Health Financia	al Syst	ems	KOSCIUSKO COMMUNITY	' HOSPI TAL			In Lie	u of Form	CMS-	2552-10
			g; 42 CFR 413.20(b)). Fail							
payments made	si nce	the beginning of the co	st reporting period being	deemed overpaymen	its (42	_USC_1395	g).	OMB NO. ()938-	-0050
			OST REPORT CERTIFICATION	Provi der CCN: 15	50133	Peri od:	01/2014	Worksheet Parts I-I		
AND SETTLEMENT	SUMMAI	RY						Date/Time 7/31/2015	e Pre	epared: 03 am
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	7/31/20	15 Tim	ie:	9:03 am
use only	2. [] Manually submitted co	st report							
	3. [0 4. [F] If this is an amended] Medicare Utilization.	report enter the number o Enter "F" for full or "L"	f times the provi for low.	der re	esubmitted	this co	ost report		
Contractor use only	(1) (2) (3)	Settled with Audit		this Provider CC his Provider CCN	11. C CN 12. [ne 5, co			
	(4)	Reopened								

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 KOSCIUSKO COMMUNITY HOSPITAL (150133) for the cost reporting period beginning 03/01/2014 and ending 02/28/2015 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	Admi ni strator	of Provider(s)	
			• •	
Title				_
11 11 0				
-				
Date				

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-58, 606	-116, 466	14, 905	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
8.00	NURSING FACILITY	0				0	8. 00
200.00	Total	0	-58, 606	-116, 466	14, 905	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150133 Peri od: Worksheet S-2 From 03/01/2014 Part I Date/Time Prepared: 02/28/2015 7/30/2015 3:14 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2101 EAST DUBOIS DRIVE 1.00 PO Box: 1.00 State: IN County: KOSCIUSKO 2.00 City: WARSAW Zip Code: 46580-2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 KOSCIUSKO COMMUNITY 150133 99915 07/01/1966 0 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 03/01/2014 02/28/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 610 202 1. 204 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0.00

0.00

61.06

61.06 Enter the amount of ACA §5503 award that is being

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provi	der CCN: 150133	Peri od: From 03/01/2014 To 02/28/2015		
		Program Name	Program Cod	de Unweighted IME FTE Count	7/30/2015 3:1 Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count. 61.20 Of the FTEs in line 61.05, special	of FTE residents uctions) Enter in - in column 2, the the IME FTE umn 4, direct GME			0. 00		61. 10
program specialty, if any, and the residents for each expanded program instructions) Enter in column 1, enter in column 2, the program column 3, the LME FTE unweighted count 4, direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column			0. 00	0.00	01. 20
					1. 00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE residents				oried for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Re	funding (see instructs that rotated from a riod of HRSA THC prog	tions) Teaching Health ram. (see instruc	Center (THC) in			62. 01
63.00 Has your facility trained resider	nts in nonprovider se	ttings during thi	s cost reporting	g period? Enter s)	N	63.00
			Unwei ghter FTEs Nonprovi de Si te	d Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
In			1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			ysThis base ye	ar is your cost m	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facility or of unweighted non tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see	y trained resider -primary care all nonprovider non-primary care column 3 the rat instructions)	io	0.00		64.00
	Program Name	Program Code	Unwei ghte FTEs Nonprovi de Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
15.00 5.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	1. 00	2. 00	3.00	4.00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to			0	0.00	0. 000000	65.00

residents attributable to rotations occurring in all non-provider settings. Enter in

non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems KOSCIUSKO COMMU	JNITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 03/01/2014	Worksheet S-2 Part I	!
		-	Го 02/28/2015	Date/Time Pre 7/30/2015 3:1	
			V 1. 00	XI X 2. 00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	al services? Er	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	N	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (d	lual certificati			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applic 93.00 Does this facility operate an ICF/MR facility for purposes		XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	n in the	N	N	94.00
applicable column.					
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.		O. O	N O. OC	95. 00 96. 00	
97.00 If line 96 is "Y", enter the reduction percentage in the ap	0.0	0.00	97. 00		
105.00 Does this hospital qualify as a Critical Access Hospital (C 106.00 of this facility qualifies as a CAH, has it elected the all	N N		105. 00 106. 00		
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligi	N		107. 00		
for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W	o in column 1.	(see			
the program would be cost reimbursed. If yes complete Wkst.	D-2, Pt. II. (Column 2: If			
this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or					
instructions) 108.00 s this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	· N	N	N	N	109. 00
				1.00	1
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	N	110. 00
The carrent cost reporting period. Effect 1 for yes of it	101 110.			2 2 2 2 2	
Miscellaneous Cost Reporting Information			1. 0	00 2.00 3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub.15-1, §2208.1.	t. If column 2 int for long terers) based on the	is "E", enter rm care (inclu ne definition	in column ides in CMS		115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu no.			"N" for N		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is 1		118. 00
Granii illade. Effet 2 11 the porrey 13 occurrence.		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		13, 06			118. 01
			1. 00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE					119. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i	N	N	120. 00		
"N" for no. Is this a rural hospital with < 100 beds that q	n column 1, "Y' ualifies for th	' for yes or ne Outpatient			
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y' ualifies for th nts? (see instr	' for yes or ne Outpatient ructions)			100.5-
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y' ualifies for th nts? (see instr	' for yes or ne Outpatient ructions)	Y		121. 00
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes or "N" for no.	n column 1, "Y' ualifies for the nts? (see instr antable devices	' for yes or ne Outpatient ructions) s charged to			121. 00 125. 00
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e	n column 1, "Y' ualifies for the ints? (see instruction antable devices for yes and "N"	' for yes or ne Outpatient ructions) s charged to	Y		
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.	n column 1, "Y' qualifies for the nts? (see instrantable devices for yes and "N" enter the certification in the ce	' for yes or ne Outpatient ructions) s charged to for no. If	Y		125. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	KOSCIUSKO COMMU IDENTIFICATION DATA	JNITY HOSPITAL Provider C	CN: 150133	Period: From 03/ To 02/		u of Form CMS- Worksheet S- Part I Date/Time Pr 7/30/2015 3:	2 epared:
				1.	. 00	2.00	
128.00 If this is a Medicare certified liv in column 1 and termination date, i 129.00 If this is a Medicare certified lur	f applicable, in column	2.		n			128. 00 129. 00
column 1 and termination date, if a 130.00 If this is a Medicare certified par date in column 1 and termination da	 ocreas transplant center,	enter the certi	fi cati on				130. 00
131.00 If this is a Medicare certified int date in column 1 and termination da	estinal transplant cente ite, if applicable, in co	er, enter the cer olumn 2.					131. 00
132.00 If this is a Medicare certified isl in column 1 and termination date, i	fapplicable, in column	2.					132. 00 133. 00
133.00 If this is a Medicare certified oth in column 1 and termination date, i 134.00 If this is an organ procurement organd termination date, if applicable	f applicable, in column panization (OPO), enter t	2.					134. 00
All Providers							
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	l" for no in column 1. If	yes, and home of	office costs		Y	449008	140. 00
1.00	2.0		0113)		3. 00		
If this facility is part of a chair home office and enter the home offi 141.00 Name: CHS/COMMUNITY HEALTH SYSTEMS	ce contractor name and o	contractor number	r	name and a			141. 00
I NC. 142. 00 Street: 4000 MERI DI AN BLVD	PO Box:	. 3	Contract	or 3 Numb		, i	142. 00
143. 00 Ci ty: FRANKLI N	State: Ti	N	Zi p Code	:	3706	7	143. 00
						1.00	_
144.00 Are provider based physicians' cost 145.00 If costs for renal services are cla only? Enter "Y" for yes or "N" for	imed on Worksheet A, lir		osts for inp	oatient se	ervi ces	Y	144. 00 145. 00
join y: Enter 1 Tor yes or 10 Tor	110.						
146.00 Has the cost allocation methodology	, shanged from the provis	walv filed east	ranart?		. 00 N	2.00	146. 00
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in c 147.00 Was there a change in the statistic 148.00 Was there a change in the order of	column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for	15-2, § 4020) If yes or "N" for r	yes, enter		N N		147. 00
149.00 Was there a change to the simplifie no.		Enter "Y" for yes	or "N" for	,	N		149. 00
		Part A 1.00	2.00		le V . 00	Title XIX 4.00	_
Does this facility contain a provious or charges? Enter "Y" for yes or "N		n exemption from	the applica and Part B.	ation of	the lowe	er of costs 3.13)	
155.00 Hospi tal		N	N		N	N	155. 00
156. 00 Subprovi der - IPF 157. 00 Subprovi der - IRF		N N	N N		N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
						1.00	
Multicampus 165.00 s this hospital part of a Multicam	npus hospital that has or	ne or more campus	ses in diffe	erent CBS/	As?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County		p Code	CBSA	FTE/Campus	
166.00 f ine 165 is yes, for each	0	1. 00	2. 00	3.00	4. 00	5.00	0 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1.00	
Health Information Technology (HIT)						1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	under Section §1886(n)? is "Y") and is a meanir	Enter "Y" for yngful user (line	es or "N" f	or no.	the	Y	167. 00 0 168. 00
169.00 If this provider is a meaningful us transition factor. (see instruction		d is not a CAH (I	ine 105 is	"N"), ent	ter the	0.5	0169. 00

Health Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DATA	Provi der CCN: 150133	Peri od:	Worksheet S-2	
			From 03/01/2014		
			To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	03/01/2014	02/28/2015	170. 00		
				1.00	
171.00 If line 167 is "Y", does this provide Medicare cost plans reported on Wkst. (see instructions)	N	171. 00			

