900		0 68, 745		190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190. 02
190. 03 19003 LI FELI NE	0	0		0 0		190. 03
190. 04 19004 COMMUNI TY RELATI ONS	5, 841, 668	33, 840	13, 95	368, 646		190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	1, 531, 934	0		0 4, 218		190.06
190. 07 19007 FOUNDTI ON	35	0		0 0		190.07
190.08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
191. 00 19100 RESEARCH	850, 924	0		0 188, 337		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	191, 110, 926	4, 330, 476	5, 465, 78	22, 847, 240	2, 391, 438	202.00

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	GOSHEN H	Provider CC	N: 15-0026	Period: From 01/01/2016	Worksheet B	2002-10
					To 12/31/2016	Part I Date/Time Pre 5/25/2017 2:4	epared:
	Cost Center Description	Subtotal		MAI NTENANCE REPAI RS	& OPERATION OF	LAUNDRY &	/ pm
		5A. 01	GENERAL 5.02	6. 00	PLANT 7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS						1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5.02	00590 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS	36, 058, 324	36, 058, 324		0		5.02
6.00 7.00	00700 OPERATION OF PLANT	3, 654, 122	849, 784		0 0 4, 503, 906		6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	668, 007			0 27, 276		8.00
9.00	00900 HOUSEKEEPI NG	1, 809, 182			0 7,074		
10.00	01000 DI ETARY	603, 058			0 36, 668		
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	724, 140			0 76,881 0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 932, 321	-		0 22, 388		1
14.00	01400 CENTRAL SERVICES & SUPPLY	791, 893			0 38, 027	0	
15.00	01500 PHARMACY	2, 639, 998			0 31, 367	0	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 259, 439 1, 090, 505			0 65,938 0 9,525		
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	200,002		0 0	0	1
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00 23.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0 222, 842	0 51, 823		0 0 0 3, 323	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	222, 042	51, 623		0 3, 323	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	13, 695, 351	3, 184, 922		0 551, 222	185, 915	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 219, 838	748, 789		0 147, 087	69, 465	
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	
40.00	04000 SUBPROVIDER - IPF	0	0		0 0	0	
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	1
42.00	04200 SUBPROVI DER	0	0		0 0	0	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	746, 547	173, 613 0		0 19,095	5, 539 0	1
44.00 45.00	04400 SKILLED NORSING FACILITY	0	0		0 0	0	1
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCI LLARY SERVICE COST CENTERS	T					
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	12, 980, 529 890, 116			0 679, 244 0 46, 814		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 583, 709			0 102, 326		1
53.00	05300 ANESTHESI OLOGY	0			0 0	0	1
53.01	05301 PAIN MANAGEMENT	600, 021	139, 538		0 0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	23, 322, 446 592, 394			0 1, 112, 914 0 12, 612	163, 147 0	54.00 55.00
56.00	05600 RADI OLOGI - THERAPEOTIC	592, 394	137,704		0 12,012	0	
56.01	05601 CARDI AC CATH LAB	2, 173, 757	505, 518		0 40, 582	5, 111	56.01
57.00	05700 CT SCAN	0	0		0 0	0	
58.00		0	0		0 0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	5, 808, 060	1, 350, 693		0 91,900	0	
60.01	06001 BLOOD LABORATORY	0,000,000	0		0 0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0 0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	1, 828, 215	425, 161		0 32,652		65.00
66.00	06600 PHYSI CAL THERAPY	3, 136, 006			0 266, 558		66.00
67.00	06700 OCCUPATI ONAL THERAPY	825, 599			0 0	0	
68.00		520, 808			0 0	0	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	211, 379	49, 157 0		0 109, 341	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 634, 255	1, 775, 384		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 789, 248	1, 346, 319		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	25, 624, 715			0 0	0	
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	<u> </u>		0 0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00		487, 478			0 29, 240		90.00
90. 02 90. 03	09002 WOUND CLINIC 09003 MOBILE CLINIC	1, 777, 617	413, 394		0 289,064	0	90.02
	09100 EMERGENCY	4, 766, 631	1, 108, 504		0 301, 824	-	90.03
91.00							

Heal th Finar	ncial Systems	GOSHEN HO	OSPI TAL		-	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider C		Fr To			
	Cost Center Description	Subtotal	OTHER ADMIN & GENERAL	MAI NTENANCE REPAI RS	&	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A. 01	5. 02	6, 00		7.00	8.00	
OTHER	REIMBURSABLE COST CENTERS							
99.00 09900	СМНС	0	0		0	0	0	99.00
101.0010100	HOME HEALTH AGENCY	2, 922, 645	679, 676		0	75, 685	0	101.00
	AL PURPOSE COST CENTERS	1		1				
	INTEREST EXPENSE							113.00
	UTILIZATION REVIEW-SNF							114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0		115.00
116.0011600		1, 735, 485			0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	179, 326, 680	33, 317, 840		0	4, 226, 627	850, 631	118.00
	I MBURSABLE COST CENTERS	2 (12 522	(07.555	1	0	1/5 /50	0	190.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN OTHER NR/CHP-GRANT I/COMMUNITY ED	2, 612, 523			0	165, 650		190.00
		338, 163	78, 641		0	68, 079		190.01
190. 02 19002	GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0	0		190.02
	COMMUNITY RELATIONS	6, 258, 112	1, 455, 355		0	43, 550		190.03
	PRI VATE DUTY	0, 250, 112	1,400,000		0	43, 550		190.04
	PROFESSIONAL DEVELOPMENT	1, 536, 152	357, 240		0	0		190.05
190.07 19007		35	8		0	0		190.07
	GOSHEN GACC CLINIC	0	0		0	0		190.08
191.0019100		1, 039, 261	241, 685		0	0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	0		0	0		192.00
193.0019300	NONPAI D WORKERS	0	0		0	0	0	193.00
200.00	Cross Foot Adjustments	0						200.00
201.00	Negative Cost Centers	0	0		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	191, 110, 926	36, 058, 324		0	4, 503, 906	850, 631	202.00

Heal th	Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2016	Worksheet B Part I	
					0 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared: 7 pm
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	
					OF PERSONNEL	ADMI NI STRATI O N	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN & GENERAL						5.01 5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0.00/.000					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 236, 990 18, 352	798, 322				9.00 10.00
11.00	01100 CAFETERI A	38, 479	0	1, 007, 902			11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	11, 205 19, 032	0	18, 793 8, 339		3, 666, 633 58	
15.00	01500 PHARMACY	15, 699	0	20, 191		42, 420	
16.00	01600 MEDI CAL RECORDS & LI BRARY	33, 002	0	30, 689		16, 525	
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	4, 767	0	16, 622 0	0	82, 864 0	17.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 663	0	0	0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	275, 884	683, 439	185, 162		1, 115, 447	30.00
31.00	03100 I NTENSI VE CARE UNI T	73, 616	114, 883	41, 857		273, 728	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00 42.00
43.00	04300 NURSERY	9, 557	0	5, 453	-	39, 792	
44.00	04400 SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0		0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS		0	0	0	0	40.00
50.00	05000 OPERATING ROOM	339, 958	0	108, 013		575, 899	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	23, 430 51, 214	0	2, 337 29, 217		98, 575 213, 202	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
53.01	05301 PALN MANAGEMENT	0	0	6, 210		14, 487	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	557, 009 6, 312	0	201, 710 7, 310		278, 725 10, 929	
56.00	05600 RADI OLOGI - MERALEONI C	0, 312	0	0	0	0	56.00
56.01	05601 CARDI AC CATH LAB	20, 311	0	7, 005	0	143, 417	56.01
57.00 58.00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	45, 995	0	49, 119	0	5, 822	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	16, 342 133, 411	0	21, 984 42, 555		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	10, 467		0	67.00
68.00		0	0	6, 245	0	0	68.00
69.00 70.00		54, 724	0	0	0	0	69.00 70.00
71.00		0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73.00 74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				1		
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90.00	09000 CLINIC	14, 635	0	4, 752	0	0	90.00
90.02	09002 WOUND CLINIC	144, 675	0	0	0	0	90.02
90.03 91.00	09003 MOBILE CLINIC 09100 EMERGENCY	0 151, 061	0	0 56, 266	0	0 346, 966	90.03 91.00
71.00		1 131,001	U U	50,200	0	J J J J J J J J J J J J J J J J J J J	1 / 1. 00

Health Financial Systems	GOSHEN HOS	SPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	
	9.00	10.00	11.00	12.00	13.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0		0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	37, 880	0	29, 26	68 0	161, 235	101.00
SPECIAL PURPOSE COST CENTERS				- : -		1
113.0011300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116.00 11600 HOSPI CE	0	0	21, 21	17 0	121, 348	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 098, 213	798, 322	930, 78	31 0	3, 541, 439	118.00
NONREI MBURSABLE COST CENTERS	· · · · ·				·	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	82, 907	0	30, 25	59 0	78, 923	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	34, 073	0	3, 08	33 0	0	190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0	0	190.02
190. 03 19003 LI FELI NE	0	0		0 0	0	190.03
190. 04 19004 COMMUNI TY RELATI ONS	21, 797	0	28, 60	04 0	68	190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0	0	190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0		0 0	0	190.06
190. 07 19007 FOUNDTI ON	0	0		0 0	0	190.07
190.08 19008 GOSHEN GACC CLINIC	0	0		0 0	0	190.08
191. 00 19100 RESEARCH	0	0	15, 17	75 0	46, 203	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	О	О		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	2, 236, 990	798, 322	1,007,90	02 0	3, 666, 633	202.00

Heal th	Financial Systems	GOSHEN HOS	SPI TAL		In Lieu	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	1	Period: From 01/01/2016		
					To 12/31/2016	5/25/2017 2:4	pared: 7 pm
	Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	
		SUPPLY 14.00	15.00	LI BRARY 16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	18.00	17.00	19.00	
1.00 2.00 4.00 5.01 5.02	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL						1.00 2.00 4.00 5.01 5.02
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 CAFETERI A	1, 041, 508	2.245.004				6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
15.00 16.00 17.00 20.00 21.00 22.00 23.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	1,476 10 34 0 0 0 0 0	3, 365, 096 0 0 0 0 0 0 0 0		7 5 1,457,919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	15.00 16.00 17.00 19.00 20.00 21.00 22.00 23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	32, 689	0	507, 25	8 1, 128, 043	0	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	8, 824 0	0	122, 65	9 123, 082 0 0	0 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0			0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0			0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0	21, 40	0 0 3 4,559	0	42.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		3 4, 559 0 0	0	43.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	46.00
50.00	05000 OPERATING ROOM	126, 323	0	594, 45		0	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	811 9, 767	0	50, 69 77, 20		0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	,,,20	0	0	53.00
53.01	05301 PALN MANAGEMENT	66	0	11, 55		0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	62, 725 803	0	986, 50 12, 81		0	54.00 55.00
56.00	05600 RADI OI SOTOPE	0	0		o c	0	56.00
56. 01 57. 00	05601 CARDI AC CATH LAB 05700 CT SCAN	5, 843	0	202, 36		0	56.01 57.00
58.00	05800 MRI	0	0			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		o c	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	46, 569	0	370, 85		0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	5, 930	0	71, 11	5 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	345	0	59, 97		0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	99 47	0	26, 40 [,] 14, 88 [,]		0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	260	0	43, 60		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	393, 089 292, 946	0	81, 82 148, 57		0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS	0	3, 365, 096	1, 613, 94		0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
/5.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90. 00 90. 02	09000 CLINIC 09002 WOUND CLINIC	483 5, 818	0	12, 35 51, 03		0	90.00 90.02
90.03	09003 MOBILE CLINIC	0	Ō		o c	0	90.03
91.00	09100 EMERGENCY	19, 684	0	262, 19	6 176, 956	0	91.00

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	
	SUPPLY		LI BRARY			
	14.00	15.00	16.00	17.00	19.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0		0 0	0	
101.00 10100 HOME HEALTH AGENCY	1, 294	0	16, 85	55 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	25, 030	0	35,60			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 040, 965	3, 365, 096	5, 396, 15	57 1, 457, 919	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	299	0		0 0		190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	5	0		0 0	0	190.01
190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0	0	190.02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNI TY RELATI ONS	221	0		0 0		190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0	0	190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0		0 0		190.06
190. 07 19007 FOUNDTI ON	0	0		0 0		190.07
190.08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
191. 00 19100 RESEARCH	18	0		0 0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	1, 041, 508	3, 365, 096	5, 396, 15	57 1, 457, 919	0	202.00

	Financial Systems	GOSHEN H		01 15 000/		u of Form CMS-2	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C	1	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	epared:
			I NTERNS &	RESI DENTS		5/25/2017 2:4	7 pm
	Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALA RY & FRI NGES	R PRGM COSTS	PARAMED ED PRGM	Subtotal	
		20.00	APPRV 21.00	APPRV 22.00	23.00	24.00	
	GENERAL SERVICE COST CENTERS	20100	1 2000		20100	2.1.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5.02	00590 OTHER ADMIN & GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00							11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS						17.00 19.00
20.00		0					20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV		c c				21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				C		22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS				279, 651		23.00
30.00		0			0 0	21, 545, 332	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	4, 943, 828	
32.00	03200 CORONARY CARE UNIT	(0 0	0	32.00
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T					0	33.00 34.00
40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					0	40.00
41.00	04100 SUBPROVI DER – I RF	(0 0	0	41.00
42.00	04200 SUBPROVI DER	(0 0		0 0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY					1, 025, 558 0	43.00 44.00
44.00	04500 NURSING FACILITY		-		0 0	0	44.00
46.00	04600 OTHER LONG TERM CARE	(0 0	0	46.00
	ANCI LLARY SERVICE COST CENTERS			1		10 (00 (70	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM					18, 622, 679 1, 319, 782	1
52.00	05200 DELIVERY ROOM & LABOR ROOM				0 0	3, 722, 448	
53.00	05300 ANESTHESI OLOGY	0	o c		o c	0	53.00
53.01	05301 PAIN MANAGEMENT	(0 0	771, 876	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	(32, 108, 935 780, 940	1
56.00	05600 RADI OLOGI - ITILKAP LOTI C				0 0	/80, 940	56.00
56.01	05601 CARDI AC CATH LAB	0	c c		0 0	3, 103, 904	1
57.00	05700 CT SCAN	(0 0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON					0	58.00 59.00
60.00	06000 LABORATORY				0 0	7, 769, 015	
60.01	06001 BLOOD LABORATORY	0			0 C	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.					0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	(0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	c c		0 0	2, 401, 399	1
66.00		(0 0	4, 368, 148	1
67.00	06700 OCCUPATIONAL THERAPY					1, 054, 571	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					663, 106 468, 469	
	07000 ELECTROENCEPHALOGRAPHY					400, 409	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	() c		0 0	9, 884, 556	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	7, 577, 088	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS					36, 562, 984 0	
75.00	07500 ASC (NON-DI STI NCT PART)					0	1
	OUTPATIENT SERVICE COST CENTERS		-				
	08800 RURAL HEALTH CLINIC	(0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					0 662, 305	1
	09002 WOUND CLINIC					2, 681, 602	

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/25/2017 2:4	7 pm
		I NTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SERVI CES-SALA			Subtotal	
	SCHOOL	RY & FRINGES		PRGM		
		APPRV	APPRV	00.00	04.00	
90. 03 09003 MOBILE CLINIC	20.00	21.00	22.00	23.00 0 0	24.00	90.03
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY				0 279,651	7, 661, 940	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			279,051	7, 001, 940	91.00
OTHER REIMBURSABLE COST CENTERS						92.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	0			0 0	-	
SPECIAL PURPOSE COST CENTERS	-	-	1			1
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	2, 342, 279	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0 0		0 279, 651	175, 967, 282	118.00
NONREI MBURSABLE COST CENTERS		1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	3, 578, 116	•
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0		0 0	522, 044	•
190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNITY RELATIONS	0	0		0 0	7, 807, 707	
190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT 190. 07 19007 FOUNDTI ON				0 0	1, 893, 392	190.06
190. 08 19008 GOSHEN GACC CLINIC	0			0 0		190.07
190. 08 19008 GUSHEN GACC CLINIC 191. 00 19100 RESEARCH	0			0 0	1, 342, 342	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0 0		191.00
193. 00 19300 NONPALD WORKERS	0					192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0			0 0		200.00
202.00 TOTAL (sum lines 118-201)	0			0 279,651	191, 110, 926	
	1		•			

	ancial Systems CATION – GENERAL SERVICE COSTS	GOSHEN HOS	Provi der CCN: 15-0026	In Lieu of Form CM Period: Worksheet	
				From 01/01/2016 Part I To 12/31/2016 Date/Time	
	Cost Center Description	Intern &	Total	5/25/2017	2:47 pm
	·	Residents			
		Cost & Post			
		Stepdown Adjustments			
		25.00	26.00		
	ERAL SERVICE COST CENTERS		20100		
	00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP				1.
	00 EMPLOYEE BENEFITS DEPARTMENT				2.
	80 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.
	90 OTHER ADMIN & GENERAL				5.
00 006	00 MAINTENANCE & REPAIRS				6.
	OO OPERATION OF PLANT				7.
	00 LAUNDRY & LINEN SERVICE				8.
	00 HOUSEKEEPI NG 00 DI ETARY				9. 10.
	DO CAFETERIA				11.
	OO MAINTENANCE OF PERSONNEL				12.
	DO NURSING ADMINISTRATION				13.
	00 CENTRAL SERVICES & SUPPLY				14
					15
	00 MEDI CAL RECORDS & LI BRARY 00 SOCI AL SERVI CE				16
	00 NONPHYSI CLAN ANESTHETI STS				19
	DO NURSI NG SCHOOL				20
	00 I&R SERVICES-SALARY & FRINGES APPRV				21
	00 I&R SERVICES-OTHER PRGM COSTS APPRV				22
	00 PARAMED ED PRGM				23
	ATIENT ROUTINE SERVICE COST CENTERS	0	21, 545, 332		30
	DO INTENSIVE CARE UNIT	0	4, 943, 828		31
	DO CORONARY CARE UNIT	0	0		32
00 033	DO BURN INTENSIVE CARE UNIT	0	0		33
	00 SURGICAL INTENSIVE CARE UNIT	0	0		34
	00 SUBPROVIDER - IPF	0	0		40
	00 SUBPROVI DER – I RF 00 SUBPROVI DER	0	0		41
	DO NURSERY	0	1,025,558		43
. 00 044	00 SKILLED NURSING FACILITY	0	0		44
	DO NURSING FACILITY	0	0		45
	00 OTHER LONG TERM CARE	0	0		46
	DO OPERATING ROOM	0	18, 622, 679		50
	DO RECOVERY ROOM	0	1, 319, 782		51
	DO DELIVERY ROOM & LABOR ROOM	0	3, 722, 448		52
	DO ANESTHESI OLOGY	0	0		53
	01 PAI N MANAGEMENT 00 RADI OLOGY-DI AGNOSTI C	0	771,876		53 54
	00 RADI OLOGY-DI AGNOSTI C	0	32, 108, 935 780, 940		55
	00 RADI OI SOTOPE	0	0		56
	01 CARDI AC CATH LAB	0	3, 103, 904		56
	DO CT SCAN	0	0		57
		0	0		58
	DO CARDI AC CATHETERI ZATI ON	0	7 760 015		59
1	00 LABORATORY 01 BLOOD LABORATORY	0	7, 769, 015		60 60
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY		ŏ		61
00 062	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62
-	00 BLOOD STORING, PROCESSING & TRANS.	0	0		63
	00 INTRAVENOUS THERAPY	0	0		64
		0	2,401,399		65 66
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	4, 368, 148 1, 054, 571		67
	00 SPEECH PATHOLOGY	0	663, 106		68
	DO ELECTROCARDI OLOGY	0	468, 469		69
	00 ELECTROENCEPHALOGRAPHY	0	0		70
	00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	9, 884, 556		71
	00 I MPL. DEV. CHARGED TO PATIENTS	0	7, 577, 088		72
	00 DRUGS CHARGED TO PATIENTS 00 RENAL DIALYSIS	0	36, 562, 984 0		73
	00 ASC (NON-DISTINCT PART)	0	0		74
	PATIENT SERVICE COST CENTERS	0	U U		- '5
	DO RURAL HEALTH CLINIC	0	0		88
00 088					
00 089	00 FEDERALLY QUALIFIED HEALTH CENTER 00 CLINIC	0	0 662, 305		89 90

Health Financial Systems	GOSHEN HOS	PI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0026		Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/25/2017 2:4		
Cost Center Description	Intern & Residents	Total					
	Cost & Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
90. 03 09003 MOBILE CLINIC	0	0				90.03	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 661, 940				91.00 92.00	
07100 009200 005 000 000 000 000 000 000 000 000	0					92.00	
99.00 09900 CMHC	0	0				99.00	
101.00 10100 HOME HEALTH AGENCY	0	3, 924, 538				101.00	
SPECIAL PURPOSE COST CENTERS		.,,	1				
113.00 11300 INTEREST EXPENSE						113.00	
114.00 11400 UTILIZATION REVIEW-SNF						114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0				115.00	
116. 00 11600 HOSPI CE	0	2, 342, 279				116.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	175, 967, 282				118.00	
NONREI MBURSABLE COST CENTERS		0 570 444				1.00.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 578, 116				190.00	
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	522, 044 0				190. 01 190. 02	
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 190. 03 19003 LIFELINE	0	0				190.02	
190. 04 19004 COMMUNITY RELATIONS	0	7, 807, 707				190.03	
190. 05 19005 PRI VATE DUTY	0	, 007, 707				190.04	
190.06 19006 PROFESSI ONAL DEVELOPMENT	0	1, 893, 392				190.06	
190. 07 19007 FOUNDTI ON	0	43				190.07	
190.08 19008 GOSHEN GACC CLINIC	0	0				190.08	
191. 00 19100 RESEARCH	0	1, 342, 342				191.00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00	
193. 00 19300 NONPAI D WORKERS	0	0				193.00	
200.00 Cross Foot Adjustments	0	0				200.00	
201.00 Negative Cost Centers	0	0				201.00	
202.00 TOTAL (sum lines 118-201)	0	191, 110, 926	I			202.00	

ALLOCATION OF CAPITAL RELATED COSTS		ncial Systems GOSHEN HOSPITAL OF CAPITAL RELATED COSTS Provider CCN: 15-00.			eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 2:4	2552-10
			CAPI TAL REL	ATED COSTS		572572017 2.4	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	-					_
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	51, 959	1, 333	53, 292	53, 292	
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	74, 680	5, 871	80, 551	719	1
5. 02	00590 OTHER ADMIN & GENERAL	0	357, 367	1, 751, 113	2, 108, 480	7, 941	5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	346, 787 21, 194	57, 295 1, 299	404, 082 22, 493	584 30	7.00
9.00	00900 HOUSEKEEPI NG	0	5, 497	3, 282	8, 779	743	
10.00	01000 DI ETARY	0	28, 493	4, 213	32, 706	187	10.00
11.00	01100 CAFETERI A	0	59, 739	8, 834	68, 573	414	11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL	0	17 204	0 297, 805	215 201	0	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	17, 396 29, 548	73, 466	315, 201 103, 014	1, 254 178	
15.00	01500 PHARMACY	0	24, 373	7, 778	32, 151	1, 369	
	01600 MEDICAL RECORDS & LIBRARY	0	51, 236	39, 287	90, 523	1, 149	
	01700 SOCIAL SERVICE	0	7, 401	2, 152	9, 553	614	
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	1
23.00	02300 PARAMED ED PRGM	0	2, 582	0	2, 582	107	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	428, 318	142, 053	570, 371	6, 184	30.00
	03100 I NTENSI VE CARE UNI T	0	428, 318 114, 291	142, 053	239, 641	1, 349	
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	
43.00	04300 NURSERY	0	14, 837	9, 786	24, 623	213	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
	04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	0	527, 795	1, 232, 408	1, 760, 203	3, 657	50.00
	05100 RECOVERY ROOM	0	36, 376	513	36, 889	426	
	05200 DELIVERY ROOM & LABOR ROOM	0	79, 511	52, 438	131, 949		52.00
53.00 53.01	05300 ANESTHESI OLOGY 05301 PALN MANAGEMENT	0	0	0	0	0 536	
	05400 RADI OLOGY-DI AGNOSTI C	0	864, 770	1, 065, 067	1, 929, 837	11, 278	
	05500 RADI OLOGY-THERAPEUTI C	0	9, 800	47, 347	57, 147	284	
	05600 RADI OI SOTOPE	0	0	0	0	0	
56.01	05601 CARDIAC CATH LAB 05700 CT SCAN	0	31, 533	204, 145	235, 678	743	
57.00 58.00	05800 MRI	0	0	0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	0	71, 409	85, 737	157, 146	2, 167	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	~	_	0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
	06500 RESPIRATORY THERAPY	0	25, 371	19, 188	44, 559	900	1
66.00	06600 PHYSI CAL THERAPY	0	207, 125	21, 110		1, 440	
		0	0	274	274	465	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 84, 961	0 17, 320	0 102, 281	289 0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0,,,01	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
75 00		0	0	0	0	0	1, 3. 00
75.00	OUTPATIENT SERVICE COST CENTERS						
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	1

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 7 pm
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI	LATED COSTS	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
90. 02 09002 WOUND CLINIC 90. 03 09003 MOBILE CLINIC	0	224, 613		2 229, 225 0 0	1	90.02 90.03
91. 00 09100 EMERGENCY	0	234, 527	91, 97	326, 502	2, 105	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REI MBURSABLE COST CENTERS						
99. 00 09900 CMHC 101. 00 10100 HOME HEALTH AGENCY	0			0 0 '9 81, 289	0	99.00 101.00
SPECIAL PURPOSE COST CENTERS	0	30, 010	22, 47	9 01, 209	1, 493	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	659	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	4, 115, 020	5, 411, 90	9, 526, 921	50, 806	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	128, 716				190.00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	52, 900		0 52, 900		190.01
190. 02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190. 02 190. 03
190. 03 19003 LI FELI NE 190. 04 19004 COMMUNI TY RELATI ONS	0	33, 840	13, 95	6 47, 798		190.03
190. 05 19005 PRI VATE DUTY	0	33, 640	15, 95	0 47,790 0 0		190.04
190. 06 19006 PROFESSIONAL DEVELOPMENT	0	0				190.05
190. 07 19007 FOUNDTI ON	0	0		0 0		190.07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
191. 00 19100 RESEARCH	0	0		0 0	439	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	_	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	4, 330, 476	5, 465, 78	9, 796, 259	53, 292	202.00

	Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2016	Worksheet B Part II	
					0 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	CASHI ERI NG/AC	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	5/25/2017 2:4 LAUNDRY &	/ pm
		COUNTS	GENERAL	REPAI RS	PLANT	LINEN SERVICE	
		RECEI VABLE 5. 01	5. 02	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	5.01	5.02	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEIVABLE	81, 270					4.00 5.01
5.02	00590 OTHER ADMIN & GENERAL	01,270	2, 116, 421				5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0	0			6.00
7.00	00700 OPERATION OF PLANT	0	49, 879			04.004	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	9, 118 24, 695		_,	34, 394 0	•
10.00	01000 DI ETARY	0	8, 232			0	•
11.00	01100 CAFETERI A	0	9, 885		.,	0	11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 40, 026	-	-	0	12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	10, 809			0	
15.00	01500 PHARMACY	0	36, 036			0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	58, 141		-,	0	16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	14, 885 0	0		0	17.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	-	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	3, 042	0	335	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	7, 629	186, 942	0	55, 631	7, 517	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 845	43, 951			2, 809	•
32.00	03200 CORONARY CARE UNIT	0	0	0	-	0	•
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	33.00 34.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	•
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 322	0 10, 190	-	0	0	
43.00	04400 SKI LLED NURSI NG FACI LI TY	0	10, 190			0	
45.00	04500 NURSING FACILITY	0	0		-	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	8, 941	177, 184	0	68, 551	8, 069	50.00
51.00	05100 RECOVERY ROOM	762	12, 150			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 161	35, 268			1, 200	1
53.00 53.01	05300 ANESTHESI OLOGY 05301 PALN MANAGEMENT	0 174	0 8, 190	-	-	0	
	05400 RADI OLOGY-DI AGNOSTI C	14, 837	318, 351		112, 316	6, 597	
55.00	05500 RADI OLOGY-THERAPEUTI C	193	8, 086	0		0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
56.01 57.00	05601 CARDIAC CATH LAB 05700 CT SCAN	3, 043	29, 672 0		4,096	207	56.01 57.00
58.00	05800 MRI	0	0	0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 578	79, 280 0		9, 275	0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 1, 070	0 24, 955		3, 295	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	902	42, 806			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	397	11, 269		0	0	67.00
68.00		224	7,109		-	0	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	656 0	2, 885 0		11, 035 0	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 231	104, 208		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 235	79, 023		0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	24, 384 0	349, 734 0		0	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		-	0	•
2.00	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
88.00	08800 RURAL HEALTH CLINIC	0	0			0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 186	0 6, 654	-	0 2,951	0	89.00 90.00
90.00 90.02	09002 WOUND CLINIC	768	24, 264		29, 173	0	90.00
90.03	09003 MOBILE CLINIC	0	0	0	-	0	
91.00	09100 EMERGENCY	3, 943	65, 065	0	30, 461	7,771	91.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0026 Period: From 01/01/2016 To 12/31/2016 Worksheet B From 01/01/2016 To 12/31/2016 Worksheet B To 12/31/2016 2:00 Cost Center Description CASHI ERING/AC COUNTS RECELVABLE CASHI ERING/AC COUNTS RECELVABLE OPERATION OF REPAIRS OPERATION OF PLANT LAUNDRY & LAUNDRY & LINEN SERVICE 92:00 09200 (DBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 7.00 90.0 99:00 00000 (CMIC 0 0 7.638 0 92.00 99:00 0000 (OMIC 0 0 7.638 0 99.00 99:00 0000 (DMIC 0 0 7.638 0 101.00 99:00 000 (SITC, FUNCE 0 0 0 113.00 1113.00 113:00 113:00 111200 REVERSE 113.00 0 0 0 0 0 0 0 113.00 114:00 011600 HOSPICE 0 0 0 0 0 0 0 0 0 0 0 0 </th <th>Health Financial Systems</th> <th>GOSHEN HO</th> <th>SPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-:</th> <th>2552-10</th>	Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
P2.00 OP200 (DBSERVATION BEDS (NON-DISTINCT PART OP900) (DBSERVATION BEDS (DATABASE) (DBSERVATION BEDS (ALLOCATION OF CAPITAL RELATED COSTS				From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	
92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER RELIMBURSABLE COST CENTERS 0 0 0 0 0 99.00 101.00 100.01 101.00 101.00 101.00 101.00 101.00 101.00 101.00 113.00 114.00 1	Cost Center Description	COUNTS RECEI VABLE	GENERAL	REPAI RS	PLANT	LINEN SERVICE	
OTHER REI MBURSABLE COST CENTERS 99. 00 09900 101.00 0 0 0 101.00 111.00 111.12 113.00 113.00 113.00 114.00 111.12 271.01 REVIEWS 113.00 114.00 0 0 0 0 114.00 0 115.00 116.00 116.00 116.00 116.00 116.00 116.00 118.00 118.00 118.00 117.00 171.12 81.270 1.955.567 0 426.561 34.394 118.00 190.01 190.01 16.718 0 190.01 190.01 190.01		5. 01	5.02	6.00	7.00	8.00	
99.00 09900 CMHC 0 </td <td>92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00 HOME HEALTH AGENCY 254 39,894 0 7,638 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11400 1111 LIZATI ON REVIEW-SNF 114.00 114.00 114.00 0 0 0 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116.00 116.00 11600 HOSP ICE 535 23,689 0 0 0 116.00 NONREI MBURSABLE COST CENTERS 190.01 190001 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 35,661 0 16,718 0 190.01 190.01 190001 OTHER NR/CHP-GRANT I /COMMUNI TY ED 0 4,616 0 6,871 0 190.01 190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 0 190.02 190.04 19004 OHER NR/CHP-GRANT I /COMMUNI TY ED 0 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
SPECIAL PURPOSE COST CENTERS 113.00 114.00 <td>99.00 09900 CMHC</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>99.00</td>	99.00 09900 CMHC	0	0		0 0	0	99.00
113.00 11300 INTEREST EXPENSE 113.00 114.00 UTI LI ZATION REVI EW-SNF 114.00 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115.00 MOREI MEURATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116.00 DI160 HOSPI CE 535 23,689 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 35,661 0 16,718 0 190.01 190.01 THEN NR/CHP-GRANT I /COMMUNI TY ED 0 4,616 0 6,871 0 190.02 190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.03 190.03 19004 COMUNI TY RELATIONS 0 85,423 0 4,395 0 190.04 190.05 IPRI VATE DUTY 0 0 0 0 0 0 0	101.00 10100 HOME HEALTH AGENCY	254	39, 894		0 7,638	0	101.00
114.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115.00 116.00 10500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115.00 116.00 10500 ASUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 NORREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 35,661 0 16,718 0 190.01 190.02 19002 GI FT, FLOWER, COFFEE SHOP & CANTEE 0 0 0 0 190.01 190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.03 190.04 19004 COMUNI TY RELATI ONS 0 85,423 0 4,395 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SPECIAL PURPOSE COST CENTERS					•	1
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116.00 HOSPICE 535 23,689 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 118.00 NORREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 35,661 0 16,718 0 190.01 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNI TY ED 0 4,616 0 6,871 0 190.02 190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.03 19003 LI FELINE 0 0 0 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.03 190.04 34395 0 190.03 190.04 190.04 190.05 190.04 190.05 190.05 190.05 190.05 190.06 190.06	113.00 11300 INTEREST EXPENSE						113.00
116.00 HOSPI CE 535 23,689 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 118.00 NONRET MBURSABLE COST CENTERS	114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116.00 HOSPI CE 535 23,689 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 118.00 NONRET MBURSABLE COST CENTERS	115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 81,270 1,955,567 0 426,561 34,394 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 35,661 0 16,718 0 190.00 190.01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 4,616 0 6,871 0 190.00 190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.02 190.03 19003 LIFELINE 0 0 0 0 190.02 190.04 19004 COMMUNI TY RELATIONS 0 0 0 0 190.04 190.05 FRI VATE DUTY 0 0 0 0 0 190.05 190.06 19006 FROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 0 190.08		535	23, 689		0 0	0	116.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 35, 661 0 16, 718 0 190.00 190.01 OTHER NR/CHP-GRANT I/COMMUNI TY ED 0 4, 616 0 6, 871 0 190.01 190.02 IPOLO GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 LI FELI NE 0 0 0 0 190.03 190.04 IPOLOK COMMUNI TY RELATI ONS 0 85, 423 0 4, 395 0 190.05 190.05 PRI VATE DUTY 0 0 0 0 0 190.05 190.06 PROFESSI ONAL DEVELOPMENT 0 20, 968 0 0 190.07 190.08 GOSHEN GACC CLINIC 0 0 0 0 190.08 190.08 GOSHEN GACC CLINIC 0 0 0 0 190.08 190.09 HYSI CLANS' PRIVATE OFFICES 0 0 0 0 192.00 <td>118.00 SUBTOTALS (SUM OF LINES 1-117)</td> <td>81, 270</td> <td>1, 955, 567</td> <td></td> <td>0 426, 561</td> <td>34, 394</td> <td>118.00</td>	118.00 SUBTOTALS (SUM OF LINES 1-117)	81, 270	1, 955, 567		0 426, 561	34, 394	118.00
190.01 0THER NR/CHP-GRANT I/COMMUNITY ED 0 4,616 0 6,871 0 190.01 190.02 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.02 190.03 19003 LI FELINE 0 0 0 0 190.03 190.04 19004 COMMUNI TY RELATI ONS 0 85,423 0 4,395 190.04 190.05 19005 PRI VATE DUTY 0 0 0 0 190.05 190.07 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESARCH 0 14,186 0 0 191.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 193.00 193.00 200.00 Cross Foot Adjustments 200.00 0 0 0 200.00 <td></td> <td>· · · · ·</td> <td></td> <td></td> <td></td> <td></td> <td>1</td>		· · · · ·					1
190.02 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 190.02 190.03 19003 LI FELI NE 0 0 0 0 190.03 190.04 19004 COMMUNI TY RELATI ONS 0 85,423 0 4,395 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 191.00 192.00 19200 NONPAI D WORKERS 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 0 0 0 200.00 201.00<	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35, 661		0 16, 718	0	190.00
190.03 19003 LI FELINE 0 0 0 0 190.03 190.04 19004 COMMUNI TY RELATIONS 0 85,423 0 4,395 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 0 190.07 190.08 1908 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 200.00 0 0 0 201.00	190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	4, 616		0 6,871	0	190.01
190.03 19003 LI FELINE 0 0 0 0 190.03 190.04 19004 COMMUNI TY RELATIONS 0 85,423 0 4,395 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 0 190.07 190.08 1908 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 200.00 0 0 0 201.00	190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0	0	190.02
190.05 PRI VATE DUTY 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 192.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 200.00 0 0 0 201.00	190. 03 19003 LI FELI NE	0	0		0 0	0	190.03
190.05 PRI VATE DUTY 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 20,968 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 192.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 200.00 0 0 0 201.00	190. 04 19004 COMMUNITY RELATIONS	0	85, 423		0 4, 395	0	190.04
190.07 FOUNDTION 0 0 0 190.07 190.07 FOUNDTION 0 0 0 0 190.07 190.08 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments	190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190.07 FOUNDTION 0 0 0 190.07 190.07 FOUNDTION 0 0 0 0 190.07 190.08 GOSHEN GACC CLINIC 0 0 0 0 190.08 191.00 19100 RESEARCH 0 14,186 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments	190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	20, 968		0 0	0	190.06
191.00 RESEARCH 0 14, 186 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	0		0 0		
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0	0	190.08
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	191, 00 19100 RESEARCH	0	14, 186		0 0	0	191.00
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 200.00	192, 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
200.00 Cross Foot Adjustments 200.00		0	0		0 0		
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>l</td> <td></td>			0			l	
		0	Ο		0 0	n –	
		81, 270	2, 116, 421		0 454, 545		

Health Financial Systems	GOSHEN HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2016	Worksheet B Part II	
				o 12/31/2016	Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAI NTENANCE	5/25/2017 2:4 NURSI NG	
				OF PERSONNEL	ADMI NI STRATI O	
	9.00	10.00	11.00	12.00	N 13.00	
GENERAL SERVICE COST CENTERS		1				
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 02 00590 OTHER ADMI N & GENERAL						5.01 5.02
5. 02 00590 OTHER ADMI N & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.02 6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	34, 931					8.00 9.00
10. 00 01000 DI ETARY	287	45, 113				10.00
11.00 01100 CAFETERIA	601	0	87, 232	0		11.00
12.00 01200 MAI NTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMI NI STRATI ON	0	0	0 1, 627	0	360, 542	12.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	297	0	722	0	6	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	245 515	0	1, 747 2, 656	0	4, 171 1, 625	15.00 16.00
17. 00 01700 SOCI AL SERVI CE	74	0	1, 439	0	8, 148	
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 02000 NURSING SCHOOL 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00 21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	26	0	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 308	38, 621	16, 026	0	109, 683	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 150	6, 492 0	3, 623	0	26, 916	
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0 0	0	0	32.00 33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER – I PF 41. 00 04100 SUBPROVI DER – I RF	0	0	0	0	0	40.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 04300 NURSERY	149	0	472	0	3, 913	
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0	0	0 0	0	0	44.00 45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	5, 309	0	9, 348	0	56, 629	50.00
51.00 05100 RECOVERY ROOM	366	0	202	0	9, 693	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	800	0	2, 529 0	0	20, 964 0	52.00 53.00
53.01 05301 PALN MANAGEMENT	0	0	537	0	1, 424	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 696	0	17, 456	0	27, 407	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	99	0	633 0	0	1, 075 0	55.00 56.00
56. 01 05601 CARDI AC CATH LAB	317	0	606	0	14, 102	56.01
57. 00 05700 CT_SCAN 58. 00 05800 MRI	0	0	0	0	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ö	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	718	0	4, 251	0	572 0	60.00 60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	255	Ö	1, 903	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	2,083	0	3, 683 906		0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	541	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	855	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00 75.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90. 00 09000 CLINIC	229	0	411	0	0	90.00
	2, 259	0	0	0	0	90.02
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY	0 2, 359	0	0 4, 870	0	0 34, 117	90.03 91.00
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ALLOCATI ON OF CAPITAL RELATED COSTS Provider CCN: 15-0026 Period: From 01/01/2016 To 12/31/2016 Worksheet B Part II Date/Time Prepared: 5/25/2017 2: 47 pm Cost Center Description HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 99.00 10.00 11.00 12.00 13.00 99.00 09900 CMHC 0 0 0 99.00 99.00 101.00 HOUSEKEEPING 0 0 0 99.00 10.00 12.00 13.00 92.01 OP200 CMHC 0 0 0 99.00 99.00 101.00 HOUSEKEEPING 0 0 0 99.00 99.00 101.00 HOUSEKEEPING 0 0 0 99.00 10.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 113.00 113.00 113.00
P2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 90.00 10.00 11.00 12.00 13.00 92.00 OTHER REI MBURSABLE COST CENTERS 92.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92.00 0THER REI MBURSABLE COST CENTERS 99.00 0 0 0 99.00 99.00 00 0 0 99.00 99.00 101.00 10100 HOME HEALTH AGENCY 592 0 2,533 0 15,854 101.00 SPECIAL PURPOSE COST CENTERS
OTHER REI MBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 99.00 101.00 10100 HOME HEALTH AGENCY 592 0 2,533 0 15,854 101.00 SPECIAL PURPOSE COST CENTERS
99.00 09900 CMHC 0 0 0 0 99.00 101.00 10100 HOME HEALTH AGENCY 592 0 2,533 0 15,854 101.00 SPECIAL PURPOSE COST CENTERS
101.00 10100 HOME HEALTH AGENCY 592 0 2, 533 0 15, 854 101.00 SPECIAL PURPOSE COST CENTERS
SPECIAL PURPOSE COST CENTERS
112 00 11200 LINTEDEST EXDENSE
II3. UU II3UUIINIERESI EAPENSE III3. UU
114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00
116.00 11600 HOSPICE 0 11,932 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 32, 764 45, 113 80, 557 0 348, 231 118.00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 295 0 2, 619 0 7, 761 190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 532 0 267 0 0 190. 01
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 0 0 190. 02
190. 03 19003 LI FELI NE 0 0 0 0 0 0 190. 03
190. 04 19004 COMMUNITY RELATIONS 340 0 2, 476 0 7 190. 04
190. 05 19005 PRI VATE DUTY 0 0 0 0 0 190. 05
190.06 PROFESSI ONAL DEVELOPMENT 0 0 0 0 0 190.06
190. 07 19007 FOUNDTI ON 0 0 190. 07
190. 08 19008 GOSHEN GACC CLINIC 0 0 0 0 190. 08
191. 00 19100 RESEARCH 0 0 1, 313 0 4, 543 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00
193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00
202.00 TOTAL (sum lines 118-201) 34,931 45,113 87,232 0 360,542 202.00

Heal th	Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2016	Worksheet B Part II	
					To 12/31/2016	Date/Time Pre 5/25/2017 2:4	epared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	
		SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	ANESTHETI STS	
		14.00	15.00	16.00	17.00	19.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN & GENERAL						5.01 5.02
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00 12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	118, 864 168	79, 053				14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1	79,033	161, 26	5		16.00
17.00	01700 SOCIAL SERVICE	4	0		35, 678		17.00
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	(0	19.00 20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	Ō	(0 0		21.00
22.00 23.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0	0				22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	Q	`			23.00
30.00	03000 ADULTS & PEDIATRICS	3, 730	0	15, 15			30.00
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	1, 007 0	0	3, 66	4 3, 012 0 0		31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0 0		33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	(34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0				41.00
42.00	04200 SUBPROVI DER	0	0		0		42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	63	9 112 0 0		43.00 44.00
45.00	04500 NURSING FACILITY	0	Ō	(0 0		45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0		46.00
50.00	05000 OPERATING ROOM	14, 416	0	17, 75			50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	93 1, 115	0	1, 51, 2, 30			51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	2, 30			53.00
53.01	05301 PALN MANAGEMENT	8	0	34!			53.01
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	7, 158	0	29, 46 38			54.00 55.00
56.00	05600 RADI OI SOTOPE	0	0	(0 0		56.00
56. 01 57. 00	05601 CARDI AC CATH LAB 05700 CT SCAN	667	0	6, 04			56.01 57.00
58.00	05800 MRI	0	0	(58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	11 07			59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 314 0	0	11, 07			60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0 0	(0		64.00
65.00	06500 RESPIRATORY THERAPY	677 39	0	2, 12			65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	11	0	1, 79: 78			66.00 67.00
68.00	06800 SPEECH PATHOLOGY	5	0	44			68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	30	0	1, 30			69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 868	Ö	2,44			71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 430	0 70 053	4,43			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	79, 053 0	48, 293			73.00 74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0		75.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0 0		89.00
90. 00 90. 02	09000 CLINIC 09002 WOUND CLINIC	55 664	0	36 ⁰ 1, 52			90.00 90.02
90.03	09003 MOBILE CLINIC	0	0	(0 0		90.03
91.00	09100 EMERGENCY	2, 246	0	7, 83	2 4, 330		91.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CN: 15-0026 Period: From 01/01/2016 To 12/31/2016 Worksheet B Part 11 Date/Time Prepared: 522/2017 2: 47 pm Cost Center Description CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SCIAL NONPHYSICIAN ANSTHETISTS 92: 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REINBURSABLE COST CENTERS 0 17.00 19.00 90: 00 0900 OD00 CMHC 0 0 0 0 99.00 90: 00 000 CMHC 0 0 0 99.00 99.00 90: 00 013: 00 INTREEST EXPENSE 0 0 0 0 101.00 113: 00 INTREEST EXPENSE 14.00 0 0 0 113.00 115.00 115.00 114: 00 I1500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 118.00 118.00 118: 00 01500 GIFT, FLUNER, COFFEE SHOP & CANTEEN 34 0 0 118.00 118: 00 116: 00 0 0 0 118.00 118.00 118: 00 118: 00	Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-	2552-10
SERVICES & SUPPLY RECORDS & LI BRARY SERVICE ANESTHETISTS 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 14.00 15.00 16.00 17.00 19.00 0101.00 09900 CMHC 0 0 0 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 101.00 100ME HEALTH AGENCY 148 0 503 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 118.00 118.00 118.00 118.00 118.00 119.00 190.01 190.01 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 <t< td=""><td>ALLOCATION OF CAPITAL RELATED COSTS</td><td></td><td>Provider CC</td><td>CN: 15-0026</td><td>From 01/01/2016 To 12/31/2016</td><td>Part II Date/Time Pre</td><td></td></t<>	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0026	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	
92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 92.00 07HER REIMBURSABLE COST CENTERS 99.00 99.00 99.00 90.00 99.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 113.00 114.00 114.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 116.00 105.01 106.01 105.01 106.01 118.00 118.00 118.00 118.00 118.00 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.02 190.02 190.02 190.02 190.02	Cost Center Description	SERVICES &	PHARMACY	RECORDS &			
OTHER RELIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 99.00 101.00 HOME HEALTH AGENCY 148 0 503 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 114.00 0 0 0 0 114.00 0 111.20 111.21 211.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 116.00 118.00 118.00 118.00 118.00 118.00 118.00 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 0 0 190.01		14.00	15.00	16.00	17.00	19.00	
99.00 09900 CMHC 0 0 0 0 99.00 101.00 HOME HEALTH AGENCY 148 0 503 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11400 UTI LIZATI ON REVIEW-SNF 113.00 114.00 115.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 118.00 118.00 118.00 100.01 190.00 190.01 190.00 190.01 190.00 190.01 190.00 190.01 190.01 190.01 190.01 190.02 190.02 190.02 190.02 190.02 190.02	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00 10100 HOME HEALTH AGENCY 148 0 503 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 114.00 116.00 116.00 116.00 116.00 118.00 116.00 116.00 116.00 116.00 116.00 118.00 116.00 118.00 116.00 118.00 116.00 118.00 116.00 118.00 116.00 118.00 118.00 118.00 118.00 1190.01 190.01 190.01 190.01 190.01 190.01	OTHER REIMBURSABLE COST CENTERS	• •				•	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00		0	0		0 0		99.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00	101.00 10100 HOME HEALTH AGENCY	148	0	50	03 0		101.00
113.00 11300 INTEREST EXPENSE 113.00 114.00 UTI LI ZATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 115.00 116.00 HOSPI CE 2,856 0 1,063 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 118,802 79,053 161,265 35,678 0 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 0 190.01 190.01 OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 0 190.02 190.02 I9002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 19003 LI FELL NE 0 0 0 190.02 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.05 190.05 190.05 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06			-1				1
114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 116.00 11600 HOSPICE 2,856 0 1,063 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 118,802 79,053 161,265 35,678 0 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 0 190.01 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 190.01 1900.02 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1113.00</td>							1113.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116.00 H0SPICE 2,856 0 1,063 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 118,802 79,053 161,265 35,678 0 118.00 NOMREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 190.00 190.01 190.02 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 34 0 0 0 190.01 190.02 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 19003 LI FELINE 0 0 190.03 190.04 190004 COMMUNI TY RELATI ONS 25 0 0 190.04 190.05 190.05 19005 PRI VATE DUTY 0 0 0 190.06 190.06 190.06 19006 POFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.07 19007 FUNDTI ION 0 0 0 190.06 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
116.00 11600 HOSPICE 2,856 0 1,063 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 118,802 79,053 161,265 35,678 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 0 190.01 190.01 19001 OTHER NR/CHP-GRANT I /COMMUNITY ED 1 0 0 190.01 190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 19003 LI FELI NE 0 0 0 190.03 190.04 19004 COMMUNI TY RELATI ONS 25 0 0 190.05 190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.07 190.08 19008 GSHEN GACC CLINIC 0 0 0 190.08 191.00 191000 RESEARCH 2 0 0 19		0	0		0 0		
118.00 SUBTOTALS (SUM OF LINES 1-117) 118,802 79,053 161,265 35,678 0 118.00 NORREI MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 190.00 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 190.00 190.02 19002 GFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 19002 GFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.04 19002 GFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.05 PRI VATE DUTY 0 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.07 190.07 19007 FOUNDTI ON 0 0 0 190.08 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08		2,856	0	1.06	53 0		
NORREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 0 190.00 190.01 OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 0 190.01 190.02 I OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 0 190.01 190.02 I OTHER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 0 190.02 190.03 I FELINE 0 0 0 0 0 190.03 190.04 19004 COMUNITY RELATIONS 25 0 0 0 190.04 190.05 19005 PRIVATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08	118.00 SUBTOTALS (SUM OF LINES 1-117)		79.053				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 34 0 0 190.00 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNI TY ED 1 0 0 190.01 190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 LIFELINE 0 0 0 190.03 190.03 190.04 19004 COMMUNI TY RELATIONS 25 0 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.08 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 192000 NOPALD WORKERS 0 0 0 192.00 200.00 Cross Foot Adjustments 0 0 0						1	
190.01 0THER NR/CHP-GRANT I/COMMUNITY ED 1 0 0 190.01 190.02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0 190.02 190.03 19003 LI FELI NE 0 0 0 190.03 190.04 19004 COMMUNI TY RELATI ONS 25 0 0 190.04 190.05 PRI VATE DUTY 0 0 0 190.06 190.05 190.07 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 190.08 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 192.00 192.00 192.00 19200 NORPAID WORKERS 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00		34	0		0 0		190.00
190.03 LIFELINE 0 0 0 190.03 190.04 19004 COMMUNITY RELATIONS 25 0 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.07 19007 FOUNDTION 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 192.00 192.00 PAYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 201.00		1	0		0 0		190.01
190.04 19004 COMMUNI TY RELATIONS 25 0 0 190.04 190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 192.00 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments	190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.02
190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 192.00 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 200.00 Cross Foot Adj ustments	190. 03 19003 LI FELI NE	0	0		0 0		190.03
190.05 19005 PRI VATE DUTY 0 0 0 190.05 190.06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0 190.06 190.07 19007 FOUNDTI ON 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 192.00 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 200.00 Cross Foot Adj ustments	190. 04 19004 COMMUNITY RELATIONS	25	0		0 0		190.04
190.07 19007 FOUNDTI ON 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190.07 19007 FOUNDTI ON 0 0 0 190.07 190.08 19008 GOSHEN GACC CLINIC 0 0 0 190.08 191.00 19100 RESEARCH 2 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0		0 0		190.06
191.00 RESEARCH 2 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 201.00	190. 07 19007 FOUNDTI ON	0	0		0 0		190.07
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	191. 00 19100 RESEARCH	2	0		0 0		191.00
200.00 Cross Foot Adjustments 0 200.00 0 200.00 0 200.00 0 200.00 0 0 200.00 0 0 201.00 0	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	o		0 0		192.00
201.00 Negative Cost Centers 0 </td <td>193. 00 19300 NONPALD WORKERS</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>193.00</td>	193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
201.00 Negative Cost Centers 0 </td <td>200.00 Cross Foot Adjustments</td> <td></td> <td></td> <td></td> <td></td> <td> 0</td> <td>200.00</td>	200.00 Cross Foot Adjustments					0	200.00
	5	o	о		0 0		
		118, 864	79, 053	161, 26	35, 678	c	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	GOSHEN I		CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/25/2017 2:4	pared:
			I NTERNS &	RESI DENTS			
	Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTH R PRGM COSTS APPRV		Subtotal	
		20.00	21.00	22.00	23.00	24.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00 5.01 5.01 5.02 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 21.00 22.00 23.00 30.00 31.00 32.00 34.00 40.00 41.00 42.00 44.00	GENERAL SERVI CE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I & SERVI CES-OTHER 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02200 JARAMED ED PRGM INPATI ENT ROUTI NE SERVI CE COST CEN				0 6, 092	1, 049, 399 350, 303 0 0 0 0 0 42, 784	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 34.\ 00\\ 41.\ 00\\ 41.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 01\\ 01\\ 01\\ 01\\ 01\\ 01\\ 01\\ 01\\ 01\\$
45.00	04500 NURSI NG FACI LI TY					0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS					0	46.00
53.01 54.00 55.00 56.01 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00 64.00 65.00 64.00 63.00 67.00 63.00 70.00 70.00 71.00 71.00 73.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OL SOTOPE 05601 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS					$\begin{array}{c} 2, 130, 063\\ 66, 820\\ 209, 378\\ 0\\ 11, 214\\ 2, 483, 400\\ 69, 265\\ 0\\ 295, 175\\ 0\\ 295, 175\\ 0\\ 0\\ 275, 378\\ 0\\ 0\\ 275, 378\\ 0\\ 0\\ 0\\ 79, 738\\ 307, 882\\ 14, 111\\ 8, 613\\ 119, 045\\ 0\\ 152, 751\\ 119, 126\\ 501, 463\\ \end{array}$	51.00 52.00 53.01 54.00 55.00 55.00 56.01 57.00 58.00 59.00 60.00 60.01 61.00 62.00 63.00 64.00 65.00 65.00 65.00 60.00 62.00 63.00 64.00 65.00 65.00 67.00 68.00 67.00 68.00 67.000 71.000 71.000 73.000
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)					0	74.00 75.00
89. 00 90. 00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09002 WOUND CLINIC					0 0 50, 133 287, 878	

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALA RY & FRI NGES APPRV	R PRGM COSTS APPRV	S PRGM	Subtotal	
	20.00	21.00	22.00	23.00	24.00	
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 491, 601	90. 03 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC					0	99.00
101.00 10100 HOME HEALTH AGENCY					150, 200	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					0	115.00
116.00 11600 HOSPI CE					42, 570	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0)	0 0	9, 308, 290	118.00
NONREI MBURSABLE COST CENTERS	·		·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					233, 746	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED					65, 347	190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE					0	190.02
190. 03 19003 LI FELI NE					0	190.03
190. 04 19004 COMMUNITY RELATIONS					141, 323	190.04
190. 05 19005 PRI VATE DUTY						190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT					20, 978	
190. 07 19007 FOUNDTI ON						190.07
190. 08 19008 GOSHEN GACC CLINIC						190.08
191. 00 19100 RESEARCH					20, 483	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES						192.00
193. 00 19300 NONPAI D WORKERS						193.00
200.00 Cross Foot Adjustments	0	0		0 6,092		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	0		6, 092	9, 796, 259	

				То	rom 01/01/2016 12/31/2016	Date/Time Prepare 5/25/2017 2:47 pr	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	L .		<u></u>	5111
		Adjustments 25.00	26.00				
	GENERAL SERVICE COST CENTERS	1					1 00
2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						4.00 5.01
5.01	00590 OTHER ADMIN & GENERAL						5.02
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
	01000 DI ETARY						0.00
	01100 CAFETERI A						1.00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						2.00
	01400 CENTRAL SERVICES & SUPPLY						3.00 4.00
	01500 PHARMACY						5.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16	6.00
	01700 SOCI AL SERVI CE						7.00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL						9.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV						1.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV						2.00
23.00	02300 PARAMED ED PRGM					23	3.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	1,049,399			20	0.00
	03100 I NTENSI VE CARE UNI T	0	350, 303				1.00
	03200 CORONARY CARE UNI T	0	000,000				2.00
	03300 BURN INTENSIVE CARE UNIT	0	0				3.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				4.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0				0.00
	04200 SUBPROVI DER	0	Ő				2.00
	04300 NURSERY	0	42, 784				3.00
	04400 SKILLED NURSING FACILITY	0	0				4.00
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0				5.00
101 00	ANCI LLARY SERVICE COST CENTERS						0.00
	05000 OPERATING ROOM	0	2, 130, 063				0.00
	05100 RECOVERY ROOM	0	66, 820				1.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	209, 378				2.00 3.00
	05301 PALN MANAGEMENT	0	11, 214				3.01
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 483, 400				4.00
	05500 RADI OLOGY-THERAPEUTI C	0	69, 265				5.00
	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB	0	0 295, 175				6. 00 6. 01
	05700 CT SCAN	0	275, 175				7.00
	05800 MRI	0	0				8.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				9.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	275, 378				0.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				1.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				2.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				3.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0				4.00
	06600 PHYSI CAL THERAPY	0	79, 738 307, 882				6.00
	06700 OCCUPATI ONAL THERAPY	0	14, 111				7.00
68.00	06800 SPEECH PATHOLOGY	0	8, 613			68	8.00
		0	119, 045				9.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 152, 751				0.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	119, 126				2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	501, 463			73	3.00
	07400 RENAL DI ALYSI S	0	0				4.00
	07500 ASC (NON-DI STI NCT PART)	0	0			75	5.00
	OUTPATIENT SERVICE COST CENTERS	0	0			88	8.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				9.00
	09000 CLINIC 09002 WOUND CLINIC	0	50, 133 287, 878				0.00