10371 I		COSCI USKO COMMUNITY HOSPITAL	CCN, 1E0122		eu of Form CMS	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNAIRE Provider	F	Period: From 03/01/2014		
			1	o 02/28/2015	Date/Time Pr 7/30/2015 3:	
				Y/N	Date	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for all NO re	esponses. Enter	1.00	2.00 the	_
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
. 00	Has the provider changed ownership immediate			N		1.0
	reporting period? If yes, enter the date of	the change in column 2. (see	instructions) Y/N	Date	V/I	_
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination		N			2.0
	voluntary or "I" for involuntary.	on and the condition of				
3. 00	Is the provider involved in business transaction tracts, with individuals or entities (e.g.	tions, including management	Y			3.0
	or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personnel					
	of directors through ownership, control, or i relationships? (see instructions)	ramity and other similar				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3.00	_
. 00	Column 1: Were the financial statements pre		N			4.0
	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or					
	column 3. (see instructions) If no, see instructions	ructions.				
. 00	Are the cost report total expenses and total those on the filed financial statements? If		N			5. 0
	those on the fired financial statements? If	yes, subilit reconciliation.		Y/N	Legal Oper.	
	Annual Educational Activities			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is the	ne provider is	N		6.0
	the legal operator of the program?	3				
. 00 . 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'		d during the	N N		7. 0 8. 0
	cost reporting period? If yes, see instruction	ons.	Ü			
. 00	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the current cos	st report? If	N		9.0
0. 00	Was an Intern-Resident program been initiated	d or renewed in the current o	cost reporting	N		10.0
1. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & P in an An	aroved	N		11.0
1. 00	Teaching Program on Worksheet A? If yes, see		51 6 V C G	14		11.0
					1. 00	_
	Bad Debts				1.00	_
	Is the provider seeking reimbursement for back		ti one		Υ	
2.00					l .	
2. 00 3. 00	If line 12 is yes, did the provider's bad del			st reporting	N N	12. 0 13. 0
3. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy change of	during this cos	, ,	l .	13. 0
3. 004. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	bt collection policy change of and/or co-payments waived? It	during this cos	ructions.	N N	13. 0
3. 004. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy change of and/or co-payments waived? In or cost reporting period? If	f yes, see inst	ructions.	N N N Part B	13. 0
3. 004. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	or cost reporting period? If Description	yes, see instructions by the second by the	ructions. ructions. rt A Date	N N Part B Y/N	13. 0
 3. 00 4. 00 	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	bt collection policy change of and/or co-payments waived? In or cost reporting period? If	f yes, see inst	ructions.	N N N Part B	13. 0
3. 00 4. 00 5. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R	or cost reporting period? If Description	yes, see instructions by the second by the	ructions. ructions. rt A Date	N N Part B Y/N	13. C
3. 00 4. 00 5. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priore. PS&R Data	or cost reporting period? If Description	yes, see instructions yes, yes, yes, yes, yes, yes, yes, yes	ructions.	N N Part B Y/N 3.00	13. (14. (15. (
3. 00 4. 00 5. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	or cost reporting period? If Description	yes, see instructions yes, yes, yes, yes, yes, yes, yes, yes	ructions.	N N Part B Y/N 3.00	13. (14. (15. (
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	or cost reporting period? If Description	yes, see instruction yes, see instruction yes, see instruction y/N 1.00	ructions.	N N Part B Y/N 3.00	13. C 14. C 15. C
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records	or cost reporting period? If Description	yes, see instructions yes, yes, yes, yes, yes, yes, yes, yes	ructions.	N N Part B Y/N 3.00	13. C 14. C 15. C
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is	or cost reporting period? If Description	yes, see instruction yes, see instruction yes, see instruction y/N 1.00	ructions.	N N Part B Y/N 3.00	13. (14. (15. (
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records	or cost reporting period? If Description	yes, see instruction yes, see instruction yes, see instruction y/N 1.00	ructions.	N N Part B Y/N 3.00	13. (14. (15. (
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior of	or cost reporting period? If Description	yes, see instruction yes, see instruction yes, see instruction y/N 1.00	ructions.	N N Part B Y/N 3.00	13. (14. (15. (16. (
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)	or cost reporting period? If Description	during this cos f yes, see inst yes, see instr Par Y/N 1.00	ructions.	N N Part B Y/N 3.00 Y	13. (14. (15. (16. (
3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file	or cost reporting period? If Description	during this cos f yes, see inst yes, see instr Par Y/N 1.00	ructions.	N N Part B Y/N 3.00 Y	13. (14. (15. (16. (
4. 00 4. 00 55. 00 66. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	or cost reporting period? If Description	during this cos f yes, see inst yes, see instr Par Y/N 1.00	ructions.	N N Part B Y/N 3.00 Y	13. (14. (15. (16. (17. (18. (
3. 00 4. 00 5. 00 6. 00 7. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior bid total bid bid total bid total bid total bid total bid total bid total bid bid total bid total bid total bid	or cost reporting period? If Description	yes, see instruction with the see instruction of the see instruction	ructions.	N N Part B Y/N 3.00 Y N	13. C 14. C 15. C 17. C 18. C
 3. 00 4. 00 	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see	or cost reporting period? If Description	yes, see instruction with the see instruction of the see instruction	ructions.	N N Part B Y/N 3.00 Y N	13. 0
3. 00 4. 00 5. 00 6. 00 7. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior bid total bid bid total bid total bid total bid total bid total bid total bid bid total bid total bid total bid	or cost reporting period? If Description	yes, see instruction with the see instruction of the see instruction	ructions.	N N Part B Y/N 3.00 Y N	13. 0 14. 0 15. 0 16. 0

Health Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL		In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	RELMBURSEMENT OUESTLONNALRE	Provi der CCN: 150133	Peri od:	Worksheet S-2

From 03/01/2014 | Part II 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Ν 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Υ 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 12/31/2013 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position JEREMY BURL FSON 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. COMMUNITY HEALTH SYSTEM 42.00 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost (615) 465-3427 JEREMY_BURLESON@CHS. NET 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150133 Peri od: Worksheet S-2 From 03/01/2014 To 02/28/2015 Part II Date/Time Prepared: 7/30/2015 3:14 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 07/27/2015 16.00 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) 17.00 Was the cost report prepared using the PS&R 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position DIRECTOR, REVENUE MANAGEMENT 41.00 held by the cost report preparer in columns 1, 2, and 3,

42.00

43.00

respecti vel y.

preparer.

42.00

43.00

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Enter the telephone number and email address of the cost

Health Financial Systems KOSCIUSKO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150133

						To 02/28/2	015	Date/Time Prep 7/30/2015 3:14	
								I/P Days / 0/P	трш
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours		Title V	
		Line Number			Avai I abl e				
		1. 00		2. 00	3. 00	4. 00		5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		58	21, 17	0 0	. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
2.00	for the portion of LDP room available beds) HMO and other (see instructions)								2. 00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO IRF Subprovider								4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							o	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							l ől	6. 00
7. 00	Total Adults and Peds. (exclude observation			58	21, 17	0 0	. 00		7. 00
7.00	beds) (see instructions)			00					7.00
8.00	INTENSIVE CARE UNIT	31. 00		14	5, 11	0 0	. 00	o	8.00
9.00	CORONARY CARE UNIT								9. 00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGICAL INTENSIVE CARE UNIT								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43. 00						0	13.00
14. 00	Total (see instructions)			72	26, 28	O C	. 00	l .	14.00
15. 00	CAH visits							0	15. 00
16. 00	SUBPROVI DER - I PF								16. 00
17. 00	SUBPROVI DER - I RF								17. 00
18. 00	SUBPROVI DER								18. 00
19.00	SKILLED NURSING FACILITY	45.00							19. 00
20.00	NURSING FACILITY	45. 00		0	1	0		0	20. 00
21. 00 22. 00	OTHER LONG TERM CARE								21. 00 22. 00
22. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)								23. 00
24. 00	HOSPICE	116. 00		0		0			24. 00
24. 00	HOSPICE (non-distinct part)	30. 00		U	1				24. 00
25. 00	CMHC - CMHC	30.00							25. 00
26. 00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER								26. 25
27. 00	Total (sum of lines 14-26)			72					27. 00
28. 00	Observation Bed Days							o	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. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days				1				33. 00

Provi der CCN: 150133

						7/30/2015 3:1	4 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 593	407	9, 445			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, 237	1, 404				2. 00
3.00	HMO IPF Subprovider	0	0	ł			3. 00
4.00	HMO IRF Subprovider	0	0	ł			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	0.500	0				6.00
7. 00	Total Adults and Peds. (exclude observation	3, 593	407	9, 445			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	520	77	1, 297			8. 00
9. 00		320	11	1, 297			9.00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		130	1, 264			13.00
14. 00	Total (see instructions)	4, 113	614			476.74	
15. 00	CAH visits	4, 113	0	,		470.74	15. 00
16. 00	SUBPROVIDER - I PF	Ŭ	O				16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY		0	0	0.00	0.00	•
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	476. 74	1
28. 00	Observation Bed Days		0	2, 990			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22 00	outpatient days (see instructions)	0					22.00
33. 00	LTCH non-covered days	l 이		I	l	I	33. 00

 Heal th Financial
 Systems
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 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA

Provi der CCN: 150133 | Peri od: | Worksheet S-3 | Part | To | 02/28/2015 | Date/Time Prepared: | Part | Pa

					02/20/2013	7/30/2015 3: 1	
		Full Time	'	Di sch	arges	.,	
		Equi val ents	- ,,	T-1.1. \0.011		-	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11.00	12. 00	13. 00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		(1, 165	372	3, 486	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	0		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6, 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	(1, 165	372	3, 486	
15. 00	CAH visits	0.00	,	1, 103	372	3, 400	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER - TRF						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	1	0. 00					20.00
21. 00	NURSING FACILITY	0.00					21. 00
	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00 24. 00
24. 00	HOSPI CE	0. 00					
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 03/01/2014 | Part II | To 02/28/2015 | Date/Time Prepared: Provi der CCN: 150133

Worksheet A Line Number Reported Rep						To	02/28/2015	Date/Time Pre 7/30/2015 3:1	
PART II - WASF DATA SALARIES Total State of the Part II - WASF DATA SALARIES Total Salaries Salari								Average Hourly	
PART_II - MIGE_BATA			Line Number	Reported					
Maintenance					Worksheet A-6)	3)	col. 4	ŕ	
SAMPLES SAMPLES 1.00 Total solaries (see		DADT II WACE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
Instructions									1
2.00 Non-physic clan anesthetist Part 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.0	1.00		200. 00	23, 398, 807	0	23, 398, 807	991, 629. 00	23. 60	1.00
3.00 Mon-physici an anesthetist Pert	2 00	· · · · · · · · · · · · · · · · · · ·		0	0	0	0.00	0.00	2 00
4.00 Physician Part A — Abin in Strative Abin in Strative Stration Part A — Teaching Control Physician Part B — Teaching Physician Part B — Teachi	2.00	. ,					0.00	0.00	2.00
Administrative ()	3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
Physician Part B	4.00	Physician-Part A -		0	О	0	0. 00	0.00	4.00
5.00 Physician-Part B									
Non-physician-Part B 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.				-	_				
30 30 30 30 30 30 30 30		Non-physician-Part B		0	Ō	0	0. 00	0. 00	6. 00
Contracted interns and residents (in an approved progress)	7. 00		21. 00	0	0	0	0.00	0. 00	7. 00
Description	7. 01			0	О	0	0. 00	0.00	7. 01
None of the personnel		` ''							
9.00 SNF	8. 00			0	0	0	0.00	0.00	8. 00
Instructions OTHER MAGES & RELATED COSTS	9.00	SNF	44. 00	0	0	0	0.00	0. 00	9. 00
OTHER WASES & RELATED COSTS 1.00 Contract I abors: Tip I rect Pati ent Care 1.448,600 0 1.448,600 26,354.00 54.97 11.00 Contract I abors: Top I evel management and other manageme	10. 00			31, 075	132, 401	163, 476	7, 379. 00	22. 15	10.00
Care Contract labor: Top level			L						
12.00 Contract labor: Top level management and other management and administrative services	11. 00			1, 448, 600	0	1, 448, 600	26, 354. 00	54. 97	11. 00
management and administrative	12. 00	1		0	О	0	0.00	0.00	12. 00
Services									
A - Administrative									
14. 00 Home office salaries & 1,519,274 0 1,519,274 28,151.00 53.97 14.00 15.00 Non-physician anesthetist Part B 18.00	13. 00			270, 253	0	270, 253	1, 666. 00	162. 22	13. 00
wage-related costs	14. 00			1, 519, 274	0	1, 519, 274	28, 151, 00	53. 97	14. 00
- Administrative				_	_	_			
16.00 Home office and Contract Physicians Part A - Teaching	15.00			O	0	0	0.00	0.00	15.00
WAGE_RELATED_COSTS Wage_rel ated costs (core) (see instructions) 17.00 wage_rel ated costs (other) 0 0 0 0 0 0 18.00 (see instructions) 19.00 Excluded areas 38,022 0 38,022 19.00 0 0 0 0 0 0 0 0 0	16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
17. 00 Wage-related costs (core) (see 18. 00 18.									1
18.00 Wage-related costs (other) 38,002 38,022 19.00 20.00 Non-physician anesthetist Part 20.00 Non-physician anesthetist Part 20.00 20.	17. 00	Wage-related costs (core) (see		5, 058, 762	0	5, 058, 762			17. 00
See instructions Excluded areas 38,022 0 38,022 19,00 20,00 Non-physician anesthetist Part 0 0 0 0 0 0 21,00 20,00 21,00 20,00 21,00 20,00 21,00 22,00 20,00 21,00 22,00 2	18 00			0	0	0			18 00
20.00 Non-physician anesthetist Part A D D D D D D D D D		(see instructions)		_	_				
21.00				38, 022	0	38, 022			
B	20.00	A		Ö					20.00
Administrative Physician Part A - Teaching 0 0 0 0 0 0 0 22.01	21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching 23. 00 Physician Part B 24. 00 0 0 0 0 0 23. 00	22. 00			0	0	0			22. 00
23.00 Physician Part B 0 0 0 0 0 24.00 24.00 24.00 25.00 1 1 1 1 1 1 1 1 1	22 01	1		0	0	0			22 01
25.00 Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIES				-	_	l ĭ			
Approved program OVERHEAD COSTS - DIRECT SALARIES Sempl oyee Benefits Department 4.00 161,902 0 161,902 5,935.00 27.28 26.00				-	_	0			24. 00
26. 00 Empl oyee Benefits Department 4. 00 161, 902 0 161, 902 5, 935. 00 27. 28 26. 00	25.00			U	0	U			25.00
27. 00 Administrative & General	0, 00			4.4.000		1/1 000	5 005 00		
28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						·			1
29. 00 Maintenance & Repairs 6. 00 0 0 0 0 0. 00 0. 00 29. 00 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Administrative & General under	5. 55	0	0	0	· ·		
30.00 Operation of Plant 7.00 512,944 0 512,944 26,055.00 19.69 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0 0 0.00 31.00 31.00 32.00 Housekeeping 9.00 580,332 0 580,332 45,536.00 12.74 32.00 0 0 0 0 0 0 0.00 33.00 (see instructions) 10.00 590,695 -464,230 126,465 9,328.00 13.56 34.00 13.50 0 instructions) 11.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00		4 00	0	0	0	0.00	0.00	20.00
31. 00 Laundry & Linen Service				512, 944	0	512, 944			1
33.00 Housekeeping under contract (see instructions) 34.00 Di etary Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 10.00 590,695 -464,230 126,465 9,328.00 13.56 34.00 0 0 0 0 0.00 0.00 35.00 11.00 0 464,230 464,230 34,240.00 13.56 36.00 0 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 908,923 236,880 1,145,803 32,294.00 35.48 38.00		Laundry & Linen Service		0	0	0		l .	
(see instructions) 34. 00 Di etary 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursi ng Administration 39. 00 Central Services and Supply 34. 00 590, 695 -464, 230 126, 465 9, 328. 00 13. 56 34. 00 0 0 0 0 0 0. 00 35. 00 11. 00 0 464, 230 464, 230 34, 240. 00 13. 56 36. 00 0 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0. 00 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 37. 00 0 0 0 0 0 0. 00 0. 00 0 0 0 0 0. 00 0 0 0 0			9. 00	580, 332 n	0	580, 332 n			
35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursi ng Administration 39.00 Central Services and Supply Di etary under contract (see on traction on the contract (see on the contra		(see instructions)		· ·					
instructions) 36.00 Cafeteria 11.00 0 464,230 464,230 34,240.00 13.56 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 908,923 236,880 1,145,803 32,294.00 35.48 38.00 39.00 Central Services and Supply 14.00 252,142 0 252,142 15,987.00 15.77 39.00			10. 00	590, 695	-464, 230	126, 465			
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 908, 923 236, 880 1, 145, 803 32, 294. 00 35. 48 38. 00 39. 00 Central Services and Supply 14. 00 252, 142 0 252, 142 15, 987. 00 15. 77 39. 00	55.00			U			0.00	0.00	33.00
38.00 Nursing Administration 13.00 908,923 236,880 1,145,803 32,294.00 35.48 38.00 39.00 Central Services and Supply 14.00 252,142 0 252,142 15,987.00 15.77 39.00		1		0	464, 230	464, 230			
39.00 Central Services and Supply 14.00 252,142 0 252,142 15,987.00 15.77 39.00				908. 923	236. 880	1, 145, 803			
40.00 Pharmacy 15.00 809,066 0 809,066 21,497.00 37.64 40.00	39. 00	Central Services and Supply	14. 00	252, 142	0	252, 142	15, 987. 00	15. 77	39. 00
	40. 00	Pharmacy	15. 00	809, 066	0	809, 066	21, 497. 00	37. 64	40.00

Health Financial Systems	K	OSCIUSKO COMMU	JNITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150133 F	Peri od:	Worksheet S-3	
				F	rom 03/01/2014		
					o 02/28/2015	Date/Time Prep 7/30/2015 3:14	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	454, 132	0	454, 132	27, 436. 00	16. 55	41. 00
Records Library							
42.00 Social Service	17. 00	C	0	(0.00	0.00	42. 00
43.00 Other General Service	18. 00	C	0	(0.00	0.00	43. 00

Provi der CCN: 150133

							7/30/2015 3: 1	4 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		23, 398, 807	0	23, 398, 807	991, 629. 00	23. 60	1. 00
	instructions)							
2.00	Excluded area salaries (see		31, 075	132, 401	163, 476	7, 379. 00	22. 15	2.00
	instructions)							
3.00	Subtotal salaries (line 1		23, 367, 732	-132, 401	23, 235, 331	984, 250. 00	23. 61	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		3, 238, 127	0	3, 238, 127	56, 171. 00	57. 65	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 058, 762	2 0	5, 058, 762	0.00	21. 77	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		31, 664, 621	-132, 401	31, 532, 220	1, 040, 421. 00	30. 31	6. 00
7.00	Total overhead cost (see		8, 942, 700	-132, 401	8, 810, 299	396, 734. 00	22. 21	7. 00
	instructions)							

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPI TAL WAGE RELATED COSTS	Provi der CCN: 150133	Peri od: Worksheet S-3 From 03/01/2014 Part IV To 02/28/2015 Date/Time Prepared:

	To 02/28/2015	Date/Time Prep 7/30/2015 3:14				
		Amount				
		Reported				
		1. 00				
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
1.00	401K Employer Contributions	382, 266	1.00			
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00			
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00			
4.00	Qualified Defined Benefit Plan Cost (see instructions)					
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					
5.00	401K/TSA Plan Administration fees	0	5.00			
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00			
7.00	Employee Managed Care Program Administration Fees	0	7.00			
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)	2, 479, 725	8. 00			
9.00	Prescription Drug Plan	0	9. 00			
10.00	Dental, Hearing and Vision Plan	40, 603	10.00			
11.00	Life Insurance (If employee is owner or beneficiary)	22, 237	11.00			
12.00	Accident Insurance (If employee is owner or beneficiary)	-267	12.00			
13.00	Disability Insurance (If employee is owner or beneficiary)	19, 677	13.00			
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00			
15.00		166, 105	15.00			
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00			
	Non cumulative portion)					
	TAXES					
17.00	FICA-Employers Portion Only	1, 324, 886	17.00			
18.00	Medicare Taxes - Employers Portion Only	309, 852	18.00			
19.00	Unempl oyment Insurance	0	19.00			
20.00	State or Federal Unemployment Taxes	190, 969	20.00			
	OTHER					
21.00		0	21.00			
	instructions))					
	Day Care Cost and Allowances	0	22.00			
	Tuition Reimbursement	0	23.00			
24.00	Total Wage Related cost (Sum of lines 1 -23)	4, 936, 053	24.00			
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	160, 730	25.00			

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 03/01/2014 To 02/28/2015	Worksheet S-3 Part V Date/Time Pre 7/30/2015 3:1	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	

			7/30/2015 3: 1	4 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - IPF			3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF	0	0	9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	Renal Dialysis			17. 00
18. 00	Other	0	0	18. 00