Health Financial Systems	GOSHEN HOS	PI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0026	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 2:4		
Cost Center Description	Intern & Residents	Total					
	Cost & Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
90. 03 09003 MOBILE CLINIC	0	0				90.03	
91.00 09100 EMERGENCY	0	491, 601				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00	
OTHER REIMBURSABLE COST CENTERS			1				
99.00 09900 CMHC	0	0				99.00	
101.00 10100 HOME HEALTH AGENCY	0	150, 200				101.00	
SPECIAL PURPOSE COST CENTERS						112 00	
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0				114.00	
116. 00 11600 H0SPI CE	0	42, 570				116.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	9, 308, 290				118.00	
NONREI MBURSABLE COST CENTERS		7,000,270				110.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	233, 746				190.00	
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	65, 347				190.01	
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0				190.02	
190. 03 19003 LI FELI NE	0	0				190.03	
190. 04 19004 COMMUNI TY RELATI ONS	0	141, 323				190. 04	
190. 05 19005 PRI VATE DUTY	0	0				190. 05	
190.06 19006 PROFESSI ONAL DEVELOPMENT	0	20, 978				190.06	
190. 07 19007 FOUNDTI ON	0	0				190. 07	
190. 08 19008 GOSHEN GACC CLINIC	0	0				190.08	
191.00 19100 RESEARCH	0	20, 483				191.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00	
193.00 19300 NONPALD WORKERS 200.00 Cross Foot Adjustments	0	0 6, 092				193.00 200.00	
200.00 Regative Cost Centers	0	0, 092				200.00	
202.00 TOTAL (sum lines 118-201)	0	9, 796, 259				201.00	
202.00 10TAL (SUII TITIES 110-201)	I U	7, 170, 237	I			202.00	

ST ALLO	DCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	CASHI ERI NG/AC COUNTS RECEI VABLE (GROSS CHAR GES)	Reconciliatio n	
		1.00	2.00	4.00	5. 01	5A. 02	
	NERAL SERVICE COST CENTERS					1	
	100 CAP REL COSTS-BLDG & FIXT	377, 382					1
	200 CAP REL COSTS-MVBLE EQUIP	4 500	6, 631, 339		,		2
	400 EMPLOYEE BENEFITS DEPARTMENT 580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 528 6, 508	1, 617 7, 123				4
	590 OTHER ADMIN & GENERAL	31, 143	2, 124, 528				5
	600 MAI NTENANCE & REPAI RS	0	0		0 0		6
00 00	700 OPERATION OF PLANT	30, 221	69, 513	757, 96	9 0	0	7
	800 LAUNDRY & LINEN SERVICE	1, 847	1, 576			-	
	900 HOUSEKEEPI NG	479	3, 982			0	9
	000 DI ETARY 100 CAFETERI A	2, 483					10
	200 MAINTENANCE OF PERSONNEL	5, 206	10, 718 0		8 0 0 0		11
	300 NURSI NG ADMI NI STRATI ON	1, 516	361, 311	1, 628, 59			13
	400 CENTRAL SERVICES & SUPPLY	2, 575	89, 132		-		14
	500 PHARMACY	2, 124	9, 437	1, 777, 92	1 0	0	15
	600 MEDICAL RECORDS & LIBRARY	4, 465	47, 665	1, 491, 80		-	16
	700 SOCIAL SERVICE	645	2, 611	797, 54		-	17
	900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	-	19
	000 NURSING SCHOOL 100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			-	20
	200 I &R SERVICES-SALART & FRINGES APPRV	0	0			-	22
	300 PARAMED ED PRGM	225	0	139, 37			23
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDI ATRI CS	37, 326	172, 345	8, 030, 89	8 53, 350, 626	0	30
	100 I NTENSI VE CARE UNI T	9, 960	152, 080				31
	200 CORONARY CARE UNIT	0	0		0 0	-	32
	300 BURN I NTENSI VE CARE UNI T	0	0		0 0	0	33
	400 SURGI CAL I NTENSI VE CARE UNI T 000 SUBPROVI DER – I PF	0	0			0	40
	100 SUBPROVI DER – I RF	0	0			0	41
	200 SUBPROVI DER	0	0		0 0	-	42
	300 NURSERY	1, 293	11, 873	276, 35	9 2, 251, 076	0	43
	400 SKILLED NURSING FACILITY	0	0		0 0		44
	500 NURSI NG FACI LI TY	0	0		0 0		45
	600 OTHER LONG TERM CARE CILLARY SERVICE COST CENTERS	0	0		0 0	0	46
	000 OPERATING ROOM	45, 995	1, 495, 214	4, 749, 34	4 62, 521, 271	0	50
00 05	100 RECOVERY ROOM	3, 170					51
00 05	200 DELIVERY ROOM & LABOR ROOM	6, 929	63, 620	1, 480, 78	7 8, 119, 620	0	52
	300 ANESTHESI OLOGY	0	0		0 0	0	53
1	301 PALN MANAGEMENT	0	0	696, 06			53
	400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C	75, 361 854	1, 292, 189 57, 443				54
	600 RADI OLOGI - THERAPEUTI C	004	57,443		0 1, 347, 957	0	56
	601 CARDI AC CATH LAB	2, 748	247,678	965, 12	-	-	56
	700 CT SCAN	0	0		0 0	0	57
	800 MRI	0	0		0 0	0	58
	900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59
		6, 223	104, 020	2, 814, 33	7 39,004,775		60
1	001 BLOOD LABORATORY 100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62
	300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63
	400 I NTRAVENOUS THERAPY	0	0		0 0	0	64
00 06	500 RESPI RATORY THERAPY	2, 211	23, 280				65
	600 PHYSI CAL THERAPY	18, 050					66
	700 OCCUPATI ONAL THERAPY	0	332	604, 16			67
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	7,404	0 21, 014	375, 88	8 1, 565, 993 0 4, 586, 440		68
	000 ELECTROENCEPHALOGRAPHY	/, 404	21,014		0 4,586,440 0 0	0	70
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	n 0		0 8, 606, 244		71
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 626, 280		72
	300 DRUGS CHARGED TO PATIENTS	0	0		0 169, 745, 587		73
	400 RENAL DIALYSIS	0	0		0 0	0	74
	500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75
	TPATIENT SERVICE COST CENTERS						
108	800 RURAL HEALTH CLINIC	0			0 0 0 0		

ealth Financial Systems OST ALLOCATION - STATISTICAL BASIS		Provider CO	NI 15 0024 1	Peri od:	Worksheet B-1	<u>2552-</u>
USI ALLUCATION - STATISTICAL DASIS			F	From 01/01/2016 To 12/31/2016		epared
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/AC	Reconciliatio	
	(SQUARE FEET)	(DOLLAR	BENEFI TS	COUNTS	n	
		VALUE)	DEPARTMENT	RECEI VABLE		
			(GROSS SALARI ES)	(GROSS CHAR GES)		
	1.00	2.00	4.00	5.01	5A. 02	
0. 00 09000 CLINIC	1, 980	19, 862	241, 05		0	90.0
0. 02 09002 WOUND CLINIC	19, 574	5, 595	1, 142	2 5, 367, 462	0	
0. 03 09003 MOBILE CLINIC	0	0	(° °	0	
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	20, 438	111, 588	2, 733, 274	27, 576, 392	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PA OTHER REIMBURSABLE COST CENTERS						92.
9. 00 09900 CMHC	0	0	(0	0	99.
01.00 10100 HOME HEALTH AGENCY	5, 125	27, 273	1, 941, 933	-	-	101.
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.
14.00 11400 UTI LI ZATI ON REVIEW-SNF						114.
15. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 16. 00 11600 HOSPI CE	0	0	054 42	0		115. 116.
18.00 SUBTOTALS (SUM OF LINES 1-117)	358, 606	6, 565, 966	856, 427 65, 940, 447			
NONREI MBURSABLE COST CENTERS	550,000	0, 303, 700	03, 940, 44	507, 550, 005	-30, 030, 324	1110.
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EN 11, 217	48, 438	1, 321, 461	0	0	190.
90.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED		0	208, 123	3 0		190.
90.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANT	EE 0	0	(0 0		190.
90. 03 19003 LI FELI NE	0	0	(0 0		190.
90. 04 19004 COMMUNITY RELATIONS	2, 949	16, 935	1, 116, 062	2 0		190. 190.
90. 05 19005 PRI VATE DUTY 90. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0	12, 77			190.
90. 07 19007 FOUNDTI ON	0	0	12, 77			190.
90. 08 19008 GOSHEN GACC CLINIC	0	0	(0		190.
91. 00 19100 RESEARCH	0	0	570, 182	2 0	0	191.
92.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.
93. 00 19300 NONPAI D WORKERS	0	0	(0 0		193.
00.00 Cross Foot Adjustments						200. 201.
01.00 Negative Cost Centers 02.00 Cost to be allocated (per Wkst. E	4, 330, 476	5, 465, 783	22, 847, 240	2, 391, 438		201.
Part I)	4, 330, 470	5,405,705	22,047,240	2, 371, 430		202.
03.00 Unit cost multiplier (Wkst. B, Pa	rt I) 11. 475047	0. 824235	0. 330310	0. 004214		203.
04.00 Cost to be allocated (per Wkst. E	3,		53, 292	81, 270		204.
Part II)						
05.00 Unit cost multiplier (Wkst. B, Pa	int l		0.000770	0. 000143		205.

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	GOSHEN H			Period:	u of Form CMS-2 Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
Cost Center Description	OTHER ADMIN & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	PLANT	LINEN SERVICE	HOUSEKEEPI NG	
	5. 02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00580 CASHI ERING/ACCOUNTS RECEI VABLE 5.02 00590 OTHER ADMIN & GENERAL 6.00 00600 MAI NTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY TI.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY ENCOMPARACY 16.00 01600 MEDICAL RECORDS & LI BRARY 17.00 01700 SOCIAL SERVICE 9.00 02000 NURSING SCHOOL 21.00 02000 NURSING SCHOOL 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	155, 052, 602 0 3, 654, 122 668, 007 1, 809, 182 603, 058 724, 140 0 2, 932, 321 791, 893 2, 639, 998 4, 259, 439 1, 090, 505 0 0 0 0	335, 203 30, 221 1, 847 2, 483 5, 206 0 1, 516 2, 575 2, 124 4, 465	304, 98; 1, 84; 47; 2, 48; 5, 20; 1, 51; 2, 57; 2, 12; 4, 46; 64; 64; 64; 64; 64; 64; 64;	7 805,031 9 0 3 0 6 0 0 0 6 0 5 0 4 0 5 0	302, 656 2, 483 5, 206 0 1, 516 2, 575 2, 124 4, 465 645 0 0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM	222, 842	-			0 225	
INPATIENT ROUTINE SERVICE COST CENTERS	222, 042	220	1 22:		225	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN I NTENSI VE CARE UNI T	13, 695, 351 3, 219, 838 0		9, 96		37, 326 9, 960 0 0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY 45. 00 04500 NURSI NG FACI LI TY 46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0 0 0 746, 547 0 0 0 0	0) 1,29) (0 0 0 0 0 0 0 0 3 5, 242 0 0 0 0 0 0 0 0	0 0 0 1, 293 0 0 0 0	34.00 40.00 41.00 42.00 43.00 44.00 45.00
50. 00 05000 OPERATI NG ROOM	12, 980, 529	45, 995	45, 99	5 188, 875	45, 995	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 33.01 05301 PAI N MANAGEMENT	890, 116 2, 583, 709 0 600, 021	3, 170 6, 929 0	3, 170 6, 929	0 0	3, 170 6, 929 0 0	51.00 52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 54. 01 05600 RADI OI SOTOPE	23, 322, 446 592, 394 0	854 0	854	4 0 0 0	75, 361 854 0	55.00 56.00
56. 01 05601 CARDIAC CATH LAB 57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDIAC CATHETERIZATION	2, 173, 757 0 0 0	2, 748 0 0 0		8 4,837 0 0 0 0 0 0	2, 748 0 0 0	57.00 58.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	5, 808, 060 0 0 0	6, 223 0 0 0	6,22	3 0 0 0 0 0 0 0	6, 223 0 0 0	60.01 61.00 62.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0 1, 828, 215 3, 136, 006 825, 599	18, 050 0	18, 050		0 2, 211 18, 050 0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS	520, 808 211, 379 0 7, 634, 255 5, 789, 248 25, 624, 715	7,404 0 0 0	7,40	0 0 4 0 0 0 0 0 0 0 0 0	0 7, 404 0 0 0 0	69.00 70.00 71.00 72.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVI CE COST CENTERS	25, 624, 715 0 0				0	74.00 75.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 02 09002 WOUND CLINIC 90. 03 09003 MOBILE CLINIC	0 0 487, 478 1, 777, 617 0	0 1, 980 19, 574) 1, 98(19, 57		19, 574	89.00 90.00

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
				rom 01/01/2016		
			1	o 12/31/2016	Date/Time Pre 5/25/2017 2:4	
Cost Center Description	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	7 pm
	GENERAL	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	
		(SQUARE FEET)		(POUNDS OF	()	
		`	`	LAUNDRY)		
	5. 02	6.00	7.00	8.00	9.00	
91.00 09100 EMERGENCY	4, 766, 631	20, 438	20, 438	181, 898	20, 438	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	C	0	0	99.00
101.00 10100 HOME HEALTH AGENCY	2, 922, 645	5, 125	5, 125	0	5, 125	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0		115.00
116. 00 11600 HOSPI CE	1, 735, 485	0	C	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	143, 268, 356	316, 427	286, 206	805, 031	283, 880	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 612, 523				11, 217	
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	338, 163	4, 610	4, 610	0		190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0	C	-		190. 02
190. 03 19003 LI FELI NE	0	0	C	, vi		190. 03
190. 04 19004 COMMUNI TY RELATI ONS	6, 258, 112	2, 949	2, 949	0		190. 04
190. 05 19005 PRI VATE DUTY	0	0	C	0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	1, 536, 152		C	0		190. 06
190. 07 19007 FOUNDTI ON	35	0	C	0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0	C	0		190. 08
191. 00 19100 RESEARCH	1, 039, 261	0	C	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPAI D WORKERS	0	0	C	0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	36, 058, 324	0	4, 503, 906	850, 631	2, 236, 990	202.00
Part I)	0 000555			4 95//44		
203.00 Unit cost multiplier (Wkst. B, Part I)					7. 391197	
204.00 Cost to be allocated (per Wkst. B,	2, 116, 421	0	454, 545	34, 394	34, 931	204.00
Part II)	0.010/50	0. 000000	1 400200	0.040704	0 115415	205 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 013650	0.00000	1. 490399	0. 042724	0. 115415	205.00
	1	l		1		

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	GOSHEN HO		CN. 15 000/		u of Form CMS-2	
COST ALLOCATION - STATISTICAL DASIS		Provider CO	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre 5/25/2017 2:4	pared:
Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	
	10.00	11.00	12.00	13.00	14.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
1.00 00100 CAP REL COSTS-BLDG & FLAT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 00590 OTHER ADMIN & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 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 12.00 01200 MAI NTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01500 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS 20.00 02000<	72, 089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 716, 703 0 32, 009 14, 204 34, 390 52, 270 28, 312 0 0 0 0 0 0		697,807 11 8,073 3,145 15,770 0	20, 348, 449 28, 830 189 674 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$
30. 00 03000 ADULTS & PEDI ATRI CS	61, 715	315, 376	(212, 284	638, 647	30.00
31. 00 03100 INTENSIVE CARE UNIT	10, 374	71, 292			172, 394	31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		-	0	32.00 33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	(0 0	0	34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	0		-	0	40.00
42. 00 04200 SUBPROVI DER	0	0		,	0	42.00
43. 00 04300 NURSERY	0	9, 287	(0	43.00
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0	0		-	0	44.00 45.00
46.00 04600 OTHER LONG TERM CARE	0	0			0	46.00
ANCI LLARY SERVI CE COST CENTERS		400.070		100 (01	0.440.004	50.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	183, 973 3, 980			2, 468, 026 15, 851	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	49, 764			190, 814	
53.00 05300 ANESTHESI OLOGY	0	0	(0 0	0	
53. 01 05301 PALN_MANAGEMENT 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 577 343, 564		2, 757 53, 045	1, 297 1, 225, 483	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	12, 451			1, 225, 485	
56. 00 05600 RADI OI SOTOPE	0	0	(0	56.00
56. 01 05601 CARDI AC CATH LAB	0	11, 932			114, 163	
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		,	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59.00
	0	83, 662	(1, 108	909, 843	60.00
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60.01 61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0		-	0 115 044	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	37, 444 72, 481		,	115, 866 6, 743	
67.00 06700 OCCUPATI ONAL THERAPY	0	17, 828	(0 0	1, 937	
68.00 06800 SPEECH PATHOLOGY	0	10, 637		0 0	914	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			5, 089 0	69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		Ó	7, 680, 007	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	5, 723, 399	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(-	0	
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART)	0	0			0	74.00 75.00
OUTPATIENT SERVICE COST CENTERS		0			0	, 5. 00
88.00 08800 RURAL HEALTH CLINIC	0	0			0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0 8, 093			0 9, 432	89.00 90.00
90. 02 09002 WOUND CLINIC	0	0,073			113, 668	1
				· · · · · · · · · · · · · · · · · · ·		

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0026	Peri od:	Worksheet B-1	
				From 01/01/2016	Data (Tima Daa	
				Го 12/31/2016	Date/Time Pre 5/25/2017 2:4	
Cost Center Description	DI ETARY	CAFETERIA	MAI NTENANCE	NURSI NG	CENTRAL	
cost conter bescription	(MEALS	(MANHOURS)	OF PERSONNEL		SERVICES &	
	SERVED)	(MANIOURS)	(NUMBER	N	SUPPLY	
	SERVED)		HOUSED)	(DI RECT	(COSTED	
			(INCOULD)	NRSING HRS)	REQUIS.)	
	10.00	11.00	12.00	13.00	14.00	
90. 03 09003 MOBILE CLINIC	0	0	(0	90.03
91.00 09100 EMERGENCY	0	95, 834	(66, 032	384, 578	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	(0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	0	49, 851	(30, 685	25, 289	101.00
SPECIAL PURPOSE COST CENTERS		· · ·		· · · · ·	· · · ·	1
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0	0	115.00
116. 00 11600 HOSPI CE	0	36, 137	(23, 094	489, 021	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	72, 089	1, 585, 348	(673, 981	20, 337, 849	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51, 538				190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	5, 251	(0 0		190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0	(0 0		190. 02
190. 03 19003 LI FELI NE	0	0	(0 0		190.03
190. 04 19004 COMMUNI TY RELATI ONS	0	48, 720	(13		190. 04
190. 05 19005 PRI VATE DUTY	0	0	(0 0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0	(0 0		190.06
190. 07 19007 FOUNDTI ON	0	0	(0 0		190.07
190. 08 19008 GOSHEN GACC CLINIC	0	0	(0 0		190. 08
191. 00 19100 RESEARCH	0	25, 846	(8, 793	351	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	798, 322	1,007,902	(3, 666, 633	1, 041, 508	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	11.074117	0. 587115	0.00000	5. 254509	0. 051184	203.00
204.00 Cost to be allocated (per Wkst. B,	45, 113	87, 232	(360, 542	118, 864	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 625796	0. 050814	0. 00000	0. 516679	0. 005841	205.00

	Financial Systems	GOSHEN HO		01 15 000/ 0		u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016	Worksheet B-1	
				T	0 12/31/2016	Date/Time Pre 5/25/2017 2:4	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		(COSTED REQUIS.)	RECORDS & LI BRARY	SERVICE (TIME SPENT)	ANESTHETI STS (ASSI GNED	SCHOOL (ASSI GNED	
		,	(GROSS CHAR		TIME)	TIME)	
		15.00	GES) 16.00	17.00	19.00	20.00	
	GENERAL SERVICE COST CENTERS	10.00	10.00		17.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5.02 6.00	00590 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5.02 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00 14.00
	01500 PHARMACY	24, 911, 250					15.00
	01600 MEDICAL RECORDS & LIBRARY	0	567, 538, 085				16.00
	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	3, 518 0			17.00 19.00
	02000 NURSI NG SCHOOL	0	0	0		0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0				21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0	0				22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0			23.00
30.00	03000 ADULTS & PEDI ATRI CS	0	53, 350, 626			0	
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	12, 900, 646 0	297 0		0	
32.00	03300 BURN I NTENSI VE CARE UNI T	0	0			0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0		C	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0	0		0	
	04100 SUBPROVIDER	0	0			0	
43.00	04300 NURSERY	0	2, 251, 076			0	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	-		0	
45.00	04600 OTHER LONG TERM CARE	0	0			0	
	ANCI LLARY SERVICE COST CENTERS			-			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	62, 521, 271 5, 332, 100			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 119, 620		0	0	
	05300 ANESTHESI OLOGY	0	0	0	0	0	
	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C	0	1, 215, 216 103, 755, 566		0	0	
	05500 RADI OLOGY-THERAPEUTI C	0	1, 347, 957		0	0	1
		0	0	-	0	0	
56.01 57.00	05601 CARDI AC CATH LAB 05700 CT SCAN	0	21, 283, 124	0	0	0	
	05800 MRI	0	0	0	0	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	39, 004, 775 0		0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	0		Ŭ	Ū	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	0	
	06500 RESPIRATORY THERAPY	0	7, 479, 478	-	0	0	1
	06600 PHYSI CAL THERAPY	0	6, 308, 233		0	0	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	2, 777, 556 1, 565, 993		0	0	
	06900 ELECTROCARDI OLOGY	0	4, 586, 440		0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 606, 244 15, 626, 280		0	0	
	07300 DRUGS CHARGED TO PATIENTS	24, 911, 250	169, 745, 587		0	0	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	-	0	0	89.00
	09000 CLINIC 09002 WOUND CLINIC	0	1, 299, 125 5, 367, 462		0	0	
70.02			5, 507, 402	1 0	, v	0	1 70.02

Health Financial Systems	GOSHEN HO	ISPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		norod.
				10 12/31/2010	5/25/2017 2:4	
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
	(COSTED	RECORDS &	SERVI CE	ANESTHETI STS	SCHOOL	
	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	
		(GROSS CHAR		TIME)	TIME)	
		GES)				
	15.00	16.00	17.00	19.00	20.00	
90. 03 09003 MOBILE CLINIC	0	0		0 0	0	
91.00 09100 EMERGENCY	0	27, 576, 392	42	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REI MBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0		0 0		
101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	0	1, 772, 749		0 0	0	101.00
113. 00 11300 INTEREST EXPENSE			1			112 00
114. 00/11400/UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	114.00
116. 00 11600 HOSPI CE	0	3, 744, 569		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24, 911, 250	567, 538, 085				118.00
NONREI MBURSABLE COST CENTERS	24,711,230	307, 330, 003	5,51	0 0		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	o	0		0 0		190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.02
190. 03 19003 LI FELI NE	0	0		0 0	0	190.03
190. 04 19004 COMMUNI TY RELATI ONS	0	0		0 0	0	190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0	0	190.05
190.06 19006 PROFESSI ONAL DEVELOPMENT	0	0		0 0	0	190.06
190. 07 19007 FOUNDTI ON	0	0		0 0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190. 08
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	3, 365, 096	5, 396, 157	1, 457, 91	9 0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 135083	0. 009508	414. 41699	8 0. 000000	0. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	79, 053	161, 265				204.00
Part II)	, 000	, 200				
205.00 Unit cost multiplier (Wkst. B, Part	0. 003173	0. 000284	10. 14155	8 0. 000000	0.000000	205.00
	'					

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS		GOSHEN HOSPITAL Provider CCN: 15		CN: 15-0026	Peri od:	u of Form CMS-2552- Worksheet B-1
					From 01/01/2016 To 12/31/2016	Date/Time Prepare
		INTEDNS &	RESIDENTS			5/25/2017 2:47 pm
			-			
	Cost Center Description		SERVI CES-OTHE	PARAMED ED		
		RY & FRI NGES APPRV	R PRGM COSTS APPRV	PRGM (ASSI GNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TIME)	TIME)			
	CENEDAL SEDVICE COST CENTEDS	21.00	22.00	23.00		
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.
. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5.
. 02 . 00	00590 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS					5.
. 00	00700 OPERATION OF PLANT					7.
. 00	00800 LAUNDRY & LINEN SERVICE					8.
. 00	00900 HOUSEKEEPI NG					9.
0.00	01000 DI ETARY					10.
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL					11. 12.
	01300 NURSI NG ADMI NI STRATI ON					13.
	01400 CENTRAL SERVICES & SUPPLY	1				14.
	01500 PHARMACY					15.
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16.
	01900 NONPHYSI CLAN ANESTHETI STS					17. 19.
	02000 NURSI NG SCHOOL					20.
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0				21.
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.
3.00	02300 PARAMED ED PRGM			10	00	23.
0. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0		0	30.
	03100 I NTENSI VE CARE UNI T	0	0		0	30.
	03200 CORONARY CARE UNI T	0	0		0	32.
	03300 BURN INTENSIVE CARE UNIT	0	0		0	33.
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	34.
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF				0	40.
	04200 SUBPROVI DER	0	0		0	42.
	04300 NURSERY	0	0		0	43.
	04400 SKI LLED NURSI NG FACI LI TY	0	0		0	44.
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	45. 46.
0.00	ANCI LLARY SERVICE COST CENTERS		0			
	05000 OPERATI NG ROOM	0			0	50.
	05100 RECOVERY ROOM	0	0		0	51.
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	52. 53.
	05301 PALN MANAGEMENT	0	0		0	53.
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.
	05500 RADI OLOGY-THERAPEUTI C	0	0		0	55.
	05600 RADI OI SOTOPE	0	0		0	56.
	05601 CARDIAC CATH LAB 05700 CT SCAN				0	56. 57.
	05800 MRI	0	0		0	58.
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.
	06000 LABORATORY	0	0		0	60.
	06001 BLOOD LABORATORY	0	0		0	60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		n –		0	61. 62.
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63.
4.00	06400 I NTRAVENOUS THERAPY	0	0		0	64.
	06500 RESPIRATORY THERAPY	0	0		0	65.
	06600 PHYSICAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0	66. 67.
	06800 SPEECH PATHOLOGY		0 0		o	68.
	06900 ELECTROCARDI OLOGY		0		0	69.
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS				0	73.
	07500 ASC (NON-DI STI NCT PART)	0	0		0	75.
8.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	88.