	Financial Systems KOSCIUSKO COMMUNITY HOS				u of Form CMS-2		
HOSPI T	FAL UNCOMPENSATED AND INDIGENT CARE DATA	ovider Co	CN: 150133	Peri od:	Worksheet S-10	0	
				From 03/01/2014 To 02/28/2015	Date/Time Pre	nared:	
					7/30/2015 3: 14		
					1. 00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	d by line	202 column	8)	0. 127714	1.00	
2. 00	Net revenue from Medicaid				8, 354, 528	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				0,001,020	3.00	
4. 00							
5. 00	If line 4 is "no", then enter DSH or supplemental payments from Med				0	4. 00 5. 00	
6. 00	Medi cai d charges				48, 034, 275	6. 00	
7. 00	Medicaid cost (line 1 times line 6)				6, 134, 649	7. 00	
8. 00	Difference between net revenue and costs for Medicaid program (line	e 7 minus	sum of lin	es 2 and 5: if	0	8.00	
	< zero then enter zero)						
	State Children's Health Insurance Program (SCHIP) (see instructions	s for eac	:h line)				
9.00	Net revenue from stand-alone SCHIP				0	9.00	
10.00	Stand-alone SCHIP charges				0	10.00	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (li	ne 11 mir	nus line 9;	if < zero then	0	12. 0	
	enter zero)						
	Other state or local government indigent care program (see instruct						
13. 00	Net revenue from state or local indigent care program (Not included			,	453, 253		
14. 00	Charges for patients covered under state or local indigent care pro	ogram (No	ot included	in lines 6 or	4, 583, 532	14.0	
45 00	10)				505 004	45.0	
15.00	State or local indigent care program cost (line 1 times line 14)		(1.1	45 ' ''	585, 381	15.00	
16. 00	Difference between net revenue and costs for state or local indiger 13; if < zero then enter zero)	nt care p	orogram (III	e 15 minus iine	132, 128	16. 00	
	Uncompensated care (see instructions for each line)						
17. 00	Private grants, donations, or endowment income restricted to funding	ng chari t	v care		0	17. 00	
18. 00	Government grants, appropriations or transfers for support of hospi				0	18. 0	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local in			s (sum of lines	132, 128		
17.00	8, 12 and 16)	nar gent e	are program	3 (30m 01 1111C3	132, 120	17.00	
			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
			1. 00	2. 00	3. 00		
20. 00	Total initial obligation of patients approved for charity care (at		1, 116, 92	75, 680	1, 192, 602	20.00	
21 00	charges excluding non-reimbursable cost centers) for the entire fac		140 (4	7 0 //5	150 010	21 0	
21. 00	Cost of initial obligation of patients approved for charity care (I times line 20)	iine i	142, 64	9, 665	152, 312	21. 00	
22. 00			2, 95	2 8, 918	11. 870	22. 00	
23. 00			139, 69		140, 442		
23.00	cost of chairty care (fine 21 millius fine 22)		137, 07	5 747	140, 442	23.00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient day		la length o	f stay limit		24.00	
	imposed on patients covered by Medicaid or other indigent care prog						
25. 00			ıram's lengt	h of stay limit	0	25. 00	
26. 00					18, 900, 324		
27. 00	Medicare bad debts for the entire hospital complex (see instruction				-20, 967		
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 2		,		18, 921, 291		
29. 00		e (line 1	times line	28)	2, 416, 514		
30.00					2, 556, 956 2, 689, 084		
	Total unreimbursed and uncompensated care cost (line 19 plus line 3						

Heal th	Financial Systems	KOSCIUSKO COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
					From 03/01/2014 To 02/28/2015	Date/Time Pre	pared:
					10 02/20/2010	7/30/2015 3:1	
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 725, 196	1, 725, 19	6 1, 174, 889	2, 900, 085	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 554, 769			4, 187, 266	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	161, 902	107, 375	269, 27	7 3, 211, 438	3, 480, 715	4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	4, 672, 564	37, 405, 797	42, 078, 36	1 -29, 797, 859	12, 280, 502	5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	0	0		0 25, 166, 594	25, 166, 594	5. 02
7.00	00700 OPERATION OF PLANT	512, 944	1, 566, 762				
8.00	00800 LAUNDRY & LINEN SERVICE	500 222	322, 298			322, 298	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	580, 332	245, 653			825, 985 270, 140	
11. 00	01100 CAFETERI A	590, 695	672, 876 0	1	993, 048		
13. 00	01300 NURSI NG ADMI NI STRATI ON	908, 923	122, 676		•	1, 266, 930	
14. 00	01400 CENTRAL SERVICES & SUPPLY	252, 142	3, 153, 369			579, 574	1
15.00	01500 PHARMACY	809, 066	5, 793, 063			1, 111, 518	1
16.00	01600 MEDICAL RECORDS & LIBRARY	454, 132	414, 156	868, 28	-1, 334	866, 954	16. 00
17. 00	01700 SOCIAL SERVICE	0	20	2	0 -20	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDI ATRI CS	3, 843, 913	2, 020, 441			5, 144, 700	
31.00	03100 INTENSIVE CARE UNIT	1, 124, 833	167, 508	1			1
43. 00 45. 00	04300 NURSERY 04500 NURSING FACILITY	0	0		0 223, 288 0 0		
45.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	0	0	45.00
50. 00	05000 OPERATING ROOM	1, 270, 158	996, 794	2, 266, 95	2 -1, 100	2, 265, 852	50.00
51. 00	05100 RECOVERY ROOM	638, 831	136, 602			774, 557	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 487, 232		1
53.00	05300 ANESTHESI OLOGY	0	924, 222	924, 22	2 -18, 402	905, 820	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 978, 516	1, 668, 235			2, 356, 720	
54. 01	05401 ULTRASOUND	492, 497	90, 897	1		269	
54. 02	05402 ONCOLOGY	142 125	127	1			
56. 00 57. 00	05600	143, 135	132, 824 312, 059			275, 959 512, 444	
58. 00	05800 MRI	246, 616 234, 749	512, 059 519, 869				
60.00	06000 LABORATORY	1, 260, 704	2, 086, 150				
65. 00	06500 RESPI RATORY THERAPY	403, 417	76, 782				
66.00	06600 PHYSI CAL THERAPY	627, 676	1, 242, 687	1			
67. 00	06700 OCCUPATI ONAL THERAPY	22, 283	217, 884	240, 16	7 -273	239, 894	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	23, 445			23, 445	1
69. 00	06900 ELECTROCARDI OLOGY	138, 919	14, 232	153, 15		153, 151	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 490, 183		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 320, 134 0 5, 373, 520		1
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 5, 373, 320	0, 373, 320	
	03610 SLEEP LAB	88, 204	38, 446	126, 65	0 -126, 650		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	48, 712	32, 907	81, 61	9 -81, 619	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	506, 342	25, 738			610, 157	
	09100 EMERGENCY	1, 355, 527	522, 801	1, 878, 32	-42, 759	1, 835, 569	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	o o	0		0 0	_	
70.00	SPECIAL PURPOSE COST CENTERS			1	<u> </u>		70.00
116.00	11600 HOSPI CE	0	0		0 0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23, 367, 732	66, 334, 660	89, 702, 39	2 -300, 761	89, 401, 631	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31, 075	26, 211				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	117, 742	117, 74	2 -165, 062		
	19201 WELLNESS CENTER	0	0		0		192. 01 194. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS		0		0 463, 983	463, 983	
	07952 SENI OR CI RCLE		-2, 296	-2, 29			194. 01
	07953 OTHER NONREIMBURSABLE COST CENTERS		2, 270	2,2/	0 2,310		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	Ó	0		0 0		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194. 05
200.00	TOTAL (SUM OF LINES 118-199)	23, 398, 807	66, 476, 317	89, 875, 12	4 0	89, 875, 124	200. 00

					02, 20, 2010	7/30/2015 3: 1	4 pm
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00	l			
1.00	00100 CAP REL COSTS-BLDG & FLXT	3, 435, 264	6, 335, 349				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-1, 138, 808		1			2.00
				1			
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 571		•			4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	-375, 577		•			5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	-22, 618, 625					5. 02
7.00	00700 OPERATION OF PLANT	0	2, 173, 354				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	21	322, 319				8. 00
9.00	00900 HOUSEKEEPI NG	0	825, 985				9. 00
10.00	01000 DI ETARY	0	270, 140	•			10.00
11. 00	01100 CAFETERI A	-354, 040					11. 00
13. 00				1			13. 00
	01300 NURSI NG ADMI NI STRATI ON	0		1			
14. 00	01400 CENTRAL SERVICES & SUPPLY	0		1			14. 00
15. 00	01500 PHARMACY	0					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	33	866, 987				16. 00
17. 00	01700 SOCI AL SERVI CE	0	0				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-1, 332, 483	3, 812, 217				30.00
31. 00	03100 INTENSIVE CARE UNIT	0					31.00
43. 00	04300 NURSERY	0					43. 00
45. 00	1			1			45. 00
45.00			1 0				45.00
F0 00	ANCILLARY SERVICE COST CENTERS		0.045.050				
50. 00	05000 OPERATI NG ROOM	0		1			50. 00
51. 00	05100 RECOVERY ROOM	0					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	487, 232				52. 00
53.00	05300 ANESTHESI OLOGY	-905, 356	464				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-81, 963					54.00
54. 01	05401 ULTRASOUND	-268					54. 01
54. 02	05402 ONCOLOGY	0	l .				54. 02
56. 00	05600 RADI OI SOTOPE	-330		•			56.00
				•			
57. 00	05700 CT SCAN	-9, 104	· ·				57. 00
58. 00	05800 MRI	-31, 740					58. 00
60.00	06000 LABORATORY	-67, 618	3, 111, 006				60.00
65.00	06500 RESPI RATORY THERAPY	0	606, 292				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 867, 715				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0					67. 00
68. 00	06800 SPEECH PATHOLOGY	0		1			68. 00
69. 00	06900 ELECTROCARDI OLOGY						69.00
			,				71.00
71. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT			1			•
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	5, 373, 520				73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 00
76. 01	03610 SLEEP LAB	0	0				76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 02
76. 03	1 1	0	0				76. 03
	OUTPATIENT SERVICE COST CENTERS			I.			
90. 00		0	610, 157				90.00
	09100 EMERGENCY	-128, 038		1			91.00
	1 1	-120,030	1, 707, 331				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	T	1	T			
95. 00	09500 AMBULANCE SERVICES	0		•			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 H0SPI CE	0	0				116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-23, 610, 203	65, 791, 428				118. 00
	NONREI MBURSABLE COST CENTERS	20/010/200	00/////120				1.10.00
100 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		56, 810				190. 00
		241 004					
	19200 PHYSI CI ANS' PRI VATE OFFI CES	241, 984	194, 664				192. 00
	1 19201 WELLNESS CENTER	0	· 0				192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 00
194.0	1 07951 MARKETI NG	0	463, 983				194. 01
194. 03	2 07952 SENI OR CIRCLE	-31, 496	-31, 476				194. 02
	3 07953 OTHER NONREI MBURSABLE COST CENTERS	1,7,7	J ., ., o				194. 03
	4 07954 OTHER NONREIMBURSABLE COST CENTERS		0				194. 04
	5 07955 OTHER NONREIMBURSABLE COST CENTERS						194. 04
		_	_				
200.00	TOTAL (SUM OF LINES 118-199)	-23, 399, 715	66, 475, 409	I			200. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-0
From 03/01/2014
To 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Provi der CCN: 150133