Health Financial Systems		GOSHEN HC	SPI TAL			In Lie	u of Form	CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS			Provider CO	CN: 15-0026	Period: From 01/0	1/201/	Worksheet	B-1
							Date/Time 5/25/2017	
		INTERNS &	RESI DENTS					
Cost Center Descripti	on	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED				
		RY & FRINGES	R PRGM COSTS	PRGM				
		APPRV	APPRV	(ASSI GNED				
		(ASSI GNED	(ASSI GNED	TIME)				
		TIME) 21.00	TIME) 22.00	23.00				
90. 00 09000 CLINIC		0	0	23.00	0			90.0
90. 02 09002 WOUND CLINIC		0	0		0			90.0
90. 03 09003 MOBILE CLINIC		0	0		0			90.0
91.00 09100 EMERGENCY		0	0	1	00			91.0
92.00 09200 OBSERVATION BEDS (NON								92.0
OTHER REIMBURSABLE COST CE	NTERS		-					
99.00 09900 CMHC		0	0		0			99.0
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTE	DC	0	0		0			101.0
113. 00 11300 INTEREST EXPENSE	NJ							113.0
114. 00 11400 UTI LI ZATI ON REVIEW-SM	NF							114.0
115. 00 11500 AMBULATORY SURGICAL		0	0		0			115.0
116.00 11600 HOSPI CE		0	0		0			116. C
118.00 SUBTOTALS (SUM OF LIN		0	0	1	00			118.0
NONREI MBURSABLE COST CENTE					-			
190. 00 19000 GI FT, FLOWER, COFFEE		0	0		0			190.0
190. 01 19001 OTHER NR/CHP-GRANT I		0	0		0			190.0
190. 02 19002 GI FT, FLOWER, COFFEE 190. 03 19003 LI FELI NE	SHUP, & CANTEE	0	0		0			190. C 190. C
190. 04 19003 LIFELINE 190. 04 19004 COMMUNITY RELATIONS		0	0		0			190. C
190. 05 19005 PRI VATE DUTY		0	0		0			190.0
190. 06 19006 PROFESSI ONAL DEVELOPM	MENT	0	0		0			190.0
190. 07 19007 FOUNDTI ON		0	0		0			190.0
190.08 19008 GOSHEN GACC CLINIC		0	0		0			190.0
191.00 19100 RESEARCH		0	0		0			191.0
192.00 19200 PHYSI CI ANS' PRI VATE (OFFI CES	0	0		0			192.0
193.00 19300 NONPALD WORKERS		0	0		0			193. C
200.00 Cross Foot Adjustment								200.0
201.00 Negative Cost Centers			~	070 /	F 1			201.0
202.00 Cost to be allocated Part I)	(per WKST. B,	0	0	279, 6	51			202.0
203.00 Unit cost multiplier	(Wkst B Part I)	0. 000000	0. 000000	2, 796. 5100	00			203.0
203.00 Cost to be allocated		0.00000	0.000000	2,790.0100				203.0
Part II)		J J	0	0,0				
205.00 Unit cost multiplier	(Wkst. B, Part	0. 000000	0. 000000	60. 9200	00			205.0
1)								

	ancial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0026	Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016		epared:
			Title	XVIII	Hospi tal	PPS	
	Cost Contor Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	Cost Center Description	(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		2100			01.00	
	0 ADULTS & PEDIATRICS	21, 545, 332		21, 545, 33		21, 545, 332	
	0 INTENSIVE CARE UNIT 10 CORONARY CARE UNIT	4, 943, 828		4, 943, 82	28 0	4, 943, 828 0	
	0 BURN I NTENSI VE CARE UNI T	0			0 0	0	
	O SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	0 SUBPROVI DER – I PF 10 SUBPROVI DER – I RF	0			0 0	0	
	0 SUBPROVIDER - TRF	0				0	
1	0 NURSERY	1, 025, 558		1, 025, 5	58 0	1, 025, 558	
	O SKILLED NURSING FACILITY	0			0 0	0	
	0 NURSING FACILITY 0 OTHER LONG TERM CARE	0			0 0	0	
	LLARY SERVICE COST CENTERS	0	I		0 0	0	40.00
50.00 0500	O OPERATING ROOM	18, 622, 679		18, 622, 6	79 0	18, 622, 679	
	O RECOVERY ROOM	1, 319, 782		1, 319, 78		1, 319, 782	
	0 DELIVERY ROOM & LABOR ROOM 10 ANESTHESIOLOGY	3, 722, 448		3, 722, 44	18 0	3, 722, 448 0	
	1 PALN MANAGEMENT	771, 876		771, 8	76 8, 978	780, 854	
	O RADI OLOGY-DI AGNOSTI C	32, 108, 935		32, 108, 93		32, 458, 294	
	0 RADI OLOGY-THERAPEUTI C	780, 940		780, 94	40 0	780, 940	
	0 RADI OI SOTOPE 11 CARDI AC CATH LAB	3, 103, 904		3, 103, 90		0 3, 103, 904	
	O CT SCAN	0		3, 103, 7	0 0	0	
		0			0 0	0	
	O CARDI AC CATHETERI ZATI ON	0		7 7 0 0	0 0	0	
	0 LABORATORY 11 BLOOD LABORATORY	7, 769, 015		7, 769, 0		7, 769, 015 0	
	0 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	
	WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	62.00
	0 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	
	0 I NTRAVENOUS THERAPY 0 RESPI RATORY THERAPY	2, 401, 399	0	2, 401, 39	0 0 99 0	0 2, 401, 399	
	0 PHYSI CAL THERAPY	4, 368, 148		4, 368, 14		4, 368, 148	
	O OCCUPATI ONAL THERAPY	1, 054, 571	0	1, 054, 5		1, 054, 571	
	0 SPEECH PATHOLOGY 0 ELECTROCARDI OLOGY	663, 106	0	663, 10		663, 106	
	0 ELECTROENCEPHALOGRAPHY	468, 469		468, 46	0 0	468, 469 0	
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	9, 884, 556		9, 884, 5		9, 884, 556	
	O IMPL. DEV. CHARGED TO PATIENTS	7, 577, 088		7, 577, 08		7, 577, 088	
73.00 0730	0 DRUGS CHARGED TO PATIENTS 0 RENAL DIALYSIS	36, 562, 984		36, 562, 98	34 0 0 0	36, 562, 984	73.00
75.00 0750	0 ASC (NON-DISTINCT PART)	0			0 0	0	
OUTP	ATIENT SERVICE COST CENTERS		1		-1		
	O RURAL HEALTH CLINIC	0			0 0	0	
89.00 0890 90.00 0900	O FEDERALLY QUALIFIED HEALTH CENTER	0 662, 305		662, 30	0 0	0 662, 305	
	2 WOUND CLINIC	2, 681, 602		2, 681, 60		2, 681, 602	
90.03 0900	3 MOBILE CLINIC	0			0 0	0	90.03
	O EMERGENCY	7, 661, 940		7,661,94		7, 770, 720	
	0 OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS	2,916,109		2, 916, 10)9	2, 916, 109	92.00
99.00 0990		0			0	0	99.00
101.001010	O HOME HEALTH AGENCY	3, 924, 538		3, 924, 53		3, 924, 538	
	I AL PURPOSE COST CENTERS		1				110 0-
	0 INTEREST EXPENSE 10 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
	0 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115.00
116.00 1160	O HOSPI CE	2, 342, 279		2, 342, 2		2, 342, 279	116.00
200.00	Subtotal (see instructions)	178, 883, 391	0			179, 350, 508	
201.00 202.00	Less Observation Beds Total (see instructions)	2, 916, 109 175, 967, 282		2, 916, 10 175, 967, 28		2, 916, 109 176, 434, 399	
202.00		1 175, 907, 282	I 0	1/5, 907, 20	407,117	170, 434, 399	202.00

	ancial Systems N OF RATIO OF COSTS TO CHARGES	GOSHEN HO	Provi der C	CN: 15-0026	In Lie Period:	u of Form CMS- Worksheet C	2552-10
COMPUTATIO				CN. 15-0020	From 01/01/2016 To 12/31/2016	Part I	-nared
						5/25/2017 2:4	
			Charges	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	ATIENT ROUTINE SERVICE COST CENTERS	· · · ·				L	
	DO ADULTS & PEDIATRICS	44, 917, 329		44, 917, 3			30.00
	DO INTENSIVE CARE UNIT DO CORONARY CARE UNIT	12, 900, 646		12, 900, 6	40		31.00 32.00
	DO BURN I NTENSI VE CARE UNI T	0			0		33.00
	DO SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
	DO SUBPROVIDER - IPF	0			0		40.00
	DO SUBPROVIDER - IRF	0			0		41.00
	DO SUBPROVI DER	0		0.051.0	0		42.00
	DO NURSERY DO SKILLED NURSING FACILITY	2, 251, 076		2, 251, 0	0		43.00
	DO NURSING FACILITY	0			0		45.00
	DO OTHER LONG TERM CARE	0			0		46.00
ANCI	LLARY SERVICE COST CENTERS				·	-	
	DO OPERATING ROOM	18, 444, 053	44,077,218			0.00000	
	DO RECOVERY ROOM	1, 771, 958	3, 560, 142				
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY	8, 119, 620	0		20 0. 458451 0 0. 000000	0.000000	
	DI PALN MANAGEMENT	1, 146	1, 214, 070				
	DO RADI OLOGY-DI AGNOSTI C	11, 416, 249	92, 339, 317			0.000000	
	DO RADI OLOGY-THERAPEUTI C	75, 152	1, 272, 805			0.000000	
	DO RADI OI SOTOPE	0	0		0 0.000000	0.00000	56.00
	D1 CARDI AC CATH LAB	9, 782, 443	11, 500, 681	21, 283, 1			
	DO CT SCAN	0	0		0 0.000000		
	DO MRI DO CARDIAC CATHETERIZATION	0	0		0 0. 000000 0 0. 000000	0.000000	
	DO LABORATORY	13, 528, 052	25, 476, 723	39,004,7		0.000000	
	D1 BLOOD LABORATORY	0	20, 170, 720	0,,001,,	0 0.000000		
	DO PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0. 000000		
	DO WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0. 000000		
	DO BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000		
	DO I NTRAVENOUS THERAPY DO RESPI RATORY THERAPY	6, 076, 325	1, 403, 153	7, 479, 4	0 0. 000000 78 0. 321065		
	DO PHYSI CAL THERAPY	1, 287, 855	5, 020, 378				
	DO OCCUPATI ONAL THERAPY	1, 128, 875	1, 648, 681				
	DO SPEECH PATHOLOGY	159, 268	1, 406, 725			0.00000	
69.00 0690	DO ELECTROCARDI OLOGY	1, 193, 318	3, 393, 122	4, 586, 4	40 0. 102142	0.00000	69.00
	DO ELECTROENCEPHALOGRAPHY	0	0		0 0.000000		
	DO MEDI CAL SUPPLI ES CHARGED TO PATI ENT	4, 939, 241	3, 667, 003				
	DO IMPL. DEV. CHARGED TO PATIENTS	8, 841, 862 32, 853, 158	6, 784, 418 136, 892, 429				
	DO RENAL DI ALYSI S	32, 853, 158	130, 892, 429		0 0. 000000		
	DO ASC (NON-DISTINCT PART)	0	0		0 0.000000		
	PATIENT SERVICE COST CENTERS	1					
	DO RURAL HEALTH CLINIC	0	0	1	0		88.00
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	1 205 925			0 000000	89.00
	DO CLINIC D2 WOUND CLINIC	3, 300 27, 581	1, 295, 825 5, 339, 881				
	D3 MOBILE CLINIC	27, 381	5, 559, 661 0		0 0.000000		
	DO EMERGENCY	5, 015, 172	22, 561, 220	27, 576, 3			
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	270, 000	8, 163, 297				
	ER REIMBURSABLE COST CENTERS	1 1		1		Γ	
99.00 0990 101 00 1010	DO CMHC DO HOME HEALTH AGENCY	0	0 1, 772, 749		0		99.00 101.00
SPEC	CIAL PURPOSE COST CENTERS						
113.001130	DO INTEREST EXPENSE						113.00
	DO UTILIZATION REVIEW-SNF						114.00
	DO AMBULATORY SURGICAL CENTER (D. P.)	0	0 744 540	0 744 -	0		115.00
116.001160 200.00	DO HOSPICE Subtotal (see instructions)	0 185, 003, 679	3, 744, 569 382, 534, 406				116.00 200.00
		100,003,079	302, 334, 406	507, 538, 0	55		
200.00	Less Observation Beds						201.00

	Financial Systems TION OF RATIO OF COSTS TO CHARGES	GOSHEN HOS	Provider CCN: 15-0026	Peri od:	of Form CMS- Worksheet C	2002-1
				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
			Title XVIII	Hospi tal	5/25/2017 2:4 PPS	4/pm
	Cost Center Description	PPS Inpatient				
		Ratio 11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
	D3000 ADULTS & PEDIATRICS					30.00
	D3100 INTENSIVE CARE UNIT D3200 CORONARY CARE UNIT					31.00
	03300 BURN I NTENSI VE CARE UNI T					33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
	D4000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
	04200 SUBPROVI DER					42.00
	D4300 NURSERY					43.00
	04400 SKILLED NURSING FACILITY					44.00
	04500 NURSING FACILITY					45.00
-	04600 OTHER_LONG_TERM_CARE					46.00
	D5000 OPERATI NG ROOM	0. 297861				50.00
	D5100 RECOVERY ROOM	0. 247516				51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0. 458451				52.00
53.00 0	D5300 ANESTHESI OLOGY	0. 000000				53.00
53.01	D5301 PALN MANAGEMENT	0. 642564				53.0
	D5400 RADI OLOGY-DI AGNOSTI C	0. 312834				54.00
	D5500 RADI OLOGY-THERAPEUTI C	0. 579351				55.00
	D5600 RADI OI SOTOPE	0. 000000				56.0
	D5601 CARDI AC CATH LAB	0. 145839				56.0
	D5700 CT SCAN	0. 000000				57.0
	D5800 MRI D5900 CARDI AC CATHETERI ZATI ON	0. 000000				58.0
	D6000 LABORATORY	0. 199181				60.00
	D6001 BLOOD LABORATORY	0. 000000				60.0
	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000				62.00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	D6400 I NTRAVENOUS THERAPY	0. 000000				64.00
	06500 RESPI RATORY THERAPY	0. 321065				65.00
	06600 PHYSI CAL THERAPY	0. 692452				66.00
	06700 OCCUPATI ONAL THERAPY	0. 379676				67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0. 423441 0. 102142				68.00 69.00
	D7000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 148533				71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 484894				72.0
73.00	D7300 DRUGS CHARGED TO PATIENTS	0. 215399				73.00
	07400 RENAL DI ALYSI S	0. 000000				74.00
	D7500 ASC (NON-DISTINCT PART)	0. 000000				75.00
	DUTPATIENT SERVICE COST CENTERS					00 00
	D8800 RURAL HEALTH CLINIC D8900 FEDERALLY QUALIFIED HEALTH CENTER					88.00
	09000 CLINIC	0. 509809				90.00
	D9002 WOUND CLINIC	0. 499603				90.02
	D9003 MOBILE CLINIC	0. 000000				90.03
	D9100 EMERGENCY	0. 281789				91.00
-	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 345785				92.00
	OTHER REIMBURSABLE COST CENTERS	1				
	09900 CMHC					99.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS					101.00
	11300 INTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0026	Period: From 01/01/2016	Worksheet C Part I	
				To 12/31/2016		pared:
		Titl	e XIX	Hospi tal	Cost	1
Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	04 545 000		04 545 0		04 545 000	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	21, 545, 332 4, 943, 828		21, 545, 3 4, 943, 8		21, 545, 332 4, 943, 828	•
32. 00 03200 CORONARY CARE UNIT	0)		0 0	0	
33. 00 03300 BURN I NTENSI VE CARE UNI T	0			0 0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF				0 0	0	
41.00 04100 SUBPROVI DER – I RF	0)		0 0	0	•
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY)	1 025 51	0 0	1 025 559	
44. 00 04400 SKILLED NURSING FACILITY	1, 025, 558		1, 025, 5	0 0	1, 025, 558 0	1
45.00 04500 NURSING FACILITY	0			0 0	0	45.00
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0			0 0	0	46.00
50. 00 05000 OPERATING ROOM	18, 622, 679		18, 622, 6	79 0	18, 622, 679	50.00
51.00 05100 RECOVERY ROOM	1, 319, 782		1, 319, 7		1, 319, 782	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	3, 722, 448		3, 722, 4	18 0 0 0	3, 722, 448 0	1
53. 01 05301 PALN MANAGEMENT	771, 876		771, 8	0 0		•
54.00 05400 RADI OLOGY-DI AGNOSTI C	32, 108, 935		32, 108, 9		32, 458, 294	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	780, 940		780, 94	40 0 0 0	780, 940 0	•
56. 01 05601 CARDI AC CATH LAB	3, 103, 904		3, 103, 90	0	3, 103, 904	•
57.00 05700 CT SCAN	0			0 0	0	
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00 06000 LABORATORY	7, 769, 015		7, 769, 0	15 0	7, 769, 015	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	•
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 401, 399 4, 368, 148		2, 401, 3 4, 368, 1		2, 401, 399 4, 368, 148	•
67. 00 06700 OCCUPATI ONAL THERAPY	1, 054, 571		1, 054, 5		1, 054, 571	
68. 00 06800 SPEECH PATHOLOGY	663, 106		663, 10		663, 106	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	468, 469		468, 40	0 0	468, 469 0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 884, 556		9, 884, 5		9, 884, 556	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 577, 088		7, 577, 0		7, 577, 088 36, 562, 984	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	36, 562, 984 0		36, 562, 98	34 0 0 0		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0)		0 0		•
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		1		0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	
90. 00 09000 CLINIC	662, 305		662, 30		662, 305	90.00
90. 02 09002 WOUND CLINIC 90. 03 09003 MOBILE CLINIC	2, 681, 602		2, 681, 60	0 0	2, 681, 602 0	•
90. 03 109003 MOBILE CLINIC 91. 00 109100 EMERGENCY	7, 661, 940		7, 661, 9			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 916, 109		2, 916, 10		2, 916, 109	
99.00 09900 CMHC	0	1	1	0	0	99.00
101.00 10100 HOME HEALTH AGENCY	3, 924, 538		3, 924, 5		0 3, 924, 538	
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	2, 342, 279		2, 342, 2		2, 342, 279	116.00
200.00Subtotal (see instructions)201.00Less Observation Beds	178, 883, 391 2, 916, 109		178, 883, 3 2, 916, 10		179, 350, 508 2, 916, 109	
202.00 Total (see instructions)	175, 967, 282					
		•	•			•

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	GOSHEN HO		CN: 15-0026	Peri od:	u of Form CMS- Worksheet C	2002-10
					From 01/01/2016 To 12/31/2016	Part I	narod
						5/25/2017 2:4	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
		(0.00		Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	-
30.00	03000 ADULTS & PEDI ATRI CS	44, 917, 329		44, 917, 32	29		30. 00
31.00	03100 INTENSIVE CARE UNIT	12, 900, 646		12, 900, 64	46		31.00
32.00	03200 CORONARY CARE UNIT	0			0		32.00
	03300 BURN I NTENSI VE CARE UNI T	0			0		33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0			0		34.00
41.00	04100 SUBPROVI DER – I RF	0			0		41.00
42.00	04200 SUBPROVI DER	0			0		42.00
43.00	04300 NURSERY	2, 251, 076		2, 251, 0	76		43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
45.00	04500 NURSI NG FACI LI TY	0			0		45.00
46.00	04600 OTHER LONG TERM CARE	0			0		46.00
50.00	ANCILLARY SERVICE COST CENTERS	18, 444, 053	44, 077, 218	62, 521, 2	0. 297861	0. 000000	50.00
	05100 RECOVERY ROOM	1, 771, 958	3, 560, 142				
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 119, 620	C			0. 000000	
53.00	05300 ANESTHESI OLOGY	0	C		0 0.000000	0. 000000	
	05301 PALN MANAGEMENT	1, 146	1, 214, 070			0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 416, 249	92, 339, 317			0. 000000 0. 000000	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	75, 152	1, 272, 805 C		0. 579351 0. 000000	0. 000000	
	05601 CARDI AC CATH LAB	9, 782, 443	11, 500, 681			0. 000000	
	05700 CT SCAN	0	C (1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		0 0.000000	0. 000000	
58.00	05800 MRI	0	C		0 0.000000	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0.000000	0. 000000	
60.00	06000 LABORATORY	13, 528, 052	25, 476, 723	39, 004, 7		0.00000	
	06001 BLOOD LABORATORY	0	C		0 0.000000	0.00000	
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0. 000000 0 0. 000000	0. 000000 0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0.000000	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0.000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	6, 076, 325	1, 403, 153	7, 479, 4	0. 321065	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	1, 287, 855	5, 020, 378			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	1, 128, 875	1, 648, 681			0.00000	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	159, 268	1, 406, 725			0.00000	
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 193, 318	3, 393, 122 C		40 0. 102142 0 0. 000000	0. 000000 0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 939, 241	3, 667, 003			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 841, 862	6, 784, 418			0.00000	
	07300 DRUGS CHARGED TO PATIENTS	32, 853, 158	136, 892, 429	169, 745, 58			73.00
	07400 RENAL DI ALYSI S	0	C		0 0.000000		
75.00	07500 ASC (NON-DI STI NCT PART)	0	C	0	0 0.00000	0. 000000	75.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C		0 0.00000	0. 000000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0.000000		
90.00	09000 CLINIC	3, 300	1, 295, 825			0. 000000	
90. 02	09002 WOUND CLINIC	27, 581	5, 339, 881		0. 499603	0. 000000	90. 02
	09003 MOBILE CLINIC	0	C		0 0.000000	0.00000	
	09100 EMERGENCY	5, 015, 172	22, 561, 220			0.00000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	270, 000	8, 163, 297	8, 433, 29	0. 345785	0.00000	92.00
99.00	09900 CMHC	0	C		0		99.00
	10100 HOME HEALTH AGENCY	0	1, 772, 749				101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF		-				114.00
	11500 AMBULATORY SURGI CAL CENTER (D. P.) 11600 HOSPI CE	0	C 3, 744, 569	3, 744, 50	40		115.00 116.00
116.00 200.00		185, 003, 679	3, 744, 569 382, 534, 406				200.00
		100,000,017	002,004,400				201.00
201.00							

		GOSHEN HOS			u of Form CMS-255	52-10
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepa	ared
					5/25/2017 2:47	
	Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	Cost	
	·	Rati o 11.00				
	TIENT ROUTINE SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·		
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT					30. 00 31. 00
	DO CORONARY CARE UNIT					31.00 32.00
	DO BURN INTENSIVE CARE UNIT					33. OC
34.00 0340	OO SURGICAL INTENSIVE CARE UNIT					34.00
	00 SUBPROVIDER - IPF					40.00
	00 SUBPROVI DER – I RF					41.00
	00 SUBPROVI DER 00 NURSERY					42.00
	00 SKILLED NURSING FACILITY					43.00 44.00
	DO NURSING FACILITY					45. OC
	OO OTHER LONG TERM CARE					46.00
ANCI	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM	0. 000000				50.00
	DO RECOVERY ROOM	0.000000				51.00
	00 DELIVERY ROOM & LABOR ROOM 00 ANESTHESIOLOGY	0.000000				52.00
	DI PALN MANAGEMENT	0.000000				53.00 53.01
	DO RADI OLOGY-DI AGNOSTI C	0. 000000				53.01 54.00
	00 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
	DO RADI OI SOTOPE	0. 000000				56.00
	D1 CARDI AC CATH LAB	0. 000000				56. Oʻ
	DO CT SCAN	0.000000				57.00
		0.000000				58.00
	00 CARDI AC CATHETERI ZATI ON 00 LABORATORY	0.000000				59.00 60.00
	D1 BLOOD LABORATORY	0. 000000				60. 00 60. 01
	OO PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				61.00
62.00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			6	62.00
	DO BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	DO I NTRAVENOUS THERAPY	0.000000				64.00
		0.000000				65.00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0.000000				66.00 67.00
	DO SPEECH PATHOLOGY	0. 000000				68. OC
	DO ELECTROCARDI OLOGY	0.000000				69.00
70.00 0700	DO ELECTROENCEPHALOGRAPHY	0. 000000			7	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
	00 I MPL. DEV. CHARGED TO PATI ENTS	0.000000				72.00
	00 DRUGS CHARGED TO PATIENTS 00 RENAL DIALYSIS	0.000000				73.00 74.00
	00 ASC (NON-DISTINCT PART)	0. 000000				74.00 75.00
	PATIENT SERVICE COST CENTERS	0.000000			· · · · · · · · · · · · · · · · · · ·	
	00 RURAL HEALTH CLINIC	0.000000			8	88.00
	0 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. OC
		0.00000				90.00
	22 WOUND CLINIC	0.000000				90.02
	03 MOBILE CLINIC DO EMERGENCY	0. 000000 0. 000000				90.03 91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				91. UC 92. OC
	R REIMBURSABLE COST CENTERS	0.000000			/	. 2. 00
99.00 0990	ОО СМНС					99. OC
	O HOME HEALTH AGENCY				10	01.00
	CIAL PURPOSE COST CENTERS	1 1				40.0-
	DOUTLITATION DEVIEW SNE					13.0C 14.0C
	00 UTILIZATION REVIEW-SNF 00 AMBULATORY SURGICAL CENTER (D.P.)					14.00 15.00
116.001160	. ,					16. OC
200.00	Subtotal (see instructions)					00.00
201.00	Less Observation Beds				20	01.00
202.00	Total (see instructions)				20	02.00

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Title	XVIII	Hospi tal	PPS	<u>, bui</u>
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I		. · · · ·			
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SUBGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVI DER - IPF 41. 00 SUBPROVI DER - IRF 42. 00 SUBPROVI DER 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30-199) Cost Center Description	1, 049, 399 350, 303 0 0 0 0 42, 784 0 1, 442, 486 I npati ent Program days	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 049, 39 350, 30 42, 78 1, 442, 48	33 2,939 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 04 2,448 0 0 0 0 0 0	0.00 17.48 0.00	31.00 32.00 33.00 34.00 40.00 41.00 42.00
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	6, 615 1, 045 0 0 0 0 0 0 0 0 0 0 0 7, 660	343, 252 124, 554 0 0 0 0 0 0 0 0 0 0 0 0 0 467, 806				30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 200.00

Health Financial Systems	GOSHEN H				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSIS	Provider C	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016		
		Title	e XVIII	Hospi tal	PPS	7 pili
Cost Center Description	Capi tal	Total Charges			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	
ANCI LLARY SERVICE COST CENTERS			T			
50. 00 05000 OPERATI NG ROOM	2, 130, 063					50.00
51.00 O5100 RECOVERY ROOM	66, 820					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	209, 378				-	52.00
53. 00 05300 ANESTHESI OLOGY	0	-			-	53.00
53. 01 05301 PALN MANAGEMENT	11, 214				7	53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 483, 400					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	69, 265				993	55.00
56. 00 05600 RADI OI SOTOPE	0	-	0100000		Ŭ	56.00
56. 01 05601 CARDI AC CATH LAB	295, 175				40, 542	56.01
57.00 05700 CT SCAN	0	-	0100000		0	57.00
58. 00 05800 MRI	0	, s			Ŭ	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-	0100000		0	59.00
60. 00 06000 LABORATORY	275, 378	39, 004, 775			40, 098	60.00
60.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 00	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-			0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	-			u u	64.00
65. 00 06500 RESPI RATORY THERAPY	79, 738					65.00
66. 00 06600 PHYSI CAL THERAPY	307, 882				32, 707	66.00
67.00 06700 OCCUPATI ONAL THERAPY	14, 111	2, 777, 556			3, 022	67.00
68.00 06800 SPEECH PATHOLOGY	8, 613					68.00
69. 00 06900 ELECTROCARDI OLOGY	119, 045					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-			-	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152, 751					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	119, 126				33, 896	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	501, 463				35, 958	73.00
74.00 07400 RENAL DIALYSIS	0	-			-	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0	0.0000	0 00	0	75.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
88.00 08800 RURAL HEALTH CLINIC	0	-			-	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			-	89.00
90. 00 09000 CLINIC	50, 133					90.00
90. 02 09002 WOUND CLINIC	287, 878					90.02
90. 03 09003 MOBILE CLINIC	0	, s	0100000		e e	90.03
91.00 09100 EMERGENCY	491, 601					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	142, 035					92.00
200.00 Total (lines 50-199)	7, 815, 069	501, 951, 716		48, 209, 746	679, 296	1200.00

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
			XVIII	Hospi tal	PPS	
Cost Center Description		Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	o	0		0	0	33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	
41. 00 04100 SUBPROVI DER – I RF	0	0			0	
42. 00 04200 SUBPROVI DER	0	0			0	
43. 00 04300 NURSERY	0	0		0	0	
44. 00 04400 SKILLED NURSING FACILITY	0	0		0		
45. 00 04400 SKILLED NORSING FACILITY 45. 00 04500 NURSING FACILITY	0	0			-	
	0	0			0	
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Pati ent	Per Diem	Inpatient	I npati ent		
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	20, 222	0.00				30.00
31.00 03100 INTENSIVE CARE UNIT	2, 939	0.00	1, 04	15 0		31.00
32.00 03200 CORONARY CARE UNIT	0	0.00		0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0.00		0 0		34.00
40. 00 04000 SUBPROVI DER – I PF	o	0.00		0 0		40.00
41. 00 04100 SUBPROVIDER – IRF	0	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0 0		42.00
43. 00 04300 NURSERY	2, 448	0.00		0 0		43.00
44. 00 04400 SKI LLED NURSING FACILITY	2, 440	0.00		0 0		44.00
45. 00 04400 SKILLED NORSING FACILITY 45. 00 04500 NURSING FACILITY	0	0.00				44.00
200.00 Total (lines 30-199)	25,609	0.00	7,60	0		45.00 200.00
200.00 10tal (11185 30-199)	20, 009		7,00		I	∠00. 00

Health Financial Systems	GOSHEN HOSF	PI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared: 7 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Healt		Total Cost	
	Anestheti st	School		Medi cal	(sum of col 1	
	Cost			Education	through col.	
	1.00			Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1	0	0	
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			-	52.00
53. 00 05300 ANESTHESI OLOGY 53. 01 05301 PALN MANAGEMENT	0	0			0	53.00 53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			-	53.01
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0	0			0	55.00
56. 00 05600 RADI 0L0GY - THERAPEOTIC	0	0			Ű	56.00
	0	0		0 0	0	
56. 01 05601 CARDI AC CATH LAB 57. 00 05700 CT SCAN	0	0			0	56.01 57.00
58. 00 05800 MRI	0	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			0	59.00
60. 00 06000 LABORATORY	0	0			0	60.00
60. 01 06000 BLOOD LABORATORY	0	0			0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/ 0.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 02 09002 WOUND CLINIC	0	0		0 0	0	90.02
90. 03 09003 MOBILE CLINIC	0	0		0 0	0	90.02
91. 00 09100 EMERGENCY	0	0	279, 6	-	279, 651	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	277,031	92.00
200.00 Total (lines 50-199)	0	0			-	•
	1 01	0	2.7,0		2,001	

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	GOSHEN H		CN: 15 0024	In Lie Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	RVICE UTHER PAS	S Provider C	CN: 15-0026	From 01/01/2016		
				To 12/31/2016	Date/Time Pre	pared:
					5/25/2017 2:4	7 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)	7.00	0.00	col. 7)	10.00	
ANCILLADY SEDVICE COST CENTEDS	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	62, 521, 271	0.00000	0.00000	5, 355, 592	50.00
51. 00 05100 RECOVERY ROOM	0				605, 474	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				005,474	51.00
53. 00 05300 ANESTHESI OLOGY	0				0	52.00
	0	-				
53. 01 05301 PALN MANAGEMENT 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	.,			748 5, 124, 990	53.01
	0					
55. 00 05500 RADI OLOGY-THERAPEUTI C	-	.,			19, 327	55.00
56. 00 05600 RADI 0I SOTOPE	0		0100000		0	56.00
56. 01 05601 CARDI AC CATH LAB	0				2, 923, 187	56.01
57. 00 05700 CT SCAN	0	-	0,00000		0	57.00
58. 00 05800 MRI	0	-			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-	0,00000		0	59.00
60. 00 06000 LABORATORY	0	39,004,775			5, 679, 670	•
60. 01 06001 BLOOD LABORATORY	0	0	0.0000	0. 000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	-			0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-			0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	-	0100000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	.,			1, 953, 550	
66. 00 06600 PHYSI CAL THERAPY	0				670, 142	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0				594, 840	•
68.00 06800 SPEECH PATHOLOGY	0	.,			88, 220	
69. 00 06900 ELECTROCARDI OLOGY	0	.,			594, 949	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				4, 446, 492	
73.00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
74.00 07400 RENAL DIALYSIS	0				0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0.00000	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	-			0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	89.00
90. 00 09000 CLINIC	0	.,,				•
90. 02 09002 WOUND CLINIC	0					90.02
90. 03 09003 MOBILE CLINIC	0	-	0,00000			90.03
91.00 09100 EMERGENCY	279, 651				2, 883, 249	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0/ 100/ 2//		0. 000000		
200.00 Total (lines 50-199)	279, 651	501, 951, 716			48, 209, 746	200.00