					7/30/2015 3:14 pm
		Increases			
	Cost Center	Li ne #	Salary	0ther	
	2.00	3. 00	4. 00	5. 00	
	A - EMPLOYEE BENEFITS		ما	0.010.000	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 213, 200	1.
2.00		0.00	0	0	2.
	0		0	3, 213, 200	
	B - OXYGEN		_1		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	43, 332	1.
	PATI ENT				
2. 00		0.00	0	0	2.
	0		0	43, 332	
	C - LEASE AND RENTAL				
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	428, 256	1.
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	618, 519	2.
3.00		0.00	0	0	3.
4.00		0.00	0	0	4.
5.00		0.00	0	0	5.
6.00		0.00	0	0	6.
7.00		0.00	0	0	7.
8.00		0.00	0	0	8.
9.00		0.00	0	0	9.
10.00		0.00	o	0	10.
11. 00		0.00	o	0	11.
12.00		0.00	o	0	12.
13. 00		0.00	O	0	13.
14. 00		0.00	o	0	14.
15. 00		0.00	o	0	15.
16. 00		0.00	o	0	16.
17. 00		0.00	ő	0	17.
18. 00		0.00	o	0	18.
19. 00		0.00	o	0	19.
20. 00		0.00	0	0	20.
21. 00		0.00	0	0	
			- 1	U	21.
22. 00		0.00			22.
	O D - OTHER CAPITAL		U	1, 046, 775	
1 00		1 00	ما	115 25/	1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115, 356	1.
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	631, 277	2.
3.00	CAP REL COSTS-MVBLE EQUIP		0_	1 <u>3, 9</u> 78	3.
	0		0	760, 611	
	E - MARKETING				
1. 00	MARKETING	1 <u>94.</u> 01	13 <u>2, 4</u> 01	33 <u>3, 8</u> 98	1.
	0		132, 401	333, 898	
	F - CNO COST				
1.00	NURSING ADMINISTRATION	1300	236, 880	0	1.
	0		236, 880	0	
	G - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	446, 851	1.
	PATI ENT				
2.00	IMPL. DEV. CHARGED TO	72. 00	O	2, 320, 134	2.
	PATI ENTS				
3.00	OPERATING ROOM	50.00	o	862	3.
		+		2, 767, 847	
	H - DRUGS		-1	,	
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5, 373, 520	1.
	0			5, 373, 520	
	I - LABOR AND DELIVERY		٥,	0,0,0,020	
1.00	NURSERY	43.00	187, 950	35, 338	1.
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	410, 121	77, 111	2.
2.00	0	52.00	598, 071	112, 449	Σ.
	J - MISC DEPARTMENTS		370, 071	112, 449	
1 00	CLINIC	90.00	48, 712	22 007	1
1.00	1			32, 907	1.
2.00	RESPIRATORY THERAPY	65.00	88, 204	37, 889	2.
3.00	OTHER ADMINISTRATIVE AND	5. 02	1, 906, 536	23, 260, 058	3.
	GENERAL	,			
4.00	SENI OR CIRCLE	194. 02	0	2, 316	4.
5.00	OTHER ADMINISTRATIVE AND	5. 01	0	20	5.
	GENERAL				
	0		2, 043, 452	23, 333, 190	
	K - RADI OLOGY				
1.00	RADI OLOGY-DI AGNOSTI C	54.00	492, 497	90, 628	1.
2.00	ONCOLOGY	54.02	760, 067	742, 802	2.
	0		1, 252, 564	833, 430	
	IO	I	1, 232, 304	033, 430	I

Heal th	Financial Systems		KOSCIUSKO COMMI	UNITY HOSPITAL		In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 150133	Peri od:	Worksheet A-	6
						From 03/01/2014 To 02/28/2015	Date/Time Pro 7/30/2015 3:	epared: 14 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4.00	5. 00				
	L - DIETARY							
1.00	CAFETERI A	11. 00	464, 230	528, 818				1. 00
	0		464, 230	528, 818				
	M - MOB UTILITIES							
1.00	OPERATION OF PLANT	7. 00	0	95, 169				1. 00
	0		0	95, 169				
500.00	Grand Total: Increases		4, 727, 598	38, 442, 239				500.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150133

Peri od: From 03/01/2014 To 02/28/2015 Worksheet A-6 Date/Ti me Prepared: 7/30/2015 3: 14 pm

1. 00 2. 00	Cost Center 6.00 A - EMPLOYEE BENEFITS	Decreases Li ne # 7.00	Sal ary	Other	Wkst. A-7 Ref.	
1. 00 2. 00	6. 00			Other		
1. 00 2. 00		7. 00 I				1
1. 00 2. 00	A - EMPLOYEE BENEFITS		8. 00	9. 00	10. 00	
2.00	OTHER ARMINI CTRATINE AND	E 01	ما	2 200 020	O	1 00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5. 01	0	3, 208, 829	٩	1.00
	PHYSICIANS' PRIVATE OFFICES	192. 00	o	4, 371	0	2.00
	0		— — ŏ	3, 213, 200	— — —	2.00
	B - OXYGEN		<u> </u>	0,2.0,200		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	24, 930	0	1.00
1	ANESTHESI OLOGY	53.00	O	18, 402	0	2. 00
				43, 332		
Ī	C - LEASE AND RENTAL		<u>'</u>		·	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 762	10	1.00
2.00	OTHER ADMINISTRATIVE AND	5. 01	O	24, 188	10	2.00
	GENERAL					
	OPERATION OF PLANT	7. 00	0	1, 521	0	3. 00
1	DI ETARY	10. 00	0	383	0	4.00
	NURSING ADMINISTRATION	13. 00	0	1, 549	0	5. 00
	CENTRAL SERVICES & SUPPLY	14. 00	0	33, 160	0	6. 00
	PHARMACY	15. 00	0	117, 091	0	7. 00
	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 334	0	8. 00
	ADULTS & PEDIATRICS	30. 00	0	9, 134	0	9. 00
	INTENSIVE CARE UNIT	31.00	0	2, 228	0	10.00
	OPERATING ROOM	50.00	0	1, 962	0	11.00
	RECOVERY ROOM	51.00	0	876	0	12.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	370, 287	0	13.00
	CT SCAN	57.00	0	45, 229	0	14.00
	MRI	58.00	0	217, 586	0	15. 00
	LABORATORY	60.00	0	168, 230	0	16.00
1	PHYSI CAL THERAPY	66.00	0	2, 648	0	17. 00
	OCCUPATI ONAL THERAPY	67.00	0	273	0	18.00
	SLEEP LAB	76. 01	0	557	0	19.00
	CLINIC	90.00	0	3, 542	0	20.00
	EMERGENCY	91.00	0	42, 759	0	21.00
	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	476	0	22. 00
	CANTEEN	+		1, 046, 775	+	
ı	D - OTHER CAPITAL		<u> </u>	1,040,775		-
	OTHER ADMINISTRATIVE AND	5. 01	0	695, 089	12	1.00
	GENERAL	0.01	Ĭ	070,007	12	1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	o	65, 522	13	2.00
3.00		0.00	o	0	12	3. 00
				760, 611	1	
	E - MARKETING					1
1.00	OTHER ADMINISTRATIVE AND	5. 01	132, 401	333, 898	0	1.00
	GENERAL					
	0		132, 401	333, 898		
	F - CNO COST					
	OTHER ADMINISTRATIVE AND	5. 01	236, 880	0	0	1. 00
ļ	GENERAL	+			+	
	0		236, 880	0		_
	G - CHARGABLE SUPPLIES	14.00	ما	0.7/7.047	0	4 00
	CENTRAL SERVICES & SUPPLY	14.00	0	2, 767, 847	0	1.00
2.00		0.00	0	0	0	2.00
3. 00					0	3. 00
	H - DRUGS		U	2, 767, 847		
	PHARMACY	15. 00	0	E 272 E20	0	1 00
1.00	O — — — — —		 	5, 37 <u>3, 5</u> 20 5, 373, 520	9	1. 00
ł	I - LABOR AND DELIVERY		U	3, 373, 320		-
1.00	ADULTS & PEDIATRICS	30.00	598, 071	112, 449	0	1.00
2.00	ADOLIS & FEDIATRICS	0.00	370, 071	112, 447	0	2.00
2.00			598, 071	112, 449	— — — 4	2.00
	J - MISC DEPARTMENTS		370, 071	112, 447	L	-
1.00	OTHER ANCILLARY SERVICE COST	76. 03	48, 712	32, 907	0	1.00
	CENTERS	, 0. 03	10, 712	32, 707	9	00
	SLEEP LAB	76. 01	88, 204	37, 889	0	2.00
	OTHER ADMINISTRATIVE AND	5. 01	1, 906, 536	23, 260, 058	o	3. 00
	GENERAL	5. 5.		.,,	٦	
	MARKETI NG	194. 01	o	2, 316	0	4.00
	SOCI AL SERVI CE	17. 00	õ	20	o	5. 00
	0		2, 043, 452	23, 333, 190	— — 1	1
	K - RADI OLOGY	<u>'</u>	,		<u> </u>	1
	ULTRASOUND	54. 01	492, 497	90, 628	0	 1.00
	RADIOLOGY-DIAGNOSTIC	54.00	<u>760, 0</u> 67	74 <u>2, 8</u> 02	0	2.00
2.00	0		1, 252, 564	833, 430	T	1

Health Financial Systems			KOSCIUSKO COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS				Provi der	CCN: 150133	Peri od: From 03/01/2014	Worksheet A-	6
						To 02/28/2015	Date/Time Pro 7/30/2015 3:	epared: 14 pm
	Decreases							
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	;		
	6. 00	7. 00	8. 00	9. 00	10. 00			
	L - DIETARY							
1.00	DI ETARY	10. 00	464, 230	528, 818		0		1. 00
	0		464, 230	528, 818				
	M - MOB UTILITIES							
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	95, 169		0		1. 00
	0		0	95, 169				
500.00	Grand Total: Decreases		4, 727, 598	38, 442, 239				500.00