Health Financial Systems	GOSHEN HC		011 15 000/		u of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/25/2017 2:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h		
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0 0 0	8, 679, 038 736, 917 0		0 0 0		50.00 51.00 52.00
53. 00 05300 ANESTHESI OLOGY 53. 01 05301 PALN MANAGEMENT 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 0 0	0 178, 536 27, 141, 018		0 0 0		53.00 53.01 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 56. 01 05601 CARDI AC CATH LAB	0 0 0	536, 010 0 3, 729, 583		0 0 0		55.00 56.00 56.01
57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0 0 0	0 0 0		0 0 0		57.00 58.00 59.00
60.00 LABORATORY 60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0 0	4, 827, 388 0	1	0		60.00 60.01 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	0 0 0	0 0 0		0 0 0		62.00 63.00 64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	414, 640 50, 345 51, 825		0 0 0		65.00 66.00 67.00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY	0	8, 152 904, 487 0		0 0 0		68.00 69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 667, 003 2, 266, 030 35, 353, 897		0		71.00 72.00 73.00
74.00 07400 RENAL DI ALYSI S 75.00 07500 ASC (NON-DI STI NCT PART)	0	0		0		74.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		88. 00 89. 00
90. 00 09000 CLINIC 90. 02 09002 WOUND CLINIC 90. 03 09003 MOBILE CLINIC	0	411, 601 2, 281, 430 0		0 0 0		90.00 90.02 90.03
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50-199)	29, 239 0 29, 239	4, 057, 189 2, 022, 693 97, 317, 782		44 0		91.00 92.00 200.00

Health Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2016		
			-	To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared: 7 pm
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C, Part I, col.	inst.)	Subject To Ded. & Coins.	Subject To Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1100	2100	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	0. 297861	8, 679, 038	(25	2, 585, 147	50.00
51.00 05100 RECOVERY ROOM	0. 247516	736, 917	(0 0	182, 399	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 458451	0) (0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0) (0 0	0	53.00
53.01 05301 PALN MANAGEMENT	0. 635176			0 0	113, 402	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 309467				8, 399, 249	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 579351	536, 010		0 0	310, 538	
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
56.01 05601 CARDI AC CATH LAB	0. 145839			0 0	543, 919	
57. 00 05700 CT SCAN	0. 000000			0 0	0	57.00
58. 00 05800 MRI	0. 000000			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			0	0	59.00
60. 00 06000 LABORATORY	0. 199181	4, 827, 388			961, 524	•
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				0	60.01 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 321065				133, 126	•
66. 00 06600 PHYSI CAL THERAPY	0. 692452				34, 861	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 379676			0 0	19,677	67.00
68.00 06800 SPEECH PATHOLOGY	0. 423441	8, 152		0 0	3, 452	
69.00 06900 ELECTROCARDI OLOGY	0. 102142			0 0	92, 386	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 148533	3, 667, 003	(0 0	4, 211, 674	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 484894	2, 266, 030	1,604	4 0	1, 098, 784	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 215399	35, 353, 897	36, 44	9 106, 691	7, 615, 194	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000			0 0	0	
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000	0	(0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS	0.000000	1	1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000				0	89.00
90. 02 09000 CLINIC 90. 02 09002 WOUND CLINIC	0. 509809 0. 499603				209, 838 1, 139, 809	90.00 90.02
90. 03 09003 MOBILE CLINIC	0. 499803		5		1, 139, 609	90.02
91. 00 09100 EMERGENCY	0. 277844				1, 127, 266	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 345785			0 0	699, 417	92.00
200.00 Subtotal (see instructions)	0.010/00	97, 317, 782				•
201.00 Less PBP Clinic Lab. Services-Program				0 0	2,, 101,002	201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		97, 317, 782	40, 16	106, 850	29, 481, 662	202.00

APPORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi d	er CCN: 15-0026	Period: From 01/01/2 To 12/31/2	Prepared
			T	itle XVIII	Hospi tal	PS
		Cos	sts			
	Cost Center Description	Cost	Cost			
		Reimbursed	Reimburs	ed		
		Servi ces	Servi ces	Not		
		Subject To	Subj ect			
		Ded. & Coins.	Ded. & Coi			
		(see inst.)	(see ins	t.)		
		6.00	7.00			
	ARY SERVICE COST CENTERS					
	OPERATING ROOM	0		7		50.00
	RECOVERY ROOM	0		0		51.00
	DELIVERY ROOM & LABOR ROOM	0		0		52.00
	ANESTHESI OLOGY	0		0		53.00
	PALN MANAGEMENT RADI OLOGY-DI AGNOSTI C	0 21		0 41		53.01 54.00
	RADI OLOGY - DI AGNOSTI C RADI OLOGY - THERAPEUTI C	0		41		54.00
	RADI OLOGY – THERAPEOTIC RADI OI SOTOPE	0		0		55.00
	CARDI AC CATH LAB	0		0		56.00
	CARDIAC CATH LAD	0		0		57.00
58.00 05800		0		0		58.00
	CARDI AC CATHETERI ZATI ON	0		o		59.00
	LABORATORY	357		o		60.00
	BLOOD LABORATORY	0		o		60.01
	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		Ŭ		61.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0		0		62.00
	BLOOD STORING, PROCESSING & TRANS.	0		o		63.00
	INTRAVENOUS THERAPY	0		0		64.00
	RESPI RATORY THERAPY	13		0		65.00
66.00 06600	PHYSI CAL THERAPY	0		0		66.00
67.00 06700	OCCUPATI ONAL THERAPY	0		0		67.00
68.00 06800	SPEECH PATHOLOGY	0		0		68.00
	ELECTROCARDI OLOGY	0		0		69.00
	ELECTROENCEPHALOGRAPHY	0		0		70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		71.00
	IMPL. DEV. CHARGED TO PATIENTS	778		0		72.00
	DRUGS CHARGED TO PATIENTS	7, 851	22	, 981		73.00
1 1	RENAL DI ALYSI S	0		0		74.00
	ASC (NON-DISTINCT PART)	0		0		 75.00
	I ENT SERVICE COST CENTERS			-		
	RURAL HEALTH CLINIC	0		0		88.00
	FEDERALLY QUALIFIED HEALTH CENTER	0		0		89.00
90.00 09000 90.02 09002		0		0		90.00 90.02
	WOUND CLINIC MOBILE CLINIC	28		o		90.02
	EMERGENCY	42		o		90.03
	OBSERVATION BEDS (NON-DISTINCT PART	42		o		91.00
1 1	Subtotal (see instructions)	9, 090	22	, 029		200.00
	Less PBP Clinic Lab. Services-Program	9,090	23	, 027		200.00
	Only Charges	0				201.00
J 11						

OMPUT	Financial Systems (ATION OF INPATIENT OPERATING COST	GOSHEN HOSPITAL Provider CCN: 15-0026	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and sw			20, 222	1.
00 00	Inpatient days (including private room days, exclu Private room days (excluding swing-bed and observa			20, 222 0	
	do not complete this line.		privato room dajo,		
00 00	Semi-private room days (excluding swing-bed and ob Total swing-bed SNF type inpatient days (including		ber 31 of the cost	17, 485 0	
00	reporting period Total swing-bed SNF type inpatient days (including	private room dave) after Decembr	or 21 of the cost	0	4
00	reporting period (if calendar year, enter 0 on this		and the cost	U	6
00	Total swing-bed NF type inpatient days (including reporting period	private room days) through Decemb	er 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including		· 31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on thi Total inpatient days including private room days a		ng swing-bed and	6, 615	9
). 00	newborn days) Swing-bed SNF type inpatient days applicable to ti	tle XVIII only (including private	e room days)	0	10
	through December 31 of the cost reporting period (see instructions)	5 /		
. 00	Swing-bed SNF type inpatient days applicable to ti December 31 of the cost reporting period (if calen		; room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to tit through December 31 of the cost reporting period	les V or XIX only (including priv	vate room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to tit			0	13
. 00	after December 31 of the cost reporting period (if Medically necessary private room days applicable to			0	14
. 00	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable reporting period	e to services through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable	e to services after December 31 c	of the cost	0.00	18
9. 00	reporting period Medicaid rate for swing-bed NF services applicable	to services through December 31	of the cost	0.00	19
). 00	reporting period Medicaid rate for swing-bed NF services applicable	to services after December 31 of	[*] the cost	0.00	20
	reporting period			21 646 222	21
	Total general inpatient routine service cost (see Swing-bed cost applicable to SNF type services thr		orting period (line	21, 545, 332 0	
3.00	5 x line 17) Swing-bed cost applicable to SNF type services aft	er December 31 of the cost report	ing period (line A	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services thro 7 x line 19)	ugh December 31 of the cost repor	ting period (line	0	24
5.00	Swing-bed cost applicable to NF type services afte x line 20)	r December 31 of the cost reporti	ng period (line 8	0	25
	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swin PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	g-bed cost (line 21 minus line 26)	21, 545, 332	27
	General inpatient routine service charges (excludi	ng swing-bed and observation bed	charges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed cha General inpatient routine service cost/charge ratio	0		0 0. 000000	
	Average private room per diem charge (line 29 ÷ li			0.00	
	Average semi-private room per diem charge (line 30			0.00	
	Average per diem private room charge differential	(line 32 minus line 33)(see instr	ructi ons)	0.00	
	Average per diem private room cost differential (I			0.00	
	Private room cost differential adjustment (line 3			0	
. 00	General inpatient routine service cost net of swin	g-bed cost and private room cost	differential (line	21, 545, 332	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUG				
	Adjusted general inpatient routine service cost pe	r diem (see instructions)		1,065.44	38
		0 11 202	I		0.00
9.00	Program general inpatient routine service cost (i Medically necessary private room cost applicable t			7, 047, 886 0	

	Financial Systems TATION OF INPATIENT OPERATING COST	GOSHEN HO	Provider C	CN- 15 0004	Period:	u of Form CMS- Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST		Provider C		From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
	Cost Center Description	Total	Title Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2) 3.00	4.00	col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	1.00	2.00		4.00 0 0		42.00
	Intensive Care Type Inpatient Hospital Units			1			
43.00 44.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	4, 943, 828 0	2, 939 0			1, 757, 847 C	
45.00	BURN INTENSIVE CARE UNIT	0	0			C	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.0	0 0	C	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	· .					1.00	
48.00 49.00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			anc)		17, 541, 658	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	JIIS)		26, 347, 391	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	467, 806	50.00
51.00	<pre>III) Pass through costs applicable to Program inp.</pre>	ationt ancillar	v services (f	rom Wkst D	sum of Parts II	708, 535	51.00
51.00	and IV)		y services (i	TOIL WKST. D,		700, 330	51.00
52.00	Total Program excludable cost (sum of lines		lated		action '	1, 176, 341	
53.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 1		elated, non-ph	ysıcıan anest	netist, and	25, 171, 050	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 C	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	C	
58.00	Bonus payment (see instructions)					0	
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996,	updated and c	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less that					C	61.00
	amount (line 56), otherwise enter zero (see		.5 (TTHES 54 X	00), 01 1% 0	i the target		
62.00	Relief payment (see instructions)					C	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)				63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	C	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	te aftar Docomh	or 21 of the	cost conortin	a pariod (Saa	C	65.00
05.00	instructions) (title XVIII only)			Cost reporting	g period (see	(05.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	ll only). For	C	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	C	67.00
07.00	(line 12 x line 19)				opor tring period		07.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		C	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
72.00	Program routine service cost (line 9 x line		The 70 + The	2)			72.00
73.00	Medically necessary private room cost applic	0	•				73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II column		74.00
75.00	26, line 45)	fout the service		Norksheet D,			/ 5.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77.00
79.00	Aggregate charges to beneficiaries for excess	,	orovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 mi	nus line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00 82.00
83.00	Reasonable inpatient routine service costs (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 86.00
20.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						30.00
		\				0 707	
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					2, 737 1, 065. 44	

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		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, 049, 399	21, 545, 332	0.04870	2, 916, 109	142, 035	90.00
91.00 Nursing School cost	0	21, 545, 332	0.00000	0 2, 916, 109	0	91.00
92.00 Allied health cost	0	21, 545, 332	0.00000	0 2, 916, 109	0	92.00
93.00 All other Medical Education	0	21, 545, 332	0.00000	2, 916, 109	0	93.00

	Financial Systems (ATION OF INPATIENT OPERATING COST	GOSHEN HOSPITAL Provider CCN: 15-0026	Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	
			To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
	Cast Castor Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and sw			20, 222	
00 00	Inpatient days (including private room days, exclu Private room days (excluding swing-bed and observa do not complete this line.			20, 222 7, 965	
00 00	Semi-private room days (excluding swing-bed and ob Total swing-bed SNF type inpatient days (including		ber 31 of the cost	9, 520 0	
00	reporting period Total swing-bed SNF type inpatient days (including	private room days) after Decembe	r 31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on thi Total swing-bed NF type inpatient days (including	s line)		0	-
00	reporting period Total swing-bed NF type inpatient days (including		31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this Total inpatient days including private room days a		ng swing-bed and	1, 081	Ģ
. 00	newborn days) Swing-bed SNF type inpatient days applicable to ti through December 31 of the cost reporting period (tle XVIII only (including private	room days)	0	10
. 00		tle XVIII only (including private	room days) after	0	1
. 00			ate room days)	0	1:
. 00				0	1:
	Medically necessary private room days applicable to Total nursery days (title V or XIX only)	o the Program (excluding swing-be	d days)	0 2, 448	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			151	
. 00	Medicare rate for swing-bed SNF services applicable reporting period	e to services through December 31	of the cost	0.00	11
. 00	Medicare rate for swing-bed SNF services applicable reporting period	e to services after December 31 o	f the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable reporting period	to services through December 31	of the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable reporting period	to services after December 31 of	the cost	0.00	20
	Total general inpatient routine service cost (see Swing-bed cost applicable to SNF type services thro 5 x line 17)		rting period (line	21, 545, 332 0	
. 00	Swing-bed cost applicable to SNF type services aft x line 18)	er December 31 of the cost report	ing period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services thro 7 x line 19)	ugh December 31 of the cost repor	ting period (line	0	24
. 00	Swing-bed cost applicable to NF type services afte x line 20)	r December 31 of the cost reporti	ng period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swin	g-bed cost (line 21 minus line 26)	0 21, 545, 332	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excludi	ng swing-bed and observation bed	charges)	38, 309, 528	29
	Private room charges (excluding swing-bed charges)			21, 969, 991	
	Semi -private room charges (excluding swing-bed cha			16, 339, 537	
	General inpatient routine service cost/charge ratio			0. 562401	
	Average private room per diem charge (line 29 ÷ li	-		2, 758. 32	
	Average semi-private room per diem charge (line 30			1, 716. 34	
	Average per diem private room charge differential		uctions)	1, 041. 98	
	Average per diem private room cost differential (I			586.01	
	Private room cost differential adjustment (line 3 General inpatient routine service cost net of swim		differential (line	4, 667, 570 16, 877, 762	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
~ ~	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUG				
	Adjusted general inpatient routine service cost pe	r aiem (see instructions)		834.62	
	Becker and the second	0 1: 00			
9.00	Program general inpatient routine service cost (li Medically necessary private room cost applicable to			902, 224 0	

	I FINANCIAL SYSTEMS	GOSHEN HO	Provider C	CN: 15-0026	Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
	Cost Contor Description	Total		e XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00		1, 025, 558	2, 448	418.9	4 151	63, 260	42.0
2 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1	2,939	1 402 1	E 100	306, 151	1 1 2
3.00 4.00	CORONARY CARE UNIT	4, 943, 828	2, 939			306, 151	
5.00	BURN I NTENSI VE CARE UNI T	0	0			0	
6.00		0	0			0	
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1 00	
8.00	Program inpatient ancillary service cost (W	kst D-3 col 3	Line 200)			1.00 473,831	48.
9.00	5		· · · ·	ons)		1, 745, 466	
	PASS THROUGH COST ADJUSTMENTS			,			
0. 00	Pass through costs applicable to Program in	patient routine	services (fro	n Wkst. D, su	m of Parts I and	0	50.
1 00)			Wiet D	and the Develop 11	0	
61.00	Pass through costs applicable to Program in and IV)	patrent and tran	y services (1)	OM WKSL. D,	Sum of Parts II	0	51.
52.00	Total Program excludable cost (sum of lines	50 and 51)				C	52.
53.00	Total Program inpatient operating cost excl		lated, non-ph	ysician anest	netist, and	0	53.
	medical education costs (line 49 minus line	52)					
1 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.
4.00	5					0.00	
6.00	Target amount (line 54 x line 55)					0.00	
7.00	5	ting cost and ta	irget amount (ine 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)	-				0	58.
9.00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, i	updated and c	ompounded by the	0.00	59.
0.00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the	markat baskat		0.00	60.
50.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			0		
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ictions)			0	63.0
4.00		sts through Dece	mber 31 of the	e cost report	ing period (See	0	64.
	instructions)(title XVIII only)					-	
5.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the o	cost reportin	g period (See	0	65.
	instructions)(title XVIII only)					0	
6. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	The costs (Tine	64 prus rine (55)(title XVI	TI ONLY). FOR	0	66. (
57.00	· · ·	ne costs through	December 31	of the cost r	eporting period	C	67.0
	(line 12 x line 19)	5					
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.0
59.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costa (lino 47 i lin	- 49)		C	69.0
J7. 00	PART III - SKILLED NURSING FACILITY, OTHER N					0	09.0
0. 00	Skilled nursing facility/other nursing faci)		70.
1.00	Adjusted general inpatient routine service	cost per diem (l		•			71.
2.00	Program routine service cost (line 9 x line	,		25)			72.
'3.00 '4.00	Medically necessary private room cost applie	U C	•				73.
4.00 5.00	Total Program general inpatient routine services Capital-related cost allocated to inpatient				Part II. column		74.
2.00	26, line 45)		55515 (11000				, 5.
6.00	Per diem capital-related costs (line 75 ÷ 1	,					76.
7.00	Program capital-related costs (line 9 x line						77.
8.00 9.00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce	,	rovidor roccr	de)			78.
9.00 0.00	Total Program routine service costs for com	• •			nus 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	•	is)				83.
4.00	Program inpatient ancillary services (see in		>				84.
5.00 6.00	Utilization review - physician compensation Total Program inpatient operating costs (su	•					85. 86.
0.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		n ough 657				- 00.
37.00	Total observation bed days (see instruction					2, 737	87.
	Adjusted general inpatient routine cost per		line 2)			1,065.44	
38.00	Observation bed cost (line 87 x line 88) (se					2, 916, 109	

Health Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Ti tl	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, 049, 399	21, 545, 332	0. 04870	7 2, 916, 109	142, 035	90.00
91.00 Nursing School cost	0	21, 545, 332	0.00000	0 2, 916, 109	0	91.00
92.00 Allied health cost	0	21, 545, 332	0.00000	0 2, 916, 109	0	92.00
93.00 All other Medical Education	0	21, 545, 332	0.00000	0 2, 916, 109	0	93.00

eal th Financial Systems GOSH NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	IEN HOSPI TAL Provi der (CCN: 15-0026	Peri od:	u of Form CMS-: Worksheet D-3	
		0010. 10 0020	From 01/01/2016		
			To 12/31/2016		
		e XVIII	Hospi tal	5/25/2017 2:4 PPS	i/pm
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center beschiption		To Charges		Program Costs	
		l lo ondriges	Charges	(col. 1 x	
			strating see	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			15, 640, 726		30.0
31.00 03100 INTENSIVE CARE UNIT			5, 438, 891		31.0
32.00 03200 CORONARY CARE UNIT			0		32.0
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.0
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.0
IO. 00 04000 SUBPROVI DER – I PF			0		40.0
1.00 04100 SUBPROVIDER - IRF			0		41.0
2. 00 04200 SUBPROVI DER			0		42.0
3.00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS			(4) 5 055 500	1 505 000	
0.00 OSOOO OPERATING ROOM		0. 2978		1, 595, 222	
1.00 05100 RECOVERY ROOM		0. 2475		149, 865	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4584		0	
3.00 05300 ANESTHESI OLOGY		0.0000		0	
3. 01 05301 PALN MANAGEMENT		0. 6425		481	
4.00 05400 RADI OLOGY-DI AGNOSTI C		0. 3128		1, 603, 271	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 5793		11, 197	
66.00 O5600 RADI OI SOTOPE		0.0000		0	
66.01 O5601 CARDI AC CATH LAB		0. 1458		426, 315	
57.00 05700 CT SCAN		0.0000		0	
8.00 05800 MRI		0.0000		0	
59.00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
0.00 06000 LABORATORY		0. 1991		1, 131, 282	
00.01 06001 BLOOD LABORATORY		0.0000		0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
22.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
33.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
04.00 06400 INTRAVENOUS THERAPY		0.0000		0	
55.00 06500 RESPIRATORY THERAPY		0.3210		627, 217	
66.00 06600 PHYSI CAL THERAPY		0.6924		464, 041	
57.00 06700 OCCUPATIONAL THERAPY		0. 3796		225, 846	
v8. 00 06800 SPEECH PATHOLOGY v9. 00 06900 ELECTROCARDI OLOGY		0. 4234		37, 356	
		0. 1021		60, 769	
		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.1485		5, 510, 449	
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4848		2, 156, 077	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2153		2, 621, 970	
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	
		0.0000	00 0	0	75.0
0UTPATI ENT_SERVICE_COST_CENTERS 38. 00 08800 RURAL_HEALTH_CLINIC		0.0000	00	0	88.0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
20. 00 099001 EDERALET ODALITTED TILALITT CENTER		0. 5098		1, 677	
20. 02 09002 WOUND CLINIC		0. 3098		12, 811	
0. 02 09002 WORD CEINIC 00. 03 09003 MOBILE CLINIC		0. 4998		0	
0. 03 09003 MOBILE CEINIC 01. 00 09100 EMERGENCY		0. 2817		812, 468	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2817		93, 344	
200.00 Total (sum of lines 50-94 and 96-98)		0. 3437	48, 209, 746	17, 541, 658	
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 41)		40, 209, 740	17, 341, 030	200.0
			· · · · · · · · · · · · · · · · · · ·		

	nci al Systems GOSHEN GOSHEN VCI LLARY SERVI CE COST APPORTI ONMENT	HOSPITAL Provider C	CN: 15-0026	Peri od:	u of Form CMS-2 Worksheet D-3	
			011. 10 0020	From 01/01/2016		,
				To 12/31/2016		
		T: +I	0 VI V	Hospi tal	5/25/2017 2:4	1/pm
	Cost Center Description		e XIX Ratio of Cos		Cost Inpatient	
	cost center bescription		To Charges		Program Costs	
				Charges	(col. 1 x	
				ondi ges	col. 2)	
			1.00	2.00	3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			580, 870		30.0
	INTENSIVE CARE UNIT			87, 595		31.0
	CORONARY CARE UNIT			0		32.0
	BURN INTENSIVE CARE UNIT			0		33.00
34.00 03400	SURGI CAL I NTENSI VE CARE UNI T			0		34.0
40.00 04000	SUBPROVIDER - IPF			0		40.00
	SUBPROVIDER – IRF			0		41.0
	SUBPROVI DER			0		42.0
	NURSERY			1, 041, 165		43.00
	LARY SERVICE COST CENTERS		0.0070	4	10.00/	1 - 0 - 0
	OPERATI NG ROOM		0. 2978		48, 306	
	RECOVERY ROOM		0. 2475		4, 338	
	DELIVERY ROOM & LABOR ROOM		0. 4584		0	
	ANESTHESI OLOGY		0.0000		0	
	PAIN MANAGEMENT		0. 6351		0	
	RADI OLOGY-DI AGNOSTI C		0. 3094		52, 100	
	RADI OLOGY-THERAPEUTI C		0. 5793		429	
	RADI OI SOTOPE		0.0000		0	
	CARDIAC CATH LAB		0. 1458		4, 176	
	CT SCAN		0.0000		0	
58.00 05800			0.0000		0	
	CARDI AC CATHETERI ZATI ON		0.0000		0	
			0. 1991		39, 366	
	BLOOD LABORATORY		0.0000		0	
	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
	BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
	INTRAVENOUS THERAPY		0.0000		0	
	RESPI RATORY THERAPY		0.3210		26, 563	
	PHYSI CAL THERAPY		0.6924		7,093	
	OCCUPATIONAL THERAPY		0.3796		3, 244	1
	SPEECH PATHOLOGY ELECTROCARDI OLOGY		0. 4234		561 932	
	ELECTROEARDI OLOGI		0. 1021		932	
	MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1485		162, 383	
	IMPL. DEV. CHARGED TO PATIENTS		0. 4848		0 102, 363	
	DRUGS CHARGED TO PATIENTS		0. 4848		96, 732	
	RENAL DIALYSIS		0.2153		90,732	
	ASC (NON-DI STINCT PART)		0.0000		0	
	TIENT SERVICE COST CENTERS		0.0000	00 0	0	15.00
	RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
	FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	CLINIC		0.5098		0	
	WOUND CLINIC		0. 4996		186	1
	MOBILE CLINIC		0.0000		0	
	EMERGENCY		0. 2778		27, 422	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 3457		0	
200.00	Total (sum of lines 50-94 and 96-98)		0.0107	1, 376, 574	473, 831	
	Less PBP Clinic Laboratory Services-Program only ch		1	., 0, 0, 0, 4	1, 0, 001	
201.00	LESS FOR CITILL LADUIALULY SELVICES-FLOUIAM ONLY CI	arges (line 61)		()		201.0

	Financial Systems GOSHEN ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0026	Period: From 01/01/2016	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1.00	DRG amounts other than outlier payments for discharges oc instructions)	curring prior to October 1	(see	0	1.0 [°]
1.02	DRG amounts other than outlier payments for discharges or instructions)	5		14, 055, 935	1.02
1.03	DRG for federal specific operating payment for Model 4 BP 1 (see instructions)	0 0		0	1.0
1.04 2.00	DRG for federal specific operating payment for Model 4 BP October 1 (see instructions) Outlier payments for discharges. (see instructions)	on or arter	883, 265	2.0	
2. 01	Outlier reconciliation amount			0	2.0
2.02 3.00	Outlier payment for discharges for Model 4 BPCI (see inst Managed Care Simulated Payments		0	2. C 3. C	
4.00	Bed days available divided by number of days in the cost Indirect Medical Education Adjustment	reporting period (see instr	uctions)	115. 52	4.0
. 00	FTE count for allopathic and osteopathic programs for the or before $12/31/1996$. (see instructions)				
5. 00 7. 00	FTE count for allopathic and osteopathic programs which m for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specif			0.00	6. C
7.00	ACA Section 5503 reduction amount to the IME cap as speci If the cost report straddles July 1, 2011 then see instru	fied under 42 CFR §412.105(0.00	7.0
3. 00	Adjustment (increase or decrease) to the FTE count for al affiliated programs in accordance with 42 CFR 413.75(b), 1998), and 67 FR 50069 (August 1, 2002).	lopathic and osteopathic pr	5	0.00	8.0
. 01	The amount of increase if the hospital was awarded FTE ca the cost report straddles July 1, 2011, see instructions.	0.00	8.0		
. 02	The amount of increase if the hospital was awarded FTE ca under section 5506 of ACA. (see instructions)	ing hospital	0.00	8.0	
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus instructions)		(see	0.00	
0.00	FTE count for allopathic and osteopathic programs in the FTE count for residents in dental and podiatric programs.	current year from your reco	rds	0.00	10.0
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that otherwise enter zero.	it year ended on or after Se	ptember 30, 1997,	0.00	
5.00 6.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 0.00	
7.00	Adjustment for residents displaced by program or hospital	closure		0.00	
8.00	Adjusted rolling average FTE count			0.00	
9.00	Current year resident to bed ratio (line 18 divided by li Prior year resident to bed ratio (see instructions)	ne 4).		0.000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0	1
2.01	IME payment adjustment - Managed Care (see instructions)	Section 422 of the MMA		0	22.
3.00	Indirect Medical Education Adjustment for the Add-on for Number of additional allopathic and osteopathic IME FTE r (f)(1)(iv)(C).		Sec. 412.105	0.00	23.
4.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter	the lower of line 23 or lin	e 24 (see	0.00 0.00	
6. 00	Resident to bed ratio (divide line 25 by line 4)		0 21 (000	0.000000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	27.
8.00	IME add-on adjustment amount (see instructions)	i ons)		0	
8.01 9.00 9.01	IME add-on adjustment amount - Managed Care (see instruct Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and			0	29.
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part	: A patient days (see instru	ctions)	2.55	
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			20. 48 23. 03	
32.00 33.00	Allowable disproportionate share percentage (see instruct	i ons)		23.03	
	Disproportionate share adjustment (see instructions)	,		294, 823	