						1/30/2015 3: 14	4 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 381, 252	0	0	0	0	1. 00
2.00	Land Improvements	1, 881, 289	63, 463	0	63, 463	0	2. 00
3.00	Buildings and Fixtures	55, 329, 567	908, 935	0	908, 935	0	3. 00
4.00	Building Improvements	44, 845	0	0	0	0	4. 00
5.00	Fixed Equipment	4, 945, 942	470, 321	0	470, 321	5, 512	5. 00
6.00	Movable Equipment	37, 908, 911	1, 031, 249	0	1, 031, 249	270, 434	6. 00
7.00	HIT designated Assets	2, 375, 096	89, 387	0	89, 387	0	7. 00
8.00	Subtotal (sum of lines 1-7)	104, 866, 902	2, 563, 355	0	2, 563, 355	275, 946	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	104, 866, 902	2, 563, 355	0	2, 563, 355	275, 946	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	2, 381, 252	0				1. 00
2.00	Land Improvements	1, 944, 752	0				2. 00
3.00	Buildings and Fixtures	56, 238, 502	0				3. 00
4.00	Building Improvements	44, 845	0				4. 00
5.00	Fixed Equipment	5, 410, 751	0				5. 00
6.00	Movable Equipment	38, 669, 726	0				6.00
7.00	HIT designated Assets	2, 464, 483	0				7. 00
8.00	Subtotal (sum of lines 1-7)	107, 154, 311	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	107, 154, 311	0				10.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150133	Period: From 03/01/2014	Worksheet A-7 Part II	
				To 02/28/2015	Date/Time Pre	pared:
-					7/30/2015 3:1	4 pm
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)	
	9. 00	10.00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUN	TS FROM WORKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0	1	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUN	TS FROM WORKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	1, 725, 196	1, 725, 196				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	3, 554, 769	3, 554, 769	1			2. 00
3.00 Total (sum of lines 1-2)	5, 279, 965	5, 279, 965				3. 00

Heal th	n Financial Systems	KOSCIUSKO COMML	JNITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 03/01/2014 Fo 02/28/2015		pared:
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	0	0		1. 000000	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(0. 000000		2. 00
3.00	Total (sum of lines 1-2)	0	0	()	1.000000		3. 00
					SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		6.00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	9.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	LIVILIA	0		1, 170, 841	349, 377	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	Ö	Ö		-1, 257, 500		2. 00
3.00	Total (sum of lines 1-2)	0	0		-86, 659		3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11. 00	12.00	12.00	instructions)	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14. 00	15.00	
1.00	CAP REL COSTS-BLDG & FLXT	2, 298, 916	115, 356	631, 27	1, 769, 582	6, 335, 349	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			3, 673, 461		2. 00
3.00	Total (sum of lines 1-2)	2, 298, 916					3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 KOSCIUSKO COMMUNITY HOSPITAL Peri od: Worksheet A-8 From 03/01/2014 To 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Provi der CCN: 150133

					0 02/28/2015	7/30/2015 3: 1	
				Expense Classification on To/From Which the Amount is			
				TO/FI OIII WITCH THE AMOUNT IS	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00	1. 00
1.00	COSTS-BLDG & FLXT (chapter 2)		0	CAL REE GOOTS BEDG & TTAT	1.00		1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	di scounts (chapter 8)		0		0.00		
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	В	016	OTHER ADMINISTRATIVE AND	5. 01	0	7. 00
7.00	stations excluded) (chapter	В	-810	GENERAL	5.01	J	7.00
8. 00	21) Television and radio service	A	24 150	CAP REL COSTS-MVBLE EQUIP	2. 00	9	8. 00
6.00	(chapter 21)	A	-24, 139	CAP REL CUSTS-WVBLE EQUIP	2.00	9	8.00
9.00	Parking Lot (chapter 21)	4.0.2	0		0.00		9. 00 10. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 456, 952			0	10.00
11. 00	Sale of scrap, waste, etc.	В	-14	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 810, 067			0	12. 00
40.00	transactions (chapter 10)				0.00		40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-354, 040	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0		0.00		15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients		· ·				
18. 00	Sale of medical records and abstracts	В	33	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00		21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL	A	1, 170, 841	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
27.00	COSTS-BLDG & FLXT	A	1 222 447	CAD DEL COSTS MADLE FOLLID	2.00	9	27. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1, 222, 447	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of		· ·				
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
0.5	limitation (chapter 14)						0.5
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	· ·	A		OTHER ADMINISTRATIVE AND	5. 01	0	33. 00
00.00		i l		GENERAL	i .	i	İ

From 03/01/2014 To 02/28/2015 Date/Time Prepared:

				T	o 02/28/2015	Date/Time Pre 7/30/2015 3:1	
	·			Expense Classification on	Worksheet A	7/30/2013 3. 1	4 piii
				To/From Which the Amount is			
				To Troil will ell the Amount 13	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	5551 551151 55551 Pt. 511	1.00	2. 00	3.00	4. 00	5. 00	
34. 00	RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00		34. 00
35. 00	MISC INCOME	В		OTHER ADMINISTRATIVE AND	5. 01	0	ı
		_	,	GENERAL		_	
36. 00	HOSPITAL BAD DEBT	A	-21, 102, 106	OTHER ADMINISTRATIVE AND	5. 02	0	36. 00
			, , , , , ,	GENERAL			
37.00	PATIENT PHONE WAGE COST	A	-7, 212	OTHER ADMINISTRATIVE AND	5. 02	0	37. 00
				GENERAL			
38.00	PATIENT PHONE BENEFIT COSTS	A	-1, 571	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	38. 00
39.00	PATIENT PHONE EXPENSE	A	-17, 269	OTHER ADMINISTRATIVE AND	5. 02	0	39. 00
				GENERAL			
40.00	PATIENT PHONE DEPRECIATION	A	-1, 230	CAP REL COSTS-MVBLE EQUIP	2. 00	9	40. 00
41.00	PATIENT TV - DEPRECIATION	A	-9, 664	CAP REL COSTS-MVBLE EQUIP	2. 00	9	41.00
42.00	MARKETING	Α	-223, 486	OTHER ADMINISTRATIVE AND	5. 01	0	42.00
				GENERAL			
43.00	PHYSICIAN RECRUITING	A	-8, 991	OTHER ADMINISTRATIVE AND	5. 01	0	43.00
				GENERAL			
44.00	CHARITABLE CONTRIBUTIONS	A	-7, 976	OTHER ADMINISTRATIVE AND	5. 01	0	44. 00
				GENERAL			
45.00	UNCOLLECTED PHYSICAN RENT	A	-11, 074	OTHER ADMINISTRATIVE AND	5. 01	0	45. 00
				GENERAL			
45. 01	MI NORI TY I NTEREST	A	-446, 466	OTHER ADMINISTRATIVE AND	5. 01	0	45. 01
				GENERAL		_	
45. 02	LOBBYING EXPENSE IN	A	-3, 041	OTHER ADMINISTRATIVE AND	5. 01	0	45. 02
	ASSOCIATION DUES			GENERAL		_	
45. 03	TRANSPORTATION COSTS	A	-428	OTHER ADMINISTRATIVE AND	5. 01	0	45. 03
45 04	LECAL FEEC		14 5/1	GENERAL	F 01		45 04
45. 04	LEGAL FEES	A	- 14, 561	OTHER ADMINISTRATIVE AND	5. 01	0	45. 04
45. 05	POB DEPRECIATION	A	101 040	GENERAL PHYSICIANS' PRIVATE OFFICES	192. 00	0	45. 05
45. 06	POB RENT	A		PHYSICIANS' PRIVATE OFFICES	192.00		
45. 07	SPECIAL EVENTS	A	· ·	1	5. 01	0	
45.07	SELUTAL EVENTS	A	-4, 022	OTHER ADMINISTRATIVE AND GENERAL	3.01		45.07
45. 08	NON-ALLOWABLE LEGAL EXPENSE	A	_EE2 04E	OTHER ADMINISTRATIVE AND	5. 01	0	45. 08
45.00	(DOJ)	A	-555,005	GENERAL	3.01	0	45.00
45. 09	MEALS AND ENTERTAINMENT	A	_18_807	OTHER ADMINISTRATIVE AND	5. 01	0	45. 09
43.07	WEALS AND ENTERTAINMENT	, A	10, 007	GENERAL	3.01	٥	13.07
45. 10			0		0.00	0	45. 10
45. 11			0		0.00		45. 11
45. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	l e	45. 12
10. 12	(3)		O		3.00		10. 12
50. 00	TOTAL (sum of lines 1 thru 49)		-23, 399, 715				50.00
	(Transfer to Worksheet A,		., ,				
	column 6, line 200.)						
				•			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 150133 Peri od: Worksheet A-8-1 From 03/01/2014 OFFICE COSTS