		IN HOSPITAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016		pared:
		Title XVIII	Hospi tal	5/25/2017 2:4 PPS	/ pm
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
35.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6, 406, 145, 534	0	35.00
35.00	Factor 3 (see instructions)		0. 000119355	0. 000118167	1
	Hospital uncompensated care payment (If line 34 is zer	ro, enter zero on this line)	764, 606	706, 339	
	(see instructions)				
35.03 36.00	Pro rata share of the hospital uncompensated care payme Total uncompensated care (sum of columns 1 and 2 on lin		572, 410 750, 446	178, 036	35.03 36.00
30.00	Additional payment for high percentage of ESRD benefici				30.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excl		0		40.00
	652, 682, 683, 684 and 685 (see instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		41.00
41.01	instructions) Total ESRD Medicare covered and paid discharges excludi	ng MS-DRGs 652 682 683 684	0		41.01
	an 685. (see instructions)	g	Ŭ		
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs	552, 682, 683, 684 an 685. (see	0		43.00
44.00	instructions) Ratio of average length of stay to one week (line 43 di	vided by line 41 divided by 7	0.00000		44.00
11.00	days)	the in a theory in	0.000000		11.00
45.00	Average weekly cost for dialysis treatments (see instru	· · · · · · · · · · · · · · · · · · ·	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times l	ine 41.01)	0		46.00
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and	MDH small rural bospitals	15, 984, 469		47.00 48.00
40.00	only. (see instructions)	Mult, small fular hospitals	0		40.00
				Amount	
				1.00	
49.00 50.00	Total payment for inpatient operating costs (see instru Payment for inpatient program capital (from Wkst. L, P			15, 984, 469 1, 198, 455	
51.00	Exception payment for inpatient program capital (Hom WKst. E, F			1, 170, 433	1
52.00	Direct graduate medical education payment (from Wkst. I			0	•
53.00	Nursing and Allied Health Managed Care payment			0	
54.00 54.01	Special add-on payments for new technologies			2, 071 0	1
55.00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,	line 69)		0	1
56.00	Cost of physicians' services in a teaching hospital (se	ee intructions)		Ő	56.00
57.00	Routine service other pass through costs (from Wkst. D,		hrough 35).	0	
58.00	Ancillary service other pass through costs from Wkst. [), Pt. IV, col. 11 line 200)		29, 239	
59.00 60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			17, 214, 234 11, 585	
61.00	Total amount payable for program beneficiaries (line 59	9 minus line 60)		17, 202, 649	
62.00	Deductibles billed to program beneficiaries	,		1, 685, 432	
63.00	Coinsurance billed to program beneficiaries			21, 896	
64.00 65.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			66, 748 43, 386	
65.00 66.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (se	e instructions)		43, 386 22, 368	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	· · · · · · · · · · · · · · · · · · ·		15, 538, 707	
68.00	Credits received from manufacturers for replaced device			0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 an	nd 96).(For SCH see instruction	s)	0	1
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	
70.88	SCH or MDH volume decrease adjustment			0	
70.89	Pioneer ACO demonstration payment adjustment amount (se			0	70.89
70 00	HSP bonus payment HVBP adjustment amount (see instructi	ons)		0	
70.90	HSP bonus payment HRR adjustment amount (see instruction	ons)		0	
70. 91	Rundlad Modal 1 discount amount (coo instructions)				1 /0.92
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			-	
70. 91 70. 92	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			41, 526 -91, 377	70.93

ALCULATION OF REIMBURSEMENT SETTLEMENT 0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1) 0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter		XVIII	Peri od: From 01/01/2016 To 12/31/2016 Hospi tal	Date/Time Pre 5/25/2017 2:4 PPS	
the corresponding federal year for the period prior to 10/1)					7 piii
the corresponding federal year for the period prior to 10/1)	in column O	FFY	$(\mathbf{V}\mathbf{V}\mathbf{V}\mathbf{V})$		
the corresponding federal year for the period prior to 10/1)	in column O			Amount	
the corresponding federal year for the period prior to 10/1)	in column O		0	1.00	
0.97 Low volume adjustment for federal fiscal year (VVVV) (Enter			0	0	
the corresponding federal year for the period ending on or a			0	0	70.97
0.98 Low Volume Payment-3				0	70.98
0.99 HAC adjustment amount (see instructions)			0	70.99	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines			15, 488, 856	71.00	
1.01 Sequestration adjustment (see instructions)				309, 777	71.01
2.00 Interim payments				15, 029, 616	72.00
3.00 Tentative settlement (for contractor use only)				0	73.00
4.00 Balance due provider (Program) (line 71 minus lines 71.01, 7			149, 463	74.00	
5.00 Protested amounts (nonallowable cost report items) in accord		2, 162, 251	75.00		
CMS Pub. 15-2, chapter 1, §115.2					1
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see in	structions)			0	1 /01 00
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	1 / 00
2.00 Operating outlier reconciliation adjustment amount (see inst				0	
3.00 Capital outlier reconciliation adjustment amount (see instru				0	
4.00 The rate used to calculate the time value of money (see inst				0.00	
5.00 Time value of money for operating expenses (see instructions				0	
6.00 Time value of money for capital related expenses (see instru	ctions)			0	96.00
			Prior to 10/1		<u> </u>
			1.00	2.00	
HSP Bonus Payment Amount			0	0	100.00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100.00
01.00 HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	101 00
02.00 HVBP adjustment amount for HSP bonus payment (see instructions)	nc)		0.000000000		101.00
HRR Adjustment for HSP Bonus Payment	115)		0	0	102.00
03.00 HRR adjustment factor (see instructions)			0.0000	0. 0000	103 00
04.00 HRR adjustment amount for HSP bonus payment (see instruction	s)		0.0000		104.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1. 01	DRG amounts other than outlier payments for	1.01	0		0	0	1.01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	14, 055, 935		14, 055, 935	14, 055, 935	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2.00	883, 265		0 883, 265	883, 265	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0839	0. 083	³⁹ 0. 0839		10.00
11.00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	294, 823		0 294, 823	294, 823	11.00
11.01	Uncompensated care payments Additional payment for high percentage of ES	36.00 RD beneficiary	750, 446	572, 41	178, 036	750, 446	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	15, 984, 469	572, 41	15, 412, 059	15, 984, 469	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15, 984, 469	572, 41	15, 412, 059	15, 984, 469	15.00
16.00	Payment for inpatient program capital	50.00	1, 198, 455		0 1, 198, 455	1, 198, 455	16.00
17.00	Special add-on payments for new technologies	54.00	2, 071		0 2, 071	2, 071	17.00
17.01	Net organ acquisition cost						17.01
	Credits received from manufacturers for	68.00	0		0 0	0	17.02
17.02	Ironlacad dovices for englicable MC DDC-						
17.02	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00

Heal th	Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	6 Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
	Capital DRG other than outlier	1.00	1, 121, 976		0 1, 121, 976	1, 121, 976	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	22, 961		0 22, 961	22, 961	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0 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. 0477	0. 047	7 0. 0477		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	53, 518		0 53, 518	53, 518	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 198, 455		0 1, 198, 455	1, 198, 455	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus payment (see instructions)	70. 96 70. 97 70. 93 70. 90	0 0 41, 526 0		0 0 41, 526 0 0	0 0 41, 526 0	27.00 28.00 29.00 30.00 30.01
	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-91, 377 0		0 -91, 377 0 0	-91, 377 0	31. 00 31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Heal th	Financial Systems GOSH	EN HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0026	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	5/25/2017 2:4 PPS	7 pm
		in the Avith		J	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00 3.00 4.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see PPS payments Outlier payment (see instructions)	instructions)		32, 119 29, 440, 518 17, 855, 294 583, 736	2.00 3.00
5.00 6.00 7.00	Enter the hospital specific payment to cost ratio (see Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6	instructions)		0.000 0 0.00	6.00
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. Organ acquisitions	D, Pt. IV, col. 13, line 200		0 41, 144 0	8.00 9.00
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		32, 119		
12 00	Reasonable charges Ancillary service charges			147, 014	12 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, co Total reasonable charges (sum of lines 12 and 13) Customary charges	I. 4, line 69)		147, 014	13.00
	Aggregate amount actually collected from patients liab Amounts that would have been realized from patients li had such payment been made in accordance with 42 CFR §	able for payment for services		0 0	
18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (comp		ine 11) (see	0. 000000 147, 014 114, 895	18.00
	instructions) Excess of reasonable cost over customary charges (comp	2		0	
22.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for Interns and residents (see instructions)			32, 119 0	22.00
	Cost of physicians' services in a teaching hospital (s Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0 18, 480, 174	
26.00	Deductibles and coinsurance (for CAH, see instructions Deductibles and Coinsurance relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 a instructions)	24 (for CAH, see instructions		1, 235 3, 486, 350 15, 024, 708	26.00
29.00	Direct graduate medical education payments (from Wkst. ESRD direct medical education costs (from Wkst. E-4, I Subtotal (sum of lines 27 through 29)			0 0 15, 024, 708	29.00
31.00	Primary payer payments Subtotal (line 30 minus line 31)			3, 121 15, 021, 587	31.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	L SERVICES)		0 192, 545	
36.00 37.00 38.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (s Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	ee instructions)		125, 154 190, 321 15, 146, 741 54	36.00 37.00 38.00
39. 50 39. 98	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see inst Partial or full credits received from manufacturers fo RECOVERY OF ACCELERATED DEPRECIATION		ctions)	0 0 0	39.50
40.00 40.01 41.00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments			15, 146, 687 302, 934 14, 916, 452	40.00 40.01 41.00
43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in §115.2	accordance with CMS Pub. 15-2,	chapter 1,	0 -72, 699 319, 476	43.00
91.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instruc The reter used to calculate the Time Value of Mensue	tions)		0	91.00
93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	92.00 93.00 94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		14, 979, 31	6 0	14, 851, 252 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/12/2016	50, 30		65, 200	3.01
3.02 3.03				0	0	3.02 3.03
3.03				0	0	3.03
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51 3.52				0	0	3.51 3.52
3.53				0	0	3.53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		50, 30		65, 200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15, 029, 61	6	14, 916, 452	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider				-	
5.01 5.02	TENTATI VE TO PROVI DER			0	0	5.01 5.02
5.02				0	0	5.02
	Provider to Program					
5.50	TENTATIVE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		149, 46	53	0	6.01
6.02	SETTLEMENT TO PROGRAM		15 170 07	0	72,699	6.02
7.00	Total Medicare program liability (see instructions)		15, 179, 07	Contractor	14,843,753 NPR Date	7.00
				Number	(Mo/Day/Yr)	
				Number	(WO/Day/TI)	

Health Financial Systems GOSHEN H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10				
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0026	Period: From 01/01/2016	Worksheet E-1					
		To 12/31/2016						
	Title XVIII	Hospi tal	PPS					
			1.00					
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS								
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION								
1.00 Total hospital discharges as defined in AARA §4102 from W	6, 721	1.00						
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines ?	7, 660 2, 670	2.00 3.00						
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2								
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines ?	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 20,							
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200)		567, 538, 085	5.00				
6.00 Total hospital charity care charges from Wkst. S-10, col.	3 line 20		0	6.00				
7.00 CAH only - The reasonable cost incurred for the purchase of line 168	of certified HIT technology	Wkst. S-2, Pt. I	0	7.00				
8.00 Calculation of the HIT incentive payment (see instructions	5)		0	8.00				
9.00 Sequestration adjustment amount (see instructions)			0	9.00				
10.00 Calculation of the HIT incentive payment after sequestrati	on (see instructions)		0	10.00				
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH								
30.00 Initial/interim HIT payment adjustment (see instructions)			0	30.00				
31.00 Other Adjustment (specify)			0	31.00				
32.00 Balance due provider (line 8 (or line 10) minus line 30 ar	nd line 31) (see instructio	ns)	0	32.00				

	Financial Systems GOSHEN HC E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2016 o 12/31/2016	Worksheet G Date/Time Pre 5/25/2017 2:4	
		General Fund	Speci fi c Purpose Fund	Endowment Fund	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	1, 379, 099	0	0	0	1.00
. 00	Temporary investments	32,000		0	0	2.00
. 00	Notes receivable	0	0	0	0	3.00
. 00 . 00	Accounts receivable Other receivable	73, 947, 798	0	0	0	4.00
. 00	Allowances for uncollectible notes and accounts receivable	-44, 153, 015	-	0	0	6.00
. 00	Inventory	5, 107, 001	0	0	0	7.00
. 00	Prepaid expenses	6, 307, 843	0	0	0	8.00
. 00	Other current assets	0	0	0	0	9.0
0.00	Due from other funds	0	0	0	0	10.0
1.00	Total current assets (sum of lines 1-10) FIXED ASSETS	42, 620, 726	0	0	0	11.0
2.00	Land	4, 027, 467	0	0	0	12.0
3.00	Land improvements	2, 988, 795		0	0	13.00
4.00	Accumulated depreciation	-1, 786, 186	0	0	0	14.0
	Bui I di ngs	110, 030, 840		0	0	15.0
	Accumulated depreciation	-41, 480, 426		0	0	16.0
	Leasehold improvements Accumulated depreciation	113, 748 -111, 695		0	0	17.0 18.0
	Fixed equipment	17, 112, 242	-	0	0	19.0
	Accumulated depreciation	-8, 696, 399		0	0	20.0
1.00	Automobiles and trucks	0	0	0	0	21.0
	Accumulated depreciation	0	0	0	0	22.0
	Major movable equipment	115, 821, 618		0	0	23.0
	Accumulated depreciation Minor equipment depreciable	-86, 649, 155	0	0	0	24.0 25.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets	0	0	0	0	27.0
	Accumulated depreciation	0	0	0	0	28.0
	Minor equipment-nondepreciable	0	0	0	0	29.0
0.00	Total fixed assets (sum of lines 12-29)	111, 370, 849	0	0	0	30.00
1 00	OTHER ASSETS Investments	0	0	0	0	31.0
	Deposits on Leases	0	0	0	0	32.0
3.00	Due from owners/officers	0	0	0	0	33.0
4.00	Other assets	201, 815, 405		0	0	34.0
5.00	Total other assets (sum of lines 31-34)	201, 815, 405		0	0	35.0
6.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	355, 806, 980	0	0	0	36.0
7 00	Accounts payable	5, 039, 855	0	0	0	37.0
	Salaries, wages, and fees payable	8, 344, 046		0	0	38.0
9.00	Payroll taxes payable	447, 571		0	0	39.0
	Notes and loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	41.0
	Accelerated payments Due to other funds	0	0	0	0	42.0 43.0
	Other current liabilities	879, 837	-	0	0	
	Total current liabilities (sum of lines 37 thru 44)	14, 711, 309		0	0	
	LONG TERM LIABILITIES					1
	Mortgage payable	0	0	0	0	
	Notes payable	0	0	0	0	47.0
	Unsecured Loans Other Long term liabilities	45, 471, 343	0	0	0	48.0 49.0
	Total long term liabilities (sum of lines 46 thru 49)	45, 471, 343	-	0	0	50.0
	Total liabilities (sum of lines 45 and 50)	60, 182, 652		0	0	51.0
	CAPI TAL ACCOUNTS					
	General fund balance	295, 624, 328				52.0
	Specific purpose fund		0			53.0
4.00 5.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54.0 55.0
6.00	Governing body created - endowment fund balance - diffestiveted			0		56.0
7.00	Plant fund balance - invested in plant			Ű	0	57.0
	Plant fund balance - reserve for plant improvement,				0	58.0
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	295, 624, 328		0	0	59.0
0.00	Total liabilities and fund balances (sum of lines 51 and	355, 806, 980	0	0	0	60. C

Health Financial Systems	GOSHEN HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016	Worksheet G-1	l epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 TEMPORARILY RESTRICTED ASSETS 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 EQUITY TRANSFER 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	748, 491 0 0 0 0 0 0 17, 975, 597 0 0 0 0 0 0 0 0	284, 764, 166 28, 087, 268 312, 851, 434 748, 491 313, 599, 925 17, 975, 597 295, 624, 328				5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 TEMPORARILY RESTRICTED ASSETS 5.00 6.00 7.00 8.00 9.00 	0			0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 10.00 10.00 Subtotal (line 3 plus line 10) 12.00 EQUITY TRANSFER 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0 0		000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			õ		19.00

	n Financial Systems GOSHEN HO				u of Form CMS-2	
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0026	Period: From 01/01/2016 To 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 5/25/2017 2:4	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services					
1.00	Hospi tal		52, 055, 5		52, 055, 522	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVIDER			0	0	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY			0	0	8.00
9.00	OTHER LONG TERM CARE			0		9.00
10.00			52,055,5	22	52, 055, 522	10.00
11 00	Intensive Care Type Inpatient Hospital Services		10 071 4	10	10 071 (10	11 00
11.00 12.00			13, 371, 6		13, 371, 612	11.00 12.00
	BURN INTENSIVE CARE UNIT			0	0	12.00
13.00				0	0	14.00
				0	0	15.00
	Total intensive care type inpatient hospital services (sum	oflipos	13, 371, 6	10	13, 371, 612	1
10.00	11-15)	of filles	13, 371, 0	12	13, 371, 012	10.00
17.00		16)	65, 427, 1	34	65, 427, 134	17.00
18.00	Ancillary services		108, 672, 5	87 329, 812, 456	438, 485, 043	18.00
19.00	Outpatient services		6, 801, 1	34, 080, 270	40, 881, 454	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
	HOME HEALTH AGENCY			1, 772, 749	1, 772, 749	22.00
23.00	AMBULANCE SERVICES					23.00
24.00				0	0	
25.00				0 0	0	25.00
26.00				0 3, 744, 569	3, 744, 569	
27.00				0 16, 784, 116	16, 784, 116	
27.01	NURSERY		16, 029, 1		18, 738, 865	
28.00		3 to Wkst.	196, 930, 0	64 388, 903, 866	585, 833, 930	28.00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			010 014 0/7		
29.00				218, 244, 367		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0 0		34.00
35.00	Total additions (our of lines 20.25)			0		35.00 36.00
36.00				0		37.00
37.00 38.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
40.00				0		40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			0		41.00
42.00		42)(transfor		218, 244, 367		42.00
-3.00				210, 244, 307		-3.00
	to Wkst. G-3, line 4)					I

Heal th	Financial Systems	GOSHEN HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
STATEM	ENT OF REVENUES AND EXPENSES	Pro	vider CCN: 15-00		Worksheet G-3		
				From 01/01/2016 To 12/31/2016	Date/Time Pre	narod	
				10 12/31/2010	5/25/2017 2:4		
				• ·			
					1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I,		3)		585, 833, 930	1.00	
2.00	Less contractual allowances and discounts on pat	tients' accounts			357, 923, 087	2.00	
3.00	Net patient revenues (line 1 minus line 2)	227, 910, 843	3.00				
4.00	Less total operating expenses (from Wkst. G-2, F	Part II, line 43)			218, 244, 367	4.00	
5.00	Net income from service to patients (line 3 minu		9, 666, 476	5.00			
	OTHER INCOME					6.00	
6.00							
7.00	Income from investments				12, 244, 869	7.00	
8.00	Revenues from telephone and other miscellaneous	communication ser	rvi ces		0	8.00	
9.00	Revenue from television and radio service				0	9.00	
10.00	Purchase di scounts				50, 000	10.00	
11.00	Rebates and refunds of expenses				781, 254		
12.00	Parking lot receipts				0	12.00	
	Revenue from Laundry and Linen service				0	13.00	
	Revenue from meals sold to employees and guests				613, 266		
	Revenue from rental of living quarters				0		
	Revenue from sale of medical and surgical suppli		patients		0		
	Revenue from sale of drugs to other than patient				0		
	Revenue from sale of medical records and abstrac				0		
	Tuition (fees, sale of textbooks, uniforms, etc.				0		
	Revenue from gifts, flowers, coffee shops, and c	canteen			0	20.00	
	Rental of vending machines				0	21.00	
	Rental of hospital space				1, 152, 122		
	Governmental appropriations				0	23.00	
	MISC OTHER OPER/NON OPER REVENUE				3, 579, 281		
	Total other income (sum of lines 6-24)				18, 420, 792		
	Total (line 5 plus line 25)				28, 087, 268		
	OTHER EXPENSES (SPECIFY)				0	27.00	
	Total other expenses (sum of line 27 and subscri				0	28.00	
29.00	Net income (or loss) for the period (line 26 mir	nus line 28)			28, 087, 268	29.00	

	SIS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS		Provider C	CN: 15-0026 15-7174	Period: From 01/01/2016 To 12/31/2016		narod
				HHA CCN:	15-7174	Home Health	Date/Time Pre 5/25/2017 2:4 PPS	7 pm
						Agency I	FF3	_
		Sal ari es	Benefits	Transportatio n (see	rchased	Pu Other Costs	Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Servi ces 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS							
0	Capital Related - Bldg. &			0		0	0	1.0
0	Fixtures Capital Related - Movable			0		3, 784	3, 784	2.0
0	Equipment Plant Operation & Maintenance	0	0	0	60, 6	55 377	61, 032	3.0
0	Transportati on	0	0	0		0 0	0	4.C
0	Administrative and General	705, 403	0	62, 869	17, 2	45 80, 295	865, 812	5.0
0	HHA REIMBURSABLE SERVICES Skilled Nursing Care	664, 932	0	0		0 0	664, 932	6.0
0	Physical Therapy	288, 339	0	0		0 0		
0	Occupational Therapy	118, 467	0	0		0 0	118, 467	
0	Speech Pathology	39, 491	0	0		0 0	39, 491	9.0
00	Medical Social Services	73, 886	0	0		0 0	,	
00	Home Health Aide	51, 414	0	0		0 0	,	
00 00	Supplies (see instructions) Drugs	0	0	0		0 29,002 0 1,553		
00		0	0	0		0 1,553 0 0		
00	HHA NONREI MBURSABLE SERVI CES	0				<u> </u>		
00	Home Dialysis Aide Services	0	0	0		0 0	0	
00	Respiratory Therapy	0	0	0		0 0	-	
00	Private Duty Nursing	0	0	0		0 0	0	
00	Clinic	0	0	0		0 0	0	
00 00	Health Promotion Activities	0	0	0			0	
00	Day Care Program Home Delivered Meals Program	0	0	0			0	20.
00	Ũ	0	0	0		0 0	0	22.
00	All Others (specify)	0	0	0		0 0	0	23.
50	Tel emedi ci ne	0	0	0		0 0	0	23.
00	Total (sum of lines 1-23)	1, 941, 932	0	62, 869			2, 197, 712	24.0
		Recl assi fi cat i on	Reclassified Trial Balance	Adjustments	Net Expense for	S		
		1011	(col. 6 +		Allocation			
			col . 7)		(col. 8 +			
					col. 9)			-
	CENERAL CERVICE COST CENTERS	7.00	8.00	9.00	10.00			
0	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0		0		1 1.
0	Fixtures	0	0	0		0		· · ·
0	Capital Related - Movable Equipment	0	3, 784	0	3, 7	84		2.
	Plant Operation & Maintenance	0	(1 022	0		30		3.
0	i i ante opoi a ti on a mariteoriarioo	0	61, 032	0	61, 0	52		4.
00	Transportati on	0	0	0		0		
0	Transportation Administrative and General	-	0			0		
00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES	0	0 865, 812	0	865, 8	0		5.
00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0 865, 812 664, 932	0	865, 8	0 12 32		
00 00 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES	0	0 865, 812	0	865, 8	0 12 32 39		5. 6.
	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0	0 865, 812 664, 932 288, 339 118, 467 39, 491	0	865, 8 664, 9 288, 3 118, 4 39, 4	0 12 32 39 67 91		5. 6. 7. 8. 9.
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	0	0 865, 812 664, 932 288, 339 118, 467 39, 491 73, 886		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8	0 12 32 39 67 91 86		5. 6. 7. 8. 9. 10.
	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 664, 932 288, 339 118, 467 39, 491 73, 886 51, 414		865, 8 664, 9 288, 3 118, 4 39, 4' 73, 8 51, 4	0 12 33 39 67 91 86 14		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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289		865, 8 664, 9 288, 3 118, 4 39, 4' 73, 8 51, 4 25, 2	0 12 33 39 67 91 86 14 89		5. 6. 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 33 39 67 91 86 14		5. 6. 7. 8. 9. 10. 11. 12. 13.
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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 33 39 67 91 886 14 89 0		5. 6. 7. 8. 9. 10. 11. 12.
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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.
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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 664, 932 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17.
	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0		5. 6. 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.
	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 Homemaker Service	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 865, 812 288, 339 118, 467 39, 491 73, 886 51, 414 25, 289 0 0		865, 8 664, 9 288, 3 118, 4 39, 4 73, 8 51, 4 25, 2	0 12 32 39 67 91 86 14 89 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.

	Financial Systems		GOSHEN HO		211 45 000 (u of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	L COST		Provider CO	IS-7174	Period: From 01/01/2016 To 12/31/2016	Worksheet H-1 Part I Date/Time Pre 5/25/2017 2:4	pared:
						Home Health Agency I	PPS	<u>, biii</u>
			Capital Rel	ated Costs		Agency		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	-
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
2.00	Fixtures Capital Related - Movable	3, 784		3, 784			C	2.00
3.00	Equipment Plant Operation & Maintenance	61, 032	0	0	61, 03	32	O	3.00
4.00 5.00	Transportation Administrative and General	0 865, 812	0	0 3, 784	61, 03	0 0 32 0	930, 628	4.00 5.00
	HHA REIMBURSABLE SERVICES							
6.00 7.00	Skilled Nursing Care Physical Therapy	664, 932 288, 339	0 0	0 0		0 0 0 0	664, 932 288, 339	
8.00	Occupational Therapy	118, 467	0	0		0 0	118, 467	
9.00 10.00	Speech Pathology Medical Social Services	39, 491 73, 886	0 0	0 0		0 0 0 0	39, 491 73, 886	
11.00 12.00	Home Health Aide	51, 414	0	0		0 0	51, 414	•
12.00	Supplies (see instructions) Drugs	25, 289 0	0	0		0	25, 289 0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	C	15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0 0 0		
18.00	Clinic	0	0	0		0 0	0	18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0		0 0		
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0		
23.50	Tel emedi ci ne	0	0	0	(1.0)	0 0	0	23.50
24.00	Total (sum of lines 1-23)	2, 192, 446 Admi ni strati v	Total (cols.	3, 784	61, 03	32 0	2, 192, 446	24.00
		e & General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	0.00	0.00					
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	930, 628						4.00 5.00
	HHA REIMBURSABLE SERVICES		4 455 055					
6.00 7.00	Skilled Nursing Care Physical Therapy	490, 407 212, 659	1, 155, 339 500, 998					6.00 7.00
8.00	Occupational Therapy	87, 373	205, 840					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	29, 126 54, 493	68, 617 128, 379					9.00 10.00
11.00	Home Health Aide	37, 919	89, 333					11.00
12.00 13.00	Supplies (see instructions) Drugs	18, 651 0	43, 940 0					12.00 13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
18.00	Clinic	0	0					18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.50	Tel emedi ci ne	0	0					23.50
∠4.00	Total (sum of lines 1-23)		2, 192, 446					24.00

Heal th	Financial Systems		GOSHEN HO				u of Form CMS-2	
COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Losts					
		BIdgs &	Movabl e	PI ant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1 00	GENERAL SERVICE COST CENTERS	5, 125				0		1.00
1.00	Capital Related - Bldg. & Fixtures	5, 125				0		1.00
2.00	Capital Related - Movable		27, 273			0		2.00
2.00	Equipment		21/210					
3.00	Plant Operation & Maintenance	0	0	5, 125		0		3.00
4.00	Transportation (see	0	0	0	117, 42	3		4.00
	instructions)							
5.00	Administrative and General	5, 125	27, 273	5, 125	3, 02	-930, 628	1, 261, 818	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0	0	69, 31	4 0	664, 932	6.00
7.00	Physical Therapy	0	0	0			288, 339	
8.00	Occupational Therapy	0	0	0	7,48		118, 467	
9.00	Speech Pathology	0	0	0	1, 06		39, 491	
10.00	Medical Social Services	0	0	0	4, 74	7 0	73, 886	10.00
11.00	Home Health Aide	0	0	0	18, 35	51 0	51, 414	11.00
12.00	Supplies (see instructions)	0	0	0		0 0	25, 289	
13.00	Drugs	0	0	0		0		
14.00		0	0	0		0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00	Day Care Program	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	00
23.00	All Others (specify)	0	0	0		0 0	0	
23.50 24.00	Telemedicine Total (sum of lines 1-23)	U E 12E	U בדר דר	5, 125	117 /		1 241 919	20.00
24.00	Cost To Be Allocated (per	5, 125	27, 273 3, 784			-930, 628	1, 261, 818 930, 628	
20.00	Worksheet H-1, Part I)		5,704	01,032			,50,020	20.00
26 00	Unit Cost Multiplier	0. 000000	0. 138745	11. 908683	0. 00000	0	0. 737530	26.00

LUCA	TION OF GENERAL SERVICE COSTS 1	FO HHA COST CEN	TERS	Provider C	CN: 15-0026 15-7174	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pare
						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	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	
		0	1.00	2.00	4.00	5.01	5A. 01	
00	Administrative and General	0	58, 810	22, 479			321, 761	
00	Skilled Nursing Care	1, 155, 339	0	0	219, 63		1, 374, 973	
00	Physical Therapy	500, 998	0	0	95, 24		596, 239	
00	Occupational Therapy	205, 840	0	0	39, 13		244, 971	
)0)0	Speech Pathology Medical Social Services	68, 617 128, 379	0	0	13, 04 24, 40		81, 661 152, 784	
00	Home Heal th Aide	89, 333	0	0	16, 98		106, 316	
00	Supplies (see instructions)	43, 940	0	0	10, 70	0 0	43, 940	
00	Drugs	0	0	0		0 0	0	
00	DME	0	0	0		0 0	0	10
00	Home Dialysis Aide Services	0	0	0		0 0	0	11
00	Respiratory Therapy	0	0	0		0 0	0	12
00	Private Duty Nursing	0	0	0		0 0	0	
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	0		0 0	0	
00	Day Care Program	0	0	0		0 0	0	
00	Home Delivered Meals Program	0	0	0		0 0	0	
00 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	1
50	Telemedicine	0	0	0		0 0	0	
00	Total (sum of lines 1-19) (2)	2, 192, 446	58, 810	22, 479	641, 44	10 7,470	2, 922, 645	
00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus						0. 000000	
	column 26, line 1, rounded to							
	<u>6 decimal places.</u> Cost Center Description	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	cost center bescription	GENERAL	REPAI RS	PLANT	LINEN SERVIC		DIETAKI	
		5. 02	6.00	7.00	8.00	9.00	10.00	
0	Administrative and General	74, 827	0	75, 685		0 37,880	0	1
00	Skilled Nursing Care	319, 758	0	0		0 0	0	
00	Physical Therapy	138, 658	0	0		0 0	0	
0	Occupational Therapy	56, 969	0	0		0 0	0	
00	Speech Pathology Medical Social Services	18, 991	0	0		0 0	0	
)0)0	Home Health Aide	35, 531 24, 724	0	0		0 0	0	
0	Supplies (see instructions)	10, 218	0	0			0	
0	Drugs	0,210	0	0		0 0	0	
00	DME	0	0	0		0 0	0	
00	Home Dialysis Aide Services	0	0	0		0 0	0	
00	Respiratory Therapy	0	0	0		0 0	0	
00	Private Duty Nursing	0	0	0		0 0	0	13
00	Clinic	0	0	0		0 0	0	14
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	
00	Homemaker Service	0	0	0		0 0	0	
00	All Others (specify)	0	0	0		0	0	
50	Telemedicine	0	0	75 405			0	
00 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	679, 676	0	75, 685		0 37,880	0	20 21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	Financial Systems TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	GOSHEN H	Provider C	CN: 15-0026 15-7174	Period: From 01/01/2016 To 12/31/2016		pared:
						Home Health Agency I	PPS	
	Cost Center Description	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	12.00	13.00	14.00	15.00	16.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	13, 004 8, 773 2, 864 1, 743 413 995 1, 476 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 161, 235 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 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 0 0 0 0 0 0 0 0 0 0	16, 855 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL		& RESI DENTS A SERVI CES-OTHE S R PRGM COSTS APPRV	PARAMED ED PRGM	
		17.00	19.00	20.00	21.00	22.00	23.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 19. \ 50\\ 20. \ 00\\ 21. \ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C	CN: 15-0026	Peri od:	Worksheet H-2	
				HHA CCN:	15-7174	From 01/01/2016 To 12/31/2016		nared
				TITIA CON.	13 / 174	10 12/31/2010	5/25/2017 2:4	
						Home Health	PPS	
						Agency I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HH			
			Residents Cost & Post		A&G (see Par II)	t Costs		
			Stepdown		11)			
			Adjustments					
	-	24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	540, 012	0	540, 012				1.00
2.00	Skilled Nursing Care	1, 864, 739	0	1, 864, 739	297, 52	25 2, 162, 264		2.00
3.00	Physical Therapy	737, 761	0	737, 761	117, 7 [.]	12 855, 473		3.00
4.00	Occupational Therapy	303, 683	0	303, 683				4.00
5.00	Speech Pathology	101, 065	0	101, 065				5.00
6.00	Medical Social Services	189, 310	0	189, 310				6.00
7.00	Home Health Aide	132, 516	0	132, 516				7.00
8.00	Supplies (see instructions)	55, 452	0	55, 452	8, 84	48 64, 300		8.00
9.00	Drugs	0	0	0		0 0		9.00
10.00	DME	0	0	0		0 0		10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0		11.00 12.00
12.00 13.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0		12.00
13.00	Clinic	0	0	0		0 0		13.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0		0 0		16.00
17.00	Home Delivered Meals Program	0	Ő	0		0 0		17.00
18.00	Homemaker Service	0	0	0		0 0		18.00
19.00	All Others (specify)	0	0	0		0 0		19.00
19.50	Tel emedi ci ne	0	0	0		0 0		19.50
20.00	Total (sum of lines 1–19) (2)	3, 924, 538	0	3, 924, 538	540, 0 ⁻	12 3, 924, 538		20.00
21.00	Unit Cost Multiplier: column				0. 1595	53		21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.		I		l	I I		I

ALLOCA	Financial Systems TION OF GENERAL SERVICE COSTS 7	TO HHA COST CEN	GOSHEN HO		CN: 15-0026	Period:	u of Form CMS-2 Worksheet H-2	
BASIS				HHA CCN:	15-7174	From 01/01/2016 To 12/31/2016		
						Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS			Agency 1		
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/A	C Reconciliatio	OTHER ADMIN &	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFI TS DEPARTMENT	COUNTS RECEI VABLE	n	GENERAL (ACCUM. COST)	
			WALUE)	(GROSS	(GROSS CHAR			
		1.00	2.00	SALARIES) 4.00	GES) 5.01	5A. 02	5.02	
1.00	Administrative and General	5, 125	27, 273	705, 403				1.00
2.00	Skilled Nursing Care	0	0			0 0	1, 374, 973	
3.00 4.00	Physical Therapy Occupational Therapy	0	0	288, 339 118, 467		0 0	596, 239 244, 971	3.00 4.00
5.00	Speech Pathology	0	0	39, 491		0 0	81, 661	5.00
6.00	Medical Social Services	0	0	73, 886		0 0	152, 784	
7.00	Home Health Aide	0	0			0 0	106, 316	
8.00 9.00	Supplies (see instructions)	0	0	0		0 0 0 0	43, 940 0	8.00 9.00
9.00 10.00	Drugs DME	0	0			0 0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	12.00
13.00	Private Duty Nursing	0	0	0		0 0	0	13.00
14.00 15.00	Clinic Health Promotion Activities	0	0	0		0 0	0	14.00 15.00
16.00	Day Care Program	0	0	0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19.00 19.50	All Others (specify) Telemedicine	0	0	0		0 0	0	19.00 19.50
19.50 20.00	Total (sum of lines 1-19)	5, 125	27, 273	1, 941, 933	1, 772, 74		2, 922, 645	
21.00	Total cost to be allocated	58, 810	22, 479				679, 676	
22.00	Unit cost multiplier	11. 475122	0. 824222	0. 330310			0. 232555	22.00
	Cost Center Description	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI N (SQUARE FEET		CAFETERIA (MANHOURS)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE FEET	SERVED)	(WANHOURS)	
		. ,		LAUNDRY)		-		
1.00	Administrative and General	6.00 5,125	7.00 5,125	8.00	9.00 5,12	10.00 25 0	11.00 22,151	1.00
2.00	Skilled Nursing Care	0	0,125			0 0		
3.00	Physical Therapy	0	0	0		0 0	4, 878	
4.00	Occupational Therapy	0	0	0		0 0	2, 968	
5.00 6.00	Speech Pathology Medical Social Services	0	0	0		0 0	703 1, 695	5.00 6.00
7.00	Home Heal th Aide	0	0	0		0 0	2, 514	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9.00	Drugs	0	0	-		0 0	S S	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0			0 0 0 0		10.00 11.00
12.00	Respiratory Therapy	0	0			0 0	0	12.00
	Private Duty Nursing	0	0	0		0 0	-	
13.00	a	0	0	0		0 0	0	14.00
14.00	Clinic							15.00
14. 00 15. 00	Health Promotion Activities	0	0	0		0 0	0	
14. 00 15. 00 16. 00	Health Promotion Activities Day Care Program	0	0 0 0	0 0 0			0	16.00
14. 00 15. 00	Health Promotion Activities	0 0 0 0	-	-		0 0	0	16.00
14.00 15.00 16.00 17.00 18.00 19.00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0	0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0	16.00 17.00 18.00 19.00
14.00 15.00 16.00 17.00 18.00 19.00 19.50	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine		0 0 0 0 0	0 0 0 0 0	F 4	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	16.00 17.00 18.00 19.00 19.50
14.00 15.00 16.00 17.00 18.00 19.00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 5, 125	0 0 0		5, 1: 37, 8i	0 0 0 0 0 0 0 0 0 0 25 0	0 0 0 0 49, 851	16.00 17.00 18.00 19.00 19.50

Health Financial Systems		GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN			CN: 15-0026 15-7174	Period: From 01/01/2016	Worksheet H-2 Part II Date/Time Pre	pared:
					Home Health	5/25/2017 2:4 PPS	/ pm
Cost Center Description	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI O N (DI RECT	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI S.)	Agency I MEDI CAL RECORDS & LI BRARY (GROSS CHAR	SOCI AL SERVI CE (TI ME SPENT)	
	12.00	NRSING HRS) 13.00	REQUIS.) 14.00	15.00	GES) 16.00	17.00	
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 14.00 Tatel cart to be allocated 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 30, 685 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 25, 289 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 1, 772, 749 0 0		$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 19.50\\ 20.00\\ 21.00\\ 14.00\\ 19.50\\ 20.00\\ 21.00\\ 10.0$
21.00 Total cost to be allocated 22.00 Unit cost multiplier	0. 000000	161, 235 5. 254522	0. 051168	0.0000	10,000	0. 000000	21.00 22.00
Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG SCHOOL (ASSI GNED TI ME)	SERVI CES-SALA RY & FRI NGES APPRV (ASSI GNED TI ME)	R PRGM COSTS APPRV (ASSIGNED TIME)	S PRGM (ASSIGNED TIME)		
1.00 Administrative and Canaral	19.00	20.00	21.00	22.00	23.00		1.00
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy Speech Pathology O Medical Social Services O Home Health Aide O Supplies (see instructions) O Drugs O Home Dialysis Aide Services O Respiratory Therapy O Private Duty Nursing O Bay Care Program O Home Delivered Meals Program O Home Delivered Meals Program O Home Dial (specify) So Tal emedicine O Day Care Program O Home Delivered Meals Program O Total (sum of lines 1-19) O Total cost to be allocated O Unit cost multiplier 		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0. 00000	0 0 0 0		$\begin{array}{c} 1. 00\\ 2. 00\\ 3. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 18. 00\\ 19. 00\\ 19. 50\\ 20. 00\\ 21. 00\\ 22. 00\\ \end{array}$

Heal th	Financial Systems		GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	ſS		Provider C		Period: From 01/01/2016	Worksheet H-3 Part I	
				HHA CCN:	15-7174	To 12/31/2016	Date/Time Prep 5/25/2017 2:4	pared: 7 pm
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		PerVisit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	Part I) 1.00	Part II) 2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
1.00	Cost Per Visit Computation Skilled Nursing Care	2.00	2, 162, 264		2, 162, 26	4 6,012	359.66	1.00
2.00	Physical Therapy	3.00		C			419.14	2.00
3.00	Occupational Therapy	4.00		0	352, 13		385.69	
4.00	Speech Pathology	5.00		0	117, 19		915.55	4.00
5.00	Medical Social Services	6.00			219, 51		1, 065. 61	5.00
6.00	Home Health Aide	7.00		0	153, 65		132.12	
7.00	Total (sum of lines 1-6)		3, 860, 238	0	3,860,23 Program Visit			7.00
						5		
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to Deductibles 8	Deductibles		
					Coi nsurance	`		
		0	1.00	2.00	3.00	4.00	5.00	
0.00	Limitation Cost Computation		21140	0	2.70			0.00
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care		21140 99915		2, 76 64			8.00 8.01
8.02	Skilled Nursing Care		23060	0		0		8.02
8.03	Skilled Nursing Care		43780	0	1			8.03
8.04	Skilled Nursing Care		50031	0		0		8.04
8. 05 9. 00	Skilled Nursing Care Physical Therapy		50032 21140		96	0		8.05 9.00
9.00 9.01	Physical Therapy		99915		18			9.00 9.01
9.02	Physical Therapy		23060	0		0		9.02
9.03	Physical Therapy		43780	0		0		9.03
9.04	Physical Therapy		50031	0		0		9.04
9. 05 10. 00	Physical Therapy Occupational Therapy		50032 21140		45	0		9. 05 10. 00
10.00	Occupational Therapy		99915	0	9			10.00
10.02	Occupational Therapy		23060	0		0		10.02
10.03	Occupational Therapy		43780	0		0		10.03
10.04	Occupational Therapy		50031	0		0		10.04
10. 05 11. 00	Occupational Therapy Speech Pathology		50032 21140		4	0		10. 05 11. 00
11.00	Speech Pathology		99915	0		0		11.00
11.02	Speech Pathology		23060	0		0		11.02
11.03	Speech Pathology		43780	0		0		11.03
11.04	Speech Pathology		50031	0		0		11.04
11.05 12.00	Speech Pathology Medical Social Services		50032 21140		11	0		11. 05 12. 00
12.00	Medical Social Services		99915	0	2			12.00
12.02	Medical Social Services		23060	0		0		12.02
12.03	Medical Social Services		43780	0		0		12.03
12.04	Medical Social Services		50031	0		0		12.04
12.05 13.00	Medical Social Services Home Health Aide		50032 21140		47	0		12. 05 13. 00
13.00	Home Health Aide		21140 99915		18			13.00 13.01
13.02	Home Heal th Ai de		23060	0		0		13.02
13.03	Home Health Aide		43780	C		0		13.03
13.04	Home Health Aide		50031	0		0		13.04
13.05	Home Health Aide		50032	0		0		13.05 14.00
14.00	Total (sum of lines 8-13)	I	l	I U	J 5, 94	'I	I I	14.00

APPOR I	Financial Systems		GOSHEN HO		01 15 000/		u of Form CMS-2	
	IONMENT OF PATIENT SERVICE COS	15		Provider C HHA CCN:		Period: From 01/01/2016 To 12/31/2016		pared:
				Title	× XVIII	Home Health Agency I	PPS	7 pm
	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	Part I)	Part II)	2.00	4.00	F 00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	5.00	
5.00 6.00	Cost of Medical Supplies	8.00 9.00		0		0 0 0 0	0. 000000 0. 000000	
			Program Visits		Cost of Services			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles &	Part A	Not Subject to	Subject to Deductibles &	
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							
. 00	Skilled Nursing Care	0	3, 415			0 1, 228, 239		1.00
00	Physi cal Therapy	0	1, 148			0 481, 173		2.00
00	Occupational Therapy	0	543			0 209, 430		3.00
00	Speech Pathology	0	45			0 41,200		4.00
. 00	Medical Social Services	0	135			0 143, 857		5.00
. 00 . 00	Home Health Aide Total (sum of lines 1-6)	0	655 5, 941			0 86, 539 0 2, 190, 438		6.00 7.00
. 00	Cost Center Description	0	5, 741			2, 170, 430		7.00
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
. 00	Skilled Nursing Care							8.00
. 01	Skilled Nursing Care							8. 01 8. 02
. 02 . 03	Skilled Nursing Care Skilled Nursing Care							8.02
. 03	Skilled Nursing Care							8.04
. 05	Skilled Nursing Care							8.05
. 00	Physi cal Therapy							9.00
. 01	Physical Therapy							9.0
. 02	Physical Therapy							9.0
. 03	Physical Therapy							9.03 9.04
. 04 . 05	Physical Therapy Physical Therapy							9.0
0.00	Occupational Therapy							10.0
0. 01	Occupational Therapy							10.0
0. 02	Occupational Therapy							10.0
0.03	1 13							10.0
0.04	Occupational Therapy							10.0
	Occupational Therapy							10.0 11.0
	ISpooch Dathology							11.0
1. 00	Speech Pathology							
1. 00 1. 01	Speech Pathology							
1.00 1.01 1.02								11.0
1.00 1.01 1.02 1.03	Speech Pathology Speech Pathology							11. 0 11. 0
1.00 1.01 1.02 1.03 1.04 1.05	Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy							11.0 11.0 11.0 11.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00	Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy Speech Pathol ogy Medi cal Soci al Servi ces							11.0 11.0 11.0 11.0 12.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							11.0 11.0 11.0 11.0 12.0 12.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.01	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services							11.0 11.0 11.0 11.0 12.0 12.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.02	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services							11.0 11.0 11.0 11.0 12.0 12.0 12.0 12.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.03 2.03	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services							11.0 11.0 11.0 12.0 12.0 12.0 12.0 12.0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.03 2.04 2.05	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services							11. 0 11. 0 11. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.03 2.04 2.05 3.00 3.01	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide							11. 0 11. 0 11. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 13. 0
0. 05 1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 2. 00 2. 01 2. 02 2. 03 2. 04 2. 05 3. 00 3. 01 3. 02	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							11. 0. 11. 0. 11. 0. 12. 0. 12. 0. 12. 0. 12. 0. 12. 0. 12. 0. 12. 0. 12. 0. 13. 0. 13. 0. 13. 0.
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.03 2.04 2.05 3.00 3.01 3.02 3.03	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide							11. 0 11. 0 11. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 13. 0 13. 0 13. 0 13. 0
1.00 1.01 1.02 1.03 1.04 1.05 2.00 2.01 2.02 2.03 2.04 2.05 3.00 3.01	Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							11. 0 11. 0 11. 0 11. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 12. 0 13. 0 13. 0 13. 0 13. 0 13. 0 13. 0

	Financial Systems TONMENT OF PATIENT SERVICE COS	ſS	GOSHEN H		CN: 15-0026	Period: From 01/01/2016	u of Form CMS-2 Worksheet H-3 Part I	
				HHA CCN:	15-7174	To 12/31/2016		eparec
				Title	× XVIII	Home Health Agency I	PPS	r piii
		Progi	ram Covered Cha	arges	Cost of Services	Agency		
			Dev	+ D	Services	Darat D		
	Cost Center Description	Part A	Not Subject to Deductibles &	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
		6.00	Coi nsurance 7. 00	8.00	9.00	Coi nsurance 10.00	11.00	
5.00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	0	C		0 0	0	15.
5.00	Cost of Drugs	0	0			0 0		
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER	0E AGGREGATE	PROGRAM COST	ACCRECATE OF T	HE PROGRAM I	IMITATION COST (
	COST LIMITATION							
00	Cost Per Visit Computation	1 000 000						1
00 00	Skilled Nursing Care Physical Therapy	1, 228, 239 481, 173						1.
00	Occupational Therapy	209, 430						3.
00	Speech Pathology	41, 200						4.
00 00	Medical Social Services Home Health Aide	143, 857						5.
00	Total (sum of lines 1-6)	86, 539 2, 190, 438						6. 7.
	Cost Center Description							
	Limitation Cost Computation	12.00						
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03 04	Skilled Nursing Care Skilled Nursing Care							8. 8.
04	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
04	Physical Therapy							9.
05	Physi cal Therapy							9.
). 00). 01	Occupational Therapy Occupational Therapy							10.
). 02	Occupational Therapy							10.
0.03	Occupational Therapy							10.
0. 04	Occupational Therapy							10.
0. 05	Occupational Therapy							10.
1.00	Speech Pathology							11.
1.01	Speech Pathology							11.
1.02 1.03	Speech Pathology Speech Pathology							11.
1.04	Speech Pathology							11.
I. 05	Speech Pathology							11.
2.00	Medical Social Services							12.
2.01	Medical Social Services							12.
2.02	Medical Social Services							12. 12.
2.03 2.04	Medical Social Services Medical Social Services							12.
2.04	Medical Social Services							12.
3.00	Home Heal th Ai de							13.
	Home Health Aide							13.
	Home Health Aide							13.
3. 01 3. 02								
3. 02 3. 03	Home Health Aide							
3. 02	Home Health Aide Home Health Aide Home Health Aide							13. 13. 13.

Health Financial Systems		GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0026	Period:	Worksheet H-3	
			HHA CCN:	15-7174	From 01/01/2016 To 12/31/2016		nared
			THIN CON.	13 /1/4	10 12/31/2010	5/25/2017 2:4	
			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	T OF HHA SERVI	CES FURNI SHED E	BY SHARED HOSP	I TAL DEPARTME	ENTS		
1.00 Physical Therapy	66.00	0. 692452	C)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 379676	C		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 423441	C		Ocol. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	1. 148533	C		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 215399	C		0 col. 2, line 1	6.00	5.00

ALCULA	Financial Systems GOSHEN HOSE ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0026		eri od:	Worksheet H-4	2552
		HHA CCN:	15-7174	Fr Tc	rom 01/01/2016 p 12/31/2016	Part I-II Date/Time Pre 5/25/2017 2:4	
		Title	XVIII		Home Health Agency I	PPS	
					Par	t B	
			Part A		Not Subject	Subject to	
					to Deductibles &	Deductibles & Coinsurance	
					Coi nsurance	cornsul ance	
			1.00		2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	TOMARY CHARGE	S		I		
	Reasonable Cost of Part A & Part B Services						
	Reasonable cost of services (see instructions)			0	0	0	-
	Total charges			0	0	0	4
	Customary Charges			0			
00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	or services		0	0	0	3
00	Amount that would have been realized from patients liable for	r navment		0	o	0	
	for services on a charge basis had such payment been made in			Ŭ	0	0	
	with 42 CFR §413.13(b)						
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0.000000	!
00	Total customary charges (see instructions)			0	0	0	
00	Excess of total customary charges over total reasonable cost	(complete		0	0	0	· ·
~	only if line 6 exceeds line 1)			~	0	0	
00	Excess of reasonable cost over customary charges (complete or 1 exceeds line 6)	niyiriine		0	0	0	8
00	Primary payer amounts			0	o	0	
					Part A	Part B	
					Servi ces	Servi ces	
				H			<u> </u>
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			-			1(
00					1.00	2.00	
00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				1.00	2.00 0 954,898 14,181	1 1:
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			-	1.00 0 0 0 0 0	2.00 0 954,898 14,181 30,331	1 1 1
00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes			-	1.00 0 0 0 0 0 0	2.00 0 954,898 14,181 30,331 3,304	1 1 1
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers	 5			1.00 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837	1 1: 1: 1: 1:
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes	s			1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0	1 1 1 1 1
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments	s			1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0	1 1 1 1 1 1
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments	S			1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0	1 1 1 1 1 1 1 1 1
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments	S		-	1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0	1 1 1 1 1 1 1 1 1 1
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments				1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 2
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)				1.00 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 0 1,005,551 0	1 1 1 1 1 1 1 1 1 2 2 2 2
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 0 1,005,551 0 1,005,551	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 1,005,551 0 1,005,551 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 2 2 2 2 2
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 0 1,005,551 0 1,005,551	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	surance)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 1,005,551 0 1,005,551 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00 0 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from dual eligible beneficiaries (see i	surance) i nstructi ons)	,		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 1,005,551 0 1,005,551 0 1,005,551	11 12 14 14 14 14 16 15 20 22 22 22 24 25 26 25 26 27 26
00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	surance) i nstructi ons)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 1,005,551 0 1,005,551 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00 0 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin	surance) i nstructi ons) ne 27)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 954,898 14,181 30,331 3,304 2,837 0 0 0 0 1,005,551 0 1,005,551 1,005,551	11 11 11 11 11 11 11 11 11 11 11 11 20 22 22 22 22 22 22 22 22 22 22 22 22
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	surance) i nstructi ons) ne 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 0 0 1,005,551 0 1,005,551 1,005,551 0	11 11 11 11 11 11 11 11 11 11 11 11 11
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	surance) i nstructi ons) ne 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 954,898 14,181 30,331 3,304 2,837 0 0 0 1,005,551 0 0 1,005,551 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 1,005,551 0 1,005,551 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
.00 .00 .00 .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	surance) i nstructi ons) ne 27)	,		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 954,898 14,181 30,331 3,304 2,837 0 0 0 1,005,551 0 0 1,005,551 0 1,005,551 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
.00 .00 .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see int Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Total cost settlement (for contractor use only)	surance) instructions) ne 27) ns))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 954,898 14,181 30,331 3,304 2,837 0 0 0 0 1,005,551 0 1,005,551 0 1,005,551 1,005,551 0 1,005,551 0 1,005,551 0 1,005,551 0 1,005,551 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 0 1,005,551 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 12 14 15 16 17 18 16 17 20 21 22 22 22 22 22 22 22 22 22 22 22 22
.00 .00 .00 .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	surance) instructions) ne 27) ns) and 33)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 954,898 14,181 30,331 3,304 2,837 0 0 0 1,005,551 0 0 1,005,551 0 1,005,551 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 1,005,551 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 12 14 15 16 17 18 16 17 18 20 21 22 22 22 22 22 22 22 22 22 22 22 22

ANALYS	Financial Systems GOSHEN HOS GIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0026	Pe	eri od:	u of Form CMS-2 Worksheet H-5	
TO PRO	OGRAM BENEFICIARIES	HHA CCN:	15-7174	Fr	rom 01/01/2016 0 12/31/2016	Date/Time Prep	narad
		HHA CON.	15-7174		12/31/2010	5/25/2017 2:47	
					Home Health Agency I	PPS	•
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		985, 439 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3.00
3. 01				0		0	3. O ²
3.02				0		0	3.02
3.03				0		0	3.03
3.04				0		0	3.04
3. 05	Dravidar to Dragram			0		0	3.0
3.50	Provider to Program			0		0	3.50
3.50				0		0	3.5
3.52				0		0	3.5
3.53				0		0	3.53
3.54				0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR			0		985, 439	4.00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5.0
5. 01				0		0	5. O´
5. 02				0		0	5.02
5.03				0		0	5.03
	Provider to Program			0			
5.50 5.51				0 0		0	5.50 5.51
5.52				0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)						6.0
o. 01	SETTLEMENT TO PROVIDER			0		0	6.0
6.02	SETTLEMENT TO PROGRAM			0		0	6.02
7.00	Total Medicare program liability (see instructions)			0	Contractor	985,439 NPR Date	7.00
					Number	(Mo/Day/Yr)	
)		1.00	2.00	

	Financial Systems	GOSHEN HOS	Provider C	°N· 15_0026	Peri od:	u of Form CMS-: Worksheet O	2552-1
ANALIS	SIS OF HUSPITAL-BASED HUSPICE CUSIS		Provider C	JN. 15-0020	From 01/01/2016	WUI KSHEEL U	
			Hospi ce CC	N: 15-1527	To 12/31/2016	Date/Time Pre	
					lloopi.co.l	5/25/2017 2:4	7 pm
		SALARI ES	OTHER	SUBTOTAL	Hospi ce I RECLASSI FI -	SUBTOTAL	
		SALARIES	UTILK	(col. 1 plus		JUDIUTAL	
				col. 2)	0,111,0110		
		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	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		736		36 0	736	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	232, 639	0	232, 63		232, 639	
4.00	ADMI NI STRATI VE & GENERAL*	0	70, 936	70, 93		70, 936	
5.00 6.00	PLANT OPERATION & MAINTENANCE* LAUNDRY & LINEN SERVICE*	0	679	6	0 0	679 0	
7.00	HOUSEKEEPING*	0	0		0 0	0	
8.00	DI ETARY*	0	442	4	42 0	442	
9.00	NURSI NG ADMI NI STRATI ON*	0	0		0 0	0	
10.00	ROUTINE MEDICAL SUPPLIES*	0	159, 482	159, 48	-44, 476	115,006	
11.00	MEDI CAL RECORDS*	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION*	0	27, 269	27, 20	69 0	27, 269	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		0 0	0	13.00
14.00	PHARMACY*	0	181, 624	181, 62	24 – 181, 624	0	1
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0 0	0	1
16.00	OTHER GENERAL SERVICE*	0	18, 578	18, 5	78 0	18, 578	
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
25 00	DI RECT PATI ENT CARE SERVICE COST CENTERS		0			0	1 25 00
25.00 26.00	I NPATI ENT CARE-CONTRACTED** PHYSI CI AN SERVI CES**	0	0		0 0	0	
27.00	NURSE PRACTITIONER**	0	0			0	
28.00	REGI STERED NURSE**	382, 136	340, 764	722, 90	0 0	722, 900	
29.00	LPN/LVN**	0	0	,,,	0 0	0	
30.00	PHYSI CAL THERAPY**	0	0		0 0	0	
31.00	OCCUPATIONAL THERAPY**	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	1
33.00	MEDICAL SOCIAL SERVICES**	0	0		0 0	0	
34.00	SPIRITUAL COUNSELING**	0	0		0 0	0	
35.00	DI ETARY COUNSELING**	0	0		0 0	0	
36.00 37.00	COUNSELING - OTHER** HOSPICE AIDE & HOMEMAKER SERVICES**	241 452	0	241, 65	52 0	0	
37.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	241, 652	5, 982	241, 63		241, 652 5, 982	
39.00	PATIENT TRANSPORTATION**	0	J, 702 0	5,70	0 0	J, 702 0	
40.00	I MAGI NG SERVI CES**	0	0		0 0	0	
41.00	LABS & DI AGNOSTI CS**	0	0		0 0	0	
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		0 0	0	42.00
43.00	OUTPATI ENT SERVI CES**	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		0 0	0	
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		0 0	0	46.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0		0 0	0	
61.00 62.00	VOLUNTEER PROGRAM * FUNDRAI SI NG*	0	0			0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			0	
64.00	PALLIATIVE CARE PROGRAM*	0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES*	0	0		0 0	0	
66.00		0	0		0 0	0	
67.00		0	0		0 0	0	
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		0 0	0	68.00
69.00		0	0		0 0	0	
70.00		0	0		0 0	0	
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0		0 0	0	
100 00	D TOTAL	856, 427	806, 492	1, 662, 9	19 -226, 100	1, 436, 819	1100 0