OTTTOL	00313			To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
	Li ne No.	Cost Center	Expense I tems	Amount of Allowable Cost	Amount	·
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:					
1.00		CAP REL COSTS-BLDG & FIXT	Direct Allocation - Capital-	2, 298, 916	0	1. 00
2.00		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	26, 712	0	2. 00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	3, 902	0	3.00
4.00	5. 01	OTHER ADMINISTRATIVE AND GEN		418, 065	0	4.00
4. 01		CAP REL COSTS-BLDG & FIXT	Pre-Acq Legacy Capital Costs		0	4. 01
4.02	l control of the cont		Pre-Acq Legacy Capital Costs		0	4. 02
4.03	5. 01	OTHER ADMINISTRATIVE AND GEN		212, 499	0	4. 03
4.04			New Capital - Building & Fix		0	4. 04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm		0	4. 05
4.06		OTHER ADMINISTRATIVE AND GEN			0	4. 06
4. 07		OTHER ADMINISTRATIVE AND GEN			0	4. 07
4. 08		OTHER ADMINISTRATIVE AND GEN			0	4. 08
4.09		OTHER ADMINISTRATIVE AND GEN		l	793, 193	4. 09
4. 10	5. 01	OTHER ADMINISTRATIVE AND GEN	401K Fees	l ol	3, 759	4. 10
4. 11	5. 01	OTHER ADMINISTRATIVE AND GEN	Audit Fees	l ol	69, 091	4. 11
4. 12		OTHER ADMINISTRATIVE AND GEN		l ol	239, 366	4. 12
4. 13	5. 01	OTHER ADMINISTRATIVE AND GEN	MIS Fees	l ol	429, 988	4. 13
4.14	5. 01	OTHER ADMINISTRATIVE AND GEN	Managed Care	l ol	58, 836	4. 14
4. 15	5. 01	OTHER ADMINISTRATIVE AND GEN	Case Management	o	188, 962	4. 15
4. 16	5. 01	OTHER ADMINISTRATIVE AND GEN	Purchase & Ancillary	o	10, 867	4. 16
4. 17	91.00	EMERGENCY	Emergency Room	o	113, 038	4. 17
4. 18	5. 01	OTHER ADMINISTRATIVE AND GEN	PPSI Fees	o	24, 420	4. 18
4. 19	5. 01	OTHER ADMINISTRATIVE AND GEN	Compliance/HIM/CCA Fees	o	50, 297	4. 19
4. 20	194. 02	SENIOR CIRCLE	Seni or Circle	o	31, 496	4. 20
4. 21	5. 02	OTHER ADMINISTRATIVE AND GEN	PASI Collection Fees	o	515, 297	4. 21
4. 22	5. 02	OTHER ADMINISTRATIVE AND GEN	EBOS Fees	o	10, 617	4. 22
4. 23	5. 02	OTHER ADMINISTRATIVE AND GEN	PASI Lien Unit Collection Fe	o	111, 198	4. 23
4. 24	5. 01	OTHER ADMINISTRATIVE AND GEN	Malpractice Allocations (Per	o	276, 622	4. 24
4. 25	5. 02	OTHER ADMINISTRATIVE AND GEN	CIG Leased Equipment (Per Ex	o	173, 983	4. 25
4. 26		LAUNDRY & LINEN SERVICE	Laundry Revenue	313, 918	0	4. 26
4. 27	8.00	LAUNDRY & LINEN SERVICE	Laundry (per GL)	o	313, 897	4. 27
5.00	TOTALS (sum of lines 1-4).			5, 224, 994	3, 414, 927	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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas not	been posted to worksheet A,	corullins i and/or 2, the alloui	it allowable sil	ouru be murcateu m corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	i
			Ownershi p		Ownershi p	í
	1. 00	2. 00	3.00	4. 00	5. 00	
	B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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

r er ilibur	Sement under title XVIII.		
6.00	В	0. 00 COMMUNITY HEALTH SYSTEMS 100. 00	6. 00
7.00	С	0. 00 H0SPI TAL LAUNDR 20. 00	7. 00
8.00	G	0. 00 PASI 0. 00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Heal th	Financial Systems	KOSCIUSKO COMM	UNITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provi der	CCN: 150133	Peri od:	Worksheet A-8	-1
OFFICE	COSTS				From 03/01/2014 To 02/28/2015		pared:
						7/30/2015 3:1	
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of	1	Name	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	4. 00	5. 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.

OFFICE	C0515				To 02/28/2015	Date/Time Pre	epared:
	Net	Wkst. A-7 Ref.				7/30/2015 3:1	4 piii
	Adjustments	WKSt. A-7 Ker.					
	(col. 4 minus						
	col. 5)*						
	6.00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED O	RGANIZATIONS OR (CLALMED	
	HOME OFFICE CO		LETTO REGOT RED THO THE REGOT OF THE WILL				
1.00	2, 298, 916						1.00
2.00	26, 712						2. 00
3.00	3, 902	14					3. 00
4.00	418, 065	o					4. 00
4.01	3, 464						4. 01
4. 02	20, 452						4. 02
4.03	212, 499						4. 03
4.04	14, 210						4. 04
4. 05	94, 338	1					4. 05
4.06	1, 361, 023						4. 06
4. 07	345, 245						4. 07
4. 08	112, 250						4. 08
4.09	-793, 193						4. 09
4. 10	-3, 759						4. 10
4. 11	-69, 091						4. 11
4. 12	-239, 366						4. 12
4. 13	-429, 988						4. 13
4.14	-58, 836	0					4. 14
4. 15	-188, 962	O					4. 15
4. 16	-10, 867	O					4. 16
4. 17	-113, 038	o					4. 17
4. 18	-24, 420	0					4. 18
4. 19	-50, 297	o					4. 19
4.20	-31, 496	0					4. 20
4. 21	-515, 297	o					4. 21
4.22	-10, 617	o					4. 22
4.23	-111, 198	0					4. 23
4.24	-276, 622	0					4. 24
4. 25	-173, 983	0					4. 25
4. 26	313, 918	0					4. 26
4. 27	-313, 897	0					4. 27
5.00	1, 810, 067						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.

Related Organization(s) and/or Home Office					
Type of Business					
6. 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.

	Sometre under the Aviiii				
6.00	HOSPITAL MANAGEMENT	6. 00			
7.00	LAUNDRY SERVICES	7. 00			
8.00	DEBT COLLECTION	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 organization.
- 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 provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 03/01/2014 | To 02/28/2015 | Date/Time Prepared: Provi der CCN: 150133

						lo 02/28/201	5 Date/lime Pre 7/30/2015 3:	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	PIII
	mot. A Line "	I denti fi er	Remuneration	Component	Component	NOE AMOUNT	i der Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 01	OTHER ADMINISTRATIVE AND	13, 104	13, 104	0	(0	1. 00
		GENERAL						
2.00	30. 00	ADULTS & PEDIATRICS	1, 332, 483	1, 332, 483	0	(0	2. 00
3.00	50. 00	OPERATING ROOM	0	0	0	(0	3. 00
4.00	53. 00	ANESTHESI OLOGY	905, 356	905, 356	0	(0	4. 00
5. 00	54. 00	RADI OLOGY-DI AGNOSTI C	81, 949	81, 949	0	(0	5. 00
6.00	54. 01	ULTRASOUND	268	268	0	(0	6. 00
7. 00	56. 00	RADI OI SOTOPE	330	330	0	(o o	7. 00
8.00	57. 00	CT SCAN	9, 104	9, 104	0	(ol o	8. 00
9.00	58. 00	MRI	31, 740	31, 740	0		ol o	9. 00
10. 00	60. 00	LABORATORY	67, 618	67, 618	0		ol o	10.00
11. 00		CLI NI C	0	0	0		ol o	11. 00
12. 00	91. 00	EMERGENCY	15, 000	15, 000	0		ol o	12. 00
200.00			2, 456, 952	2, 456, 952	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				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	5. 01	OTHER ADMINISTRATIVE AND	0	0	0	(0	1. 00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0			(0	2. 00
3.00	50. 00	OPERATING ROOM	0	0		(0	3. 00
4.00		ANESTHESI OLOGY	0	0	0	(0	4. 00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	0	(0	5. 00
6.00		ULTRASOUND	0	0	0	(0	6. 00
7.00		RADI OI SOTOPE	0	0	0	(0	7. 00
8.00		CT SCAN	0	0	0	(0	8. 00
9. 00	58. 00	MRI	0	0	0	(0	9. 00
10.00	60. 00	LABORATORY	0	0	0	C	0	10.00
11. 00	90. 00	CLI NI C	0	0	0	C	0	11. 00
12.00	91. 00	EMERGENCY	0	0	0	C	0	12. 00
200.00			0	0	0	(0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		OTHER ADMINISTRATIVE AND	0	0	0	13, 104	1	1. 00
		GENERAL	_	_	_			
2. 00		ADULTS & PEDIATRICS	0	0	_	1, 332, 483	3	2. 00
3. 00		OPERATING ROOM	0	0		(3. 00
4. 00		ANESTHESI OLOGY	0	0	_	905, 356	•	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	0	_	81, 949	•	5. 00
6. 00		ULTRASOUND	0	0		268	•	6. 00
7. 00		RADI OI SOTOPE	0	0	_	330	•	7. 00
8. 00		CT SCAN	0	0		9, 104	•	8. 00
9. 00	58. 00		0	0	_	31, 740	•	9. 00
10. 00		LABORATORY	0	0	_	67, 618	3	10. 00
11. 00		CLINIC	0	0	_	(11. 00
12. 00	91. 00	EMERGENCY	0	0		15, 000	•	12. 00
200.00			0	0	0	2, 456, 952	2	200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150133