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

ALYSI :	S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	l: 15-0026	Period:	Worksheet 0	
			Hospi ce CCN:	15-1527	From 01/01/2016 To 12/31/2016	Date/Time Prepa 5/25/2017 2:47	
		ADJUSTMENTS	T0TAL (col. 5 ± col. 6)		Hospi ce I		
		6.00	7.00				
G	GENERAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT*	0					1
	CAP REL COSTS-MVBLE EQUIP*	0					2
	EMPLOYEE BENEFITS DEPARTMENT* ADMINISTRATIVE & GENERAL*	0	232, 639				3
	PLANT OPERATION & MAINTENANCE*	0	70, 936 679				4 5
	LAUNDRY & LINEN SERVICE*	0	0				6
	HOUSEKEEPI NG*	0	0				7
	DI ETARY*	0	442				8
00 00	NURSI NG ADMI NI STRATI ON*	0	0				9
00 F	ROUTINE MEDICAL SUPPLIES*	0	115, 006				10
	MEDI CAL RECORDS*	0	0				11
	STAFF TRANSPORTATION*	0	27, 269				12
	VOLUNTEER SERVICE COORDINATION*	0	0				13
	PHARMACY* PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0				14 15
	OTHER GENERAL SERVICE*	0	-				16
	PATIENT/RESIDENTIAL CARE SERVICES	0	10, 370				17
-	DI RECT PATI ENT CARE SERVI CE COST CENTERS		II				
_	INPATIENT CARE-CONTRACTED**	0	0				25
00 F	PHYSICIAN SERVICES**	0	0				26
00	NURSE PRACTI TI ONER**	0	0				27
	REGI STERED NURSE**	0	722, 900				28
		0	0				29
	PHYSICAL THERAPY**	0	0				30
	CCUPATIONAL THERAPY** SPEECH/LANGUAGE PATHOLOGY**	0	0				3
	MEDICAL SOCIAL SERVICES**	0	0				33
	SPIRITUAL COUNSELING**	0	0				34
	DI ETARY COUNSELI NG**	0	0				35
	COUNSELING - OTHER**	0	0				36
00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	241, 652				37
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	5, 982				38
	PATIENT TRANSPORTATION**	0	0				39
	I MAGI NG SERVI CES**	0	0				40
	LABS & DI AGNOSTI CS**	0	0				4
	MEDICAL SUPPLIES-NON-ROUTINE** DUTPATIENT SERVICES**	0	0				42
	PALLIATIVE RADIATION THERAPY**		0				4
	PALLIATIVE CHEMOTHERAPY**	0					45
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0					46
N	IONREI MBURSABLE COST CENTERS		· · · ·				
00 E	BEREAVEMENT PROGRAM *	0	0				60
	VOLUNTEER PROGRAM *	0	0				6
	FUNDRALSING*	0	0				62
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	PALLI ATI VE CARE PROGRAM* OTHER PHYSI CI AN SERVI CES*	0	0				64
	RESIDENTIAL CARE*						65 66
	ADVERTI SI NG*						67
	TELEHEALTH/TELEMONI TORI NG*						68
	THRI FT_STORE*	0	0				69
	VURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREI MBURSABLE (SPECIFY)*	0	o				71
	TOTAL	0	1, 436, 819				100

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

Health Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provider CO	CN: 15-0026	Period:	Worksheet 0-2	
CARE		Hospi ce CCM	N: 15-1527	From 01/01/2016 To 12/31/2016		pared.
		1100001 00 001	10 1027	10 12/01/2010	5/25/2017 2:4	
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
	1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25. 00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	372, 564	332, 228	704, 79	92 0	704, 792	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 MEDI CAL SOCI AL SERVI CES	0	0		0 0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0	0	36.00

 34. 00 SPI RI TUAL COUNSELING 35. 00 DI ETARY COUNSELING 35. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 39. 00 PATI ENT TRANSPORTATI ON 40. 00 IMAGING SERVI CES 41. 00 LABS & DI AGNOSTI CS 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE 43. 00 OUTPATI ENT SERVI CES 44. 00 PALLI ATI VE RADI ATI ON THERAPY 45. 00 PATI ENT CARE SERVI CES (SPECI FY) 100. 00 TOTAL * 	00 00 235,599 00 00 00 00 00 00 00 00 00 00 00 00 0		0 0 235, 599 5, 982 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 33.00 0 34.00 0 35.00 0 36.00 235,599 37.00 5,982 38.00 0 39.00 0 40.00 0 41.00 0 42.00 0 43.00 0 44.00 0 45.00 0 46.00 946,373 100.00
	ADJUSTMENTS	TOTAL (col. 5		
	(± col. 6)		
DUDECT DATIENT CADE CEDVICE COST CENTERS	6.00	7.00		
DI RECT PATI ENT CARE SERVI CE COST CENTERS				25.00
26. 00 PHYSI CI AN SERVI CES	0	0		25.00
27. 00 NURSE PRACTITIONER	0	0		27.00
28. 00 REGI STERED NURSE	0	704, 792		28.00
29. 00 LPN/LVN	0	,04,772		29.00
30. 00 PHYSI CAL THERAPY	0	0		30.00
31. 00 OCCUPATI ONAL THERAPY	0	Ő		31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00 MEDI CAL SOCI AL SERVI CES	0	0		33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		34.00
35.00 DI ETARY COUNSELI NG	0	0		35.00
36.00 COUNSELING - OTHER	0	0		36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	235, 599		37.00
38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	5, 982		38.00
39.00 PATIENT TRANSPORTATION	0	0		39.00
40.00 I MAGI NG SERVICES	0	0		40.00
41.00 LABS & DIAGNOSTICS	0	0		41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00 OUTPATIENT SERVICES	0	0		43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00 TOTAL *	0	946, 373		100.00
* Transfer the amount in column 7 to Wkst. 0-5, cc	lumn 1, line 51			

Heal th	Financial Systems	GOSHEN HOS	SPI TAL		In Lie	u of Form CMS-:	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE INPATIENT	Provider CC		Peri od:	Worksheet 0-3	
RESPI T	E CARE		Hospi ce CCN		From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
			HUSPICE CCM	N. 15-1527	10 12/31/2010	5/25/2017 2:4	
					Hospice I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS		-1		-	-	
	INPATIENT CARE-CONTRACTED	0	0		0 0	0	20.00
26.00	PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	1, 613	1, 438	3, 05	0	3, 051	•
29.00	LPN/LVN	0	0		0 0	0	
30.00	PHYSI CAL THERAPY	0	0		0 0	0	
	OCCUPATIONAL THERAPY	0	0		0 0	0	01100
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
	COUNSELING - OTHER	0	0		0 0	0	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	1, 020	0	1, 02	20 0	1, 020	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	
40.00	I MAGI NG SERVI CES	0	0		0 0	0	
41.00	LABS & DIAGNOSTICS	0	0		0 0	0	
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	
43.00	OUTPATIENT SERVICES	0	0		0 0	0	
44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	
100.00	TOTAL *	2, 633	1, 438	4,07	/1 0	4, 071	100.00

 46.00
 OTHER
 PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 2,633

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

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	1	6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	3, 051		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1, 020		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	4, 071	1	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52	•		

Heal th	Financial Systems	GOSHEN HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provider CC	N: 15-0026	Period:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCN	: 15-1527	From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
			nospi ce con	. 15-1527	10 12/31/2010	5/25/2017 2:4	7 pm
					Hospi ce I		_
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
	1	1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED	0	0		0 0	0	
26.00	PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00	NURSE PRACTI TI ONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	7, 959	7, 098	15, 0	57 0	15, 057	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
	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	5, 033	0	5,0	33 0	5, 033	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	07100
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
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
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00	TOTAL *	12, 992	7, 098	20, 0	90 0	20, 090	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 12,992

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	RECT PATIENT CARE SERVICE COST CENTERS			
	NPATIENT CARE-CONTRACTED	0	0	25.00
	HYSI CI AN SERVI CES	0	0	26.00
	JRSE PRACTITIONER	0	0	27.00
	EGI STERED NURSE	0	15, 057	28.00
	PN/LVN	0	0	29.00
	HYSI CAL THERAPY	0	0	30.00
	CCUPATIONAL THERAPY	0	0	31.00
	PEECH/LANGUAGE PATHOLOGY	0	0	32.00
	EDICAL SOCIAL SERVICES	0	0	33.00
	PIRITUAL COUNSELING	0	0	34.00
	ETARY COUNSELING	0	0	35.00
	DUNSELING - OTHER	0	0	36.00
	OSPICE AIDE & HOMEMAKER SERVICES	0	5, 033	37.00
	JRABLE MEDICAL EQUIPMENT/OXYGEN			38.00
	ATI ENT TRANSPORTATI ON	0	0	39.00
	MAGING SERVICES	0	0	40.00
	ABS & DIAGNOSTICS	0	0	41.00
	EDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
	JTPATI ENT SERVI CES	0	0	43.00
	ALLIATIVE RADIATION THERAPY	0	0	44.00
	ALLIATIVE CHEMOTHERAPY	0	0	45.00
	THER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00 T0	DTAL *	0	20, 090	100.00
* Transfe	er the amount in column 7 to Wkst. 0-5, col	umn 1, line 53		

Heal th	Financial Systems GOSHEN HOSI	PITAL		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0026	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION			From 01/01/2016		
		Hospi ce CC	N: 15-1527	To 12/31/2016		
				lleeni ee l	5/25/2017 2:4	/ pm
	Descriptions		HOSPI CE	Hospi ce I GENERAL	TOTAL	
	Descriptions		DI RECT	SERVI CE	EXPENSES (sum	
				e EXPENSES FROM		
				s) WKST B PART I	2)	
				(see	2)	
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0		
2.00	CAP REL COSTS-MVBLE EQUIP			36 C		
3.00	EMPLOYEE BENEFITS DEPARTMENT		232, 6			
4.00	ADMINISTRATIVE & GENERAL		70, 9			1
5.00	PLANT OPERATION & MAINTENANCE		6	79 C		•
6.00	LAUNDRY & LINEN SERVICE			0 0	-	
7.00	HOUSEKEEPING			0 0	-	7.00
8.00	DI ETARY		4	42 C		8.00
9.00	NURSI NG ADMI NI STRATI ON			0 121, 348	121, 348	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		115, 0	06 25, 030	140, 036	10.00
11.00	MEDI CAL RECORDS			0 35, 603	35, 603	11.00
12.00	STAFF TRANSPORTATION		27, 2	69	27, 269	•
13.00	VOLUNTEER SERVICE COORDINATION			0	0	
14.00	PHARMACY			0 0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	
16.00	OTHER GENERAL SERVICE		18, 5			16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			C	0	17.00
	LEVEL OF CARE		-		1	
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	
51.00	HOSPICE ROUTINE HOME CARE		946, 3		946, 373	
52.00	HOSPICE INPATIENT RESPITE CARE		4,0		4, 071	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		20, 0	90	20, 090	53.00
	NONREI MBURSABLE COST CENTERS		1			
60.00	BEREAVEMENT PROGRAM			0	0	
61.00	VOLUNTEER PROGRAM			0	0	
62.00	FUNDRAI SI NG			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	
	THRI FT STORE			0	0	
70.00	NURSING FACILITY ROOM & BOARD			0	0	
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	
	NEGATIVE COST CENTER			0	0	
100.00	TOTAL		1, 436, 8	905, 460	2, 342, 279	100.00

Heal th	Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C	CN: 15-0026	Peri od:	Worksheet 0-6	
				N 15 1507	From 01/01/2016		
			Hospi ce CC	N: 15-1527	To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pareu: 7 nm
-					Hospi ce I	5/25/2017 2.4	<u>, bui</u>
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVB		SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS	CODITINE	
		2/11 2/10/20	u i i n	Laon	DEPARTMENT		
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	736			36		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	515, 525	0		0 515, 525		3.00
4.00	ADMI NI STRATI VE & GENERAL	511, 529	0	7	36 515, 525	1, 027, 790	4.00
5.00	PLANT OPERATION & MAINTENANCE	679	0	-	0 0	679	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	
8.00	DI ETARY	442	0		0 0	442	8.00
9.00	NURSI NG ADMI NI STRATI ON	121, 348	0		0 0	121, 348	
10.00	ROUTI NE MEDI CAL SUPPLI ES	140, 036	0		0 0	140, 036	
11.00	MEDI CAL RECORDS	35, 603	0		0 0	35, 603	
	STAFF TRANSPORTATION	27, 269	0		0 0	27, 269	
	VOLUNTEER SERVICE COORDINATION	27,209	0			27,209	
	PHARMACY	0	0		0 0	0	
		0	0			0	
	PHYSI CLAN ADMI NI STRATI VE SERVI CES				0 0	-	
	OTHER GENERAL SERVICE PATI ENT/RESI DENTI AL CARE SERVICES	18, 578	0		0	18, 578	
17.00	LEVEL OF CARE		0	1	0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0		1	0	0	50.00
	HOSPICE CONTINUOUS HOME CARE	946, 373			0	946, 373	
52.00	HOSPICE ROUTINE HOME CARE	4, 071	C		0 0		
		20, 090			0 0	4,071	•
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	20, 090	0		0 0	20, 090	53.00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
61.00 62.00	FUNDRALSING	0	0		0 0	0	62.00
63.00		0	0		0 0	0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM	0			0 0	-	63.00
64.00		0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES	0			0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
	ADVERTI SI NG	0	0		0 0	0	67.00
	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
	THRIFT STORE	0	0	1	0 0	0	
	NURSING FACILITY ROOM & BOARD	0			0	0	
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
99.00	NEGATIVE COST CENTER	0	0		0 0	0 040 070	99.00
100.00	IUIAL	2, 342, 279	0	'l /	36 515, 525	2, 342, 279	100.00

Health Financial Systems GOSHEN HOSPITAL In Li						In Lieu	u of Form CMS-2	2552-10
COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0026 N: 15-1527		riod: om 01/01/2016 12/31/2016	Worksheet 0-6 Part I Date/Time Pre 5/25/2017 2:4	pared:
						Hospi ce I		
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVIO		HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00		7.00	8.00	
	GENERAL SERVICE COST CENTERS							
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	MEDI CAL RECORDS STAFF TRANSPORTATI ON VOLUNTEER SERVI CE COORDI NATI ON PHARMACY PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE	1, 027, 790 531 0 346 94, 881 109, 493 27, 838 21, 321 0 0 0 14, 526	1, 210 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		788	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00 \end{array}$
17.00	LEVEL OF CARE							17.00
50.00 51.00 52.00 53.00	HOSPI CE CONTINUOUS HOME CARE HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE HOSPI CE GENERAL I NPATI ENT CARE	0 739, 963 3, 183 15, 708	1, 210 0		0	0 0	135 653	
99.00	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)	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 0 788	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	Health Financial Systems GOSHEN HOSPITAL In Lieu of Form CMS-2552-10								
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0026	Peri od:	Worksheet 0-6			
			Hospi ce CCI	N: 15-1527	From 01/01/2016 To 12/31/2016		nared		
			nospi ce coi	N. 10 1027	10 12/31/2010	5/25/2017 2:4	7 pm		
	,				Hospi ce I				
	Descriptions	NURSI NG	ROUTINE	MEDI CAL	STAFF	VOLUNTEER			
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0				
		N 9.00	SUPPLI ES 10. 00	11.00	<u>N</u> 12.00	COORDINATION 13.00			
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00			
1.00	CAP REL COSTS-BLDG & FLXT						1 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	216, 229					9.00		
10.00	ROUTINE MEDICAL SUPPLIES	0	249, 529				10.00		
11.00	MEDICAL RECORDS	0		63, 4			11.00		
12.00	STAFF TRANSPORTATION	0			48, 590		12.00		
13.00	VOLUNTEER SERVICE COORDINATION	0				0			
14.00 15.00	PHARMACY	0							
16.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE	0					1		
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0				0	17.00		
17.00	LEVEL OF CARE			1		1	17.00		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0 0	50.00		
51.00	HOSPICE ROUTINE HOME CARE	0	243, 390	61, 8	80 C	0	1		
52.00	HOSPICE INPATIENT RESPITE CARE	216, 229	1, 054	2	68 48, 590	0	52.00		
53.00	HOSPICE GENERAL INPATIENT CARE	0	5, 085	1, 2	93 C	0	53.00		
	NONREI MBURSABLE COST CENTERS			1					
60.00	BEREAVEMENT PROGRAM	0			C	-			
61.00	VOLUNTEER PROGRAM	0			C	0			
62.00	FUNDRAI SI NG	0			C	0			
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0			
64.00	PALLIATIVE CARE PROGRAM	0							
65.00 66.00	OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE	0							
67.00	ADVERTI SI NG	0							
68.00	TELEHEALTH/TELEMONI TORI NG	0							
69.00	THRI FT STORE	0			0				
70.00	NURSING FACILITY ROOM & BOARD						70.00		
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0			C	0 0	1		
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00		
100.00	TOTAL	216, 229	249, 529	63, 4	41 48, 590	0	100.00		

COST A	Financial Systems NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL	GOSHEN H	Provider C	CN: 15-0026	Period: From 01/01/2016	Worksheet 0-0 Part I	6
			Hospi ce CCI	N: 15-1527	To 12/31/2016		epared: 47 pm
			_		Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENER SERVI CE	AL PATIENT/ RESIDENTIAL CARE SERVICES	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
	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
	STAFF TRANSPORTATION						12.00
13.00							13.00
							14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE		° °		04		15.00 16.00
	PATIENT/RESIDENTIAL CARE SERVICES			33, 1	04		17.00
17.00	LEVEL OF CARE				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	(0 0		0	(50.00
	HOSPICE ROUTINE HOME CARE		-		0	1, 991, 606	
	HOSPI CE I NPATI ENT RESPI TE CARE				-	307, 844	
	HOSPICE GENERAL INPATIENT CARE		ol o		0 0	42, 829	
	NONREIMBURSABLE COST CENTERS	- I	· ·	1			
60.00	BEREAVEMENT PROGRAM	(0	C	60.00
61.00	VOLUNTEER PROGRAM	(0	C	61.00
62.00	FUNDRAI SI NG	(0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	(0	C	63.00
64.00	PALLIATIVE CARE PROGRAM	(0	C	64.00
65.00	OTHER PHYSICIAN SERVICES	(0	C	65.00
	RESI DENTI AL CARE	(0 0		0 0	C	66.00
	ADVERTI SI NG	(0	C	
	TELEHEALTH/TELEMONI TORI NG	(0	C	
	THRI FT STORE	() I		0	C	
	NURSING FACILITY ROOM & BOARD					C	
	OTHER NONREI MBURSABLE (SPECI FY)	(-		0 0	C	
	NEGATIVE COST CENTER		-		0 0	0	
100.00	TOTAL		0 0	33, 1	04 0	2, 342, 279	7100.00

Heal th	Financial Systems	GOSHEN HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0026	Period:	Worksheet 0-6	
STATI S	TI CAL BASI S		Hospi ce CCI	N: 15-1527	From 01/01/2016 To 12/31/2016		nared
			nospi ce oo	1. 10 1027	10 12/01/2010	5/25/2017 2:4	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCILIATIO		
		& FLX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS SALARI ES)		COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		2.00	0100			
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		6, 718				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	856, 42	27		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	6, 718	856, 42	-1, 027, 790	1, 314, 489	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	679	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	442	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	121, 348	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0		0 0	140, 036	
11.00	MEDI CAL RECORDS	0	0		0 0	35, 603	
12.00	STAFF TRANSPORTATION	0	0		0 0	27, 269	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	-		0 0	18, 578	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.00
F0 00	LEVEL OF CARE	1	1	[0	0	
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00 52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0	0		0 0	946, 373	51.00 52.00
52.00 53.00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0			0 0	4, 071 20, 090	
55.00	NONREI MBURSABLE COST CENTERS	0	0		0 0	20,090	55.00
60, 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0 0	0	61.00
62.00	FUNDRALSING	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSI CLAN SERVI CES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	736			1, 027, 790	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 109556	0. 60194	9	0. 781893	101.00

Heal th	Financial Systems	GOSHEN HO)SPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	ERVICE COSTS	Provider C		Period: From 01/01/2016	Worksheet 0-6 Part II	
			Hospi ce CC	N: 15-1527	To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
					Hospi ce I	0/20/2011 211	/ p
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET) (IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		5.00	6.00	7.00	8.00	HRS.) 9.00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	1.00	0.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1, 126					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 536		8.00
9.00	NURSING ADMINISTRATION	0			0	183, 126	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
50.00	LEVEL OF CARE						F0 00
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1 10/	0		0 00	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 126	0		0 92 0 444		52.00
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0	0		0 444	0	53.00
60,00	BEREAVEMENT PROGRAM	0		1	0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLI ATI VE 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	-	66.00
67.00	ADVERTI SI NG	0	-		0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1, 210	0		0 788	216, 229	100.00
101.00	UNIT COST MULTIPLIER	1.074600	0. 000000	0.0000	1. 470149	1. 180766	101.00

Heal th	Financial Systems	GOSHEN HOS	PI TAL		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TCAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II	pared:
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATI C N (MI LEAGE)	COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
		DAYS) 10. 00	11.00	12.00	SERVICE) 13.00	14.00	
0	GENERAL SERVICE COST CENTERS	10100		12100	10100	11100	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES _EVEL OF CARE	21, 787	21, 787	45, 21	3 0 0 0 0 0 0 0 0 0	0 0 0	15.00
50. 00 51. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	0 21, 251	0 21, 251			0	51.00
	HOSPI CE I NPATI ENT RESPI TE CARE HOSPI CE GENERAL I NPATI ENT CARE	92 444	92 444		3 O O O	0	
-	NONREIMBURSABLE COST CENTERS						
61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part 1)	249, 529	63, 441			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00
	UNIT COST MULTIPLIER	11. 453114	2. 911874				

Heal th	Financial Systems	GOSHEN H	OSPI TAL		In Lie	u of Form CMS	-2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0026	Peri od:	Worksheet 0-	6
STATI S	TI CAL BASI S			N 45 4507	From 01/01/2016	Part II	
			Hospi ce CC	N: 15-1527	To 12/31/2016	Date/Time Pr 5/25/2017 2:	
					Hospi ce I	5/25/2017 2.	47 piii
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL	_		
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATI ENT	BASI S)	(IN-FACILIT			
		DAYS)	, í	DAYS)			
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0					15.00
16.00	OTHER GENERAL SERVICE		30, 803				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE			1			_
50.00	HOSPICE CONTINUOUS HOME CARE	0	-				50.00
51.00	HOSPICE ROUTINE HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		1	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
	NONREI MBURSABLE COST CENTERS		-	1			
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRALSING		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	0		0		65.00
66.00 67.00	RESI DENTI AL CARE ADVERTI SI NG	0			0		66.00 67.00
68.00	TELEHEALTH/TELEMONI TORI NG						68.00
69.00 70.00	THRIFT STORE NURSING FACILITY ROOM & BOARD						69.00 70.00
		0	0		0		70.00
71.00 99.00	OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER	0			U		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	_	33, 104		0		100.00
	UNIT COST MULTIPLIER	0. 000000			00		100.00
101.00		0.00000	1 1.074701	0.0000			1.01.00

пеат (Г	Financial Systems	GOSHEN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPOR	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	RVICE COSTS BY	Provider CC	CN: 15-0026	Period:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	N: 15-1527	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
					Hospi ce I	372372017 2.4	- piii
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	HCHC	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00	0. 692452		0 0	0	
2.00	OCCUPATIONAL THERAPY	67.00	0. 379676		0 0	0	
3.00	SPEECH PATHOLOGY	68.00	0. 423441		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 215399		0 0	0	
5.00 6.00	DURABLE MEDI CAL EQUI P-RENTED LABORATORY	96.00 60.00	0. 199181		0 0	0	5.00
6.00	BLOOD LABORATORY	60.01	0. 000000		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	1. 148533		0 0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	1. 140333		0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0. 579351		0 0	0	•
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
		Charges by LOC (from		Shared Servi	ce Costs by LOC		
		Provi der					
	Cost Center Descriptions	Records) HGI P	HCHC (col. 1	HRHC (col.	1 HIRC (col. 1	HGIP (col. 1	
	Cost Center Descriptions	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	
2.00	OCCUPATIONAL THERAPY	0	0		0 0	0	
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	0	0		0	0	5.00
6. 00 6. 01	LABORATORY BLOOD LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	8.00
	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
9 00						0	1 7.00
9.00 10.00	OTHER ANCI LLARY SERVICE COST CENTERS						10.00

CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-0026	Peri od:	Worksheet 0-8	
		Hospi ce CCI	N: 15-1527	From 01/01/2016 To 12/31/2016		
				Hospi ce I		
			TITLE XVIII		TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1. (
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0 0		4.
00	Program cost (line 3 times line 4)			0 0		5.
	HOSPICE ROUTINE HOME CARE					
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			1, 991, 606	6.
	line 11)					
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				21, 251	
00	Total average cost per diem (line 6 divided by line 7)				93.72	
00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	16, 8			9.
0. 00	Program cost (line 8 times line 9)		1, 575, 9	02 0		10.
	HOSPICE INPATIENT RESPITE CARE			-	I	
	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0- line 11)	7, col. 8,			307, 844	
2. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.
3.00	Total average cost per diem (line 11 divided by line 12)				3, 346. 13	13.
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		84 0		14.
5.00	Program cost (line 13 times line 14)		281, 0	75 0		15.
	HOSPI CE GENERAL I NPATI ENT CARE					
5.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0- line 11)	7, col. 9,			42, 829	16.
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				444	17.
. 00	Total average cost per diem (line 16 divided by line 17)				96.46	18.
0.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	2	99 0		19.
	Program cost (line 18 times line 19)	- /	28, 8			20.
	TOTAL HOSPICE CARE					1
. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				2, 342, 279	21.
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				21, 787	
	Average cost per diem (line 21 divided by line 22)				107.51	

Health Financial Systems	GOSHEN HOSPI TAL		u of Form CMS-2	2552-1
CALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0026	Peri od: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Pre 5/25/2017 2:4	
	Title XVIII	Hospi tal	PPS	
			1 00	
PART I - FULLY PROSPECTIVE METHOD			1.00	
CAPITAL FEDERAL AMOUNT				1
1.00 Capital DRG other than outlier			1, 121, 976	1.00
1.01 Model 4 BPCI Capital DRG other than outlier			0	
2.00 Capital DRG outlier payments			22, 961	
2.01 Model 4 BPCI Capital DRG outlier payments			0	
3.00 Total inpatient days divided by number of days 4.00 Number of interns & residents (see instructions		tructions)	56.45 0.00	
5.00 Indirect medical education percentage (see inst			0.00	
6.00 Indirect medical education adjustment (multiply		1 columns 1 and	0.00	
1.01) (see instructions)			0	0.0
7.00 Percentage of SSI recipient patient days to Med	icare Part A patient days (Worksheet I	E, part A line	2.55	7.0
30) (see instructions)				
8.00 Percentage of Medicaid patient days to total day	ys (see instructions)		20.48	
9.00 Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (se	a instructions)		23.03	
10.00 Allowable disproportionate share percentage (se 11.00 Disproportionate share adjustment (see instruct			4.77 53.518	
12.00 Total prospective capital payments (see instruct			1, 198, 455	
			1, 170, 100	12.0
			1.00	
PART II - PAYMENT UNDER REASONABLE COST		1		
1.00 Program inpatient routine capital cost (see ins			0	
2.00 Program inpatient ancillary capital cost (see i 3.00 Total inpatient program capital cost (line 1 pl			0	
4.00 Capital cost payment factor (see instructions)			0	
5.00 Total inpatient program capital cost (line 3 x	line 4)		0	
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1.00 Program inpatient capital costs (see instructio	ns)		0	1.0
2.00 Program inpatient capital costs for extraordina			0	2.0
3.00 Net program inpatient capital costs (line 1 min	us line 2)		0	3.0
4.00 Applicable exception percentage (see instructio	·		0.00	
5.00 Capital cost for comparison to payments (line 3			0	
5.00 Percentage adjustment for extraordinary circums			0.00	
7.00 Adjustment to capital minimum payment level for		k line 6)	0	
3.00 Capital minimum payment level (line 5 plus line 9.00 Current year capital payments (from Part I, lin			0	
10.00 Current year comparison of capital minimum paym		less line 9)	0	
11.00 Carryover of accumulated capital minimum paymen Worksheet L, Part III, line 14)			0	
12.00 Net comparison of capital minimum payment level	to capital payments (line 10 plus lin	ne 11)	0	12.0
13.00 Current year exception payment (if line 12 is p			0	
	t level over capital payment for the t		0	
14.00 Carryover of accumulated capital minimum paymen (if line 12 is negative, enter the amount on th	is line)			
(if line 12 is negative, enter the amount on th	·		0	1
(if line 12 is negative, enter the amount on th	yment (see instructions) nstructions)		0	