COST Center Description					10	02/28/2015	Date/lime Pre 7/30/2015 3:1	
DESIRAL SERVICE COST CENTERS				CAPI TAL REI	LATED COSTS		77 007 2010 0. 1	
DESIRAL SERVICE COST CENTERS								
DEBBAL SERVICE COST CENTERS 1.00		Cost Center Description		BLDG & FIXT	MVBLE EQUIP		Subtotal	
Coll 77 Coll 70 1.00 2.00 4.00 4A Coll 7.00 1.00 2.00 4.00 4A Coll 7.00 1.00 2.00 4.00 4A Coll 7.00 4.00 4A Coll 7.00 4.00						DEFARTMENT		
DEMPAIL SERVICE OST CENTERS								
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000				1. 00	2.00	4. 00	4A	
2.00 00000 CAP REL DOSTS - WELL EDUIL P 3.048, 458 2.00 00000 CAP REL DOSTS - WELL EDUIL P 3.079, 144 16, 476 7.928 3,503, 548 7.727 5.00 5.01 000000								
4.00 0.0000 DEPUZYEE BEREFITS DEPARTMENT 3, 479, 144 16, 476 7, 928 2, 503, 548 7, 100 100								1
5.01 0.0540 OTHER ADMINISTRATIVE AID CENERAL 11,004,925 307,014 148,1s3 361,370 12,722,272 5,01 7.00 0.00700 OTHER ADMINISTRATIVE AID CENERAL 2,173,354 504,534 504,534 222,773 77,339 2,996,000 7,00								
0.000 0.00								1
7.00 00700 DOPERATION OF PLANT 2,173,354 504,554 242,773 77,379 2,999,000 7,00 70,00						•		1
8.00 0.0000 DAUNDRY & LINEN SERVICE 322, 319 10, 223 4, 197 0 0.0000 DOISTREPHING 885, 995 21, 570 11, 100 100 DOISTREPHING 885, 995 27, 570 10, 20 10000 DETARY 270, 140 59, 259 28, 151 10, 068 376, 981 10, 000 10000 DETARY 270, 140 59, 259 28, 151 10, 068 376, 981 10, 000 10000 DETARY 270, 140 59, 259 28, 151 10, 068 376, 981 10, 000 10000 DETARY 270, 140 10, 000 10000 DETARY 270, 140 10, 000 10000 DETARY 270, 140 10, 000 DETARY 270, 140 10, 000 DETARY 270, 140 10, 000 DETARY 270, 140 DETARRY 270, 140 DET								1
9.00 (0.990) (UISENEFFING BY 9.270, 140 (95.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (25.95) (25.9 (2								1
11.00 0 1100 CAFETERIA						87, 500		1
13.00 01300 NURSI NO. ADMINI STRATION 1. 266, 930 12, 898 6, 204 172, 758 1.4 98, 792 13.00	10.00		270, 140	59, 259	28, 514	19, 068	376, 981	10. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 579, 574 34, 247 10, 479 38, 017 608, 317 14, 00 16.00 01400 MEDICAL RECORDS & LIBRARY 866, 987 47, 106 22, 710 68, 472 1, 005, 365 16.00 17.00 170, 0								1
15.00 01500 PHARMACY 1.111, 518 4.2, 766 20, 578 121, 987 1, 296, 849 15.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0								1
1-0.00 10-000 MEDI CAL, RECORDS & LIBRARY 806, 997								1
17.00 01700 SOCIAL SERVICE OST CENTERS 3.812,217 716,591 344,811 489,993 5.363,012 30.00 30000 ADULTS & PEDIATRICS 3.812,217 716,591 344,811 489,993 5.363,012 30.00 31.		l						1
INPATI ENT ROUTINE SERVICE COST CENTERS 3,812,217 716,591 344,811 489,992 5,363,012 30.00 30.00 03000 DAUTIS & PEDIATRIC S 7,7074 169,597 1,696,960 31.00 03000 MINESRY 223,288 15,334 7,377 28,338 274,339 43.00 04500 MINESRY 223,288 15,334 7,377 28,338 274,339 43.00 04500 MINESRY 200 0 0 0 0 0 0 0 0			1					1
0.000 0.0000 ADULTS & PEDIATRICS 3.812, 217 716, 591 344, 811 499, 392 5.303, 012 30. 00 31	17.00			0	0	<u> </u>	0	17.00
31.00 03100 NTEINS IVE CARE UNIT	30. 00		3, 812, 217	716, 591	344, 811	489, 393	5, 363, 012	30.00
		l						
MACL LLARY SERVICE COST CENTERS	43.00	04300 NURSERY	223, 288	15, 334	7, 379	28, 338	274, 339	43.00
50.00	45.00		0	0	0	0	0	45. 00
51.00								
52.00 05200 DELIVERY ROOM & LABOR ROOM 487, 232 58, 645 28, 219 61,836 635,932 52.00 530.00 05300 ARSTHESI DLOGY 464 50 0 0 0 646 53.00 530.00 05300 ARSTHESI DLOGY 464 50.00 0 0 0 0 154 60.00 0 0 0 0 154 60.00 0 0 0 0 0 0 0 0 0								1
53.00 05300 ARESTHESIOLOGY 464								1
54.00 05400 RADIOLOGY-DI ACNOSTIC 2, 274, 757 222, 143 106, 892 257, 968 2, 861, 760 54.00 54.01 05401 ULTRASOUND 1 0 0 0 0 1 54.01 54.02 05402 ONCOLOGY 1, 502, 996 201, 084 96, 758 114, 599 1, 915, 437 54.02 55.00 05600 RADIOL ISOTOPE 275, 629 8, 706 4, 189 21, 581 310, 105 56.00 57.00 05700 CT SCAN 564, 342 33, 003 15, 880 37, 184 590, 409 57.00 68.00 05800 MRI 565, 292 59, 923 28, 834 35, 394 699, 443 58.00 60.00 06000 RESPIRATORY HERRAPY 606, 292 51, 506 62.24 784 74, 122 755, 706 65.00 66.00 06000 RESPIRATORY HERRAPY 606, 292 51, 506 62.24 784 74, 122 755, 706 65.00 66.00 06000 RESPIRATORY HERRAPY 23, 111, 106 103, 848 49, 970 94, 638 2, 188, 243 66.00 66.00 06000 RESPIRATORY HERRAPY 239, 894 0 0 0 3, 360 243, 254 67, 00 68.00 06000 SPECEL PATHOLOGY 23, 445 1, 704 820 0 23, 264 70, 264		05200 DELIVERY ROOM & LABOR ROOM						1
54.00 OS401 ULTRASOUND				J	-	_		1
54.02 OS402 ONCOLOGY			1	0		0		1
57.00 05700 CT SCAN 504, 342 33, 003 15, 880 37, 184 590, 409 57.00			1, 502, 996	201, 084	96, 758	114, 599	1, 915, 437	
58.00 05800 MR 505, 292 59, 923 28, 834 35, 394 629, 443 58.00 00 00 00	56.00	05600 RADI OI SOTOPE	275, 629	8, 706	4, 189	21, 581	310, 105	56. 00
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000 0.000 0.000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000								1
65.00 06500 RESPI RATORY THERAPY 606, 292 51, 506 24, 784 74, 124 756, 706 65, 00		l						1
66.00 06600 PHYSI CAL THERAPY 1,867,715 150,481 72,400 94,638 2,185,243 66.00		l						1
67:00 06700								1
68.00 06800 SPEECH PATHOLOGY 23, 445 1, 704 820 0 25, 669 68. 00 69.00 06900 ELECTROCARDI OLOGY 153, 151 852 410 20, 946 175, 359 69. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 490, 183 0 0 0 0 0 490, 183 71. 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 320, 134 0 0 0 0 2, 320, 134 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 373, 520 0 0 0 0 0 5, 373, 520 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.01 03610 SLEEP LAB 0 0 0 0 0 0 0 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 0 0 0 0 0 76.03 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.04 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 76.05 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 76.07 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 76.08 09900 CLI NI C 09900 DESERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 76.09 09900 DESERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 76.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 76.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 76.01 116.00 10590C SERVICES 0 0 0 0 0 0 0 76.02 09900 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 76.03 09900 09900 0FFT, FLOWER COFFEE SHOP & CANTEEN 194, 664 2,097, 364 1,009, 213 0 3,301, 241 192.00 76.04 194, 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 76.04 194, 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0		l						1
69-00				_	-			1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 490, 183 0 0 0 490, 183 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74.		l I			1	_	· ·	1
73. 00 07300 DRUGS CHARGED TO PATIENTS					1			1
76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 00 76. 01 03610 SLEEP LAB 0 0 0 0 0 0 0 76. 00 76. 02 03550 PSYCHIA ITRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 76. 04, 881 31, 220 83, 688 789, 946 90. 00 77. 05 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 78. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 79. 00 O9200 OUTPATI ENT SERVI CES 0 0 0 0 0 0 0 79. 00 O9200 OUTPATI ENT SERVI CES 0 0 0 0 0 0 0 79. 00 O9500 OURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 79. 00 O9500 OURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 O9500 OUTPATI ENT SERVI CES 0 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 79. 00 OUTPATI	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 320, 134	0	0	0	2, 320, 134	72. 00
76. 01 03610 SLEEP LAB			5, 373, 520			0		1
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76. 02 76. 03 03551 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 03 00 0 0 0 0 0 0 0 0			0			-		
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS 90. 00 09000 CLI NI C 610, 157 64, 881 31, 220 83, 688 789, 946 90. 00 91. 00 09000 CLI NI C 1, 707, 531 228, 311 109, 859 204, 380 2, 250, 081 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 POSSON OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 POSSON OBSERVED 0 92. 00 POSSON OB			0	_	-	ŭ		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICES OUTPATIENT SER			0			-		1
90. 00 09000 CLINIC 610, 157 64, 881 31, 220 83, 688 789, 946 90. 00 91. 00 92. 00 09200 BERERGENCY 1, 707, 531 228, 311 109, 859 204, 380 2, 250, 081 91. 00 92. 00 09200 BERERGENCY 09200 BEREVATION BEDS (NON-DISTINCT PART 092. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70.03			0	0	<u> </u>	0	70.03
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0 0 0 0 0	90.00		610, 157	64, 881	31, 220	83, 688	789, 946	90. 00
OTHER REI MBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O	91.00							
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0			_					
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 65,791,428 3,990,949 1,920,376 3,478,900 62,294,298 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 56,810 10,478 5,042 4,685 77,015 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194,664 2,097,364 1,009,213 0 3,301,241 192.00 192.00 19200 HUSLNESS CENTER 0 200,931 96,684 0 297,615 192.01 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 463,983 35,627 17,143 19,963 536,716 194.01 194.02 07952 SENI OR CI RCLE -31,476 0 0 0 0 -31,476 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.03 194.04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.03 194.04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.05 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.05 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.05 194.05 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194.05 1								
116. 00 118. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) SUBTOTAL SUBTOTALS (SUM OF LINES 1-117) SUBTOTAL SUBTOTALS (SUM OF LINES 1-117) SUBTOTAL SUB	96. 00		0	0	0	0	0	96. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 65, 791, 428 3, 990, 949 1, 920, 376 3, 478, 900 62, 294, 298 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 56, 810 10, 478 5, 042 4, 685 77, 015 190. 00 19200 PHYSI CI ANN' PRI VATE OFFI CES 194, 664 2, 097, 364 1, 009, 213 0 3, 301, 241 192. 00 19200	11/ 00		1	_		0	0	11/ 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 56,810 10,478 5,042 4,685 77,015 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194,664 2,097,364 1,009,213 0 3,301,241 192. 00 192.01			1					1
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 56, 810 10, 478 5, 042 4, 685 77, 015 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194, 664 2, 097, 364 1, 009, 213 0 3, 301, 241 192. 00 192. 01 19	110.00		05, 791, 420	3, 770, 747	1, 720, 370	3, 476, 700	02, 274, 270	1110.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194, 664 2, 097, 364 1, 009, 213 0 3, 301, 241 192. 00 192. 01 19201 WELLNESS CENTER 0 200, 931 96, 684 0 297, 615 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 463, 983 35, 627 17, 143 19, 963 536, 716 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00		56, 810	10. 478	5. 042	4. 685	77. 015	190. 00
192. 01 19201 WELLNESS CENTER 0 200, 931 96, 684 0 297, 615 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 463, 983 35, 627 17, 143 19, 963 536, 716 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 200. 00 0 0 0 0 194. 05 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
194. 01 07951 MARKETING 463, 983 35, 627 17, 143 19, 963 536, 716 194. 01 194. 02 07952 SENI OR CIRCLE -31, 476 0 0 0 0 -31, 476 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 03 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0	297, 615	192. 01
194. 02 07952 SENI OR CIRCLE			0	0	_	0		
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 200. 00 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05 0 194. 05 0 0 194. 05 0 0 194. 05 0 0 194. 05 0 19				35, 627	17, 143	19, 963		
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00			-31, 476	0	0	0		1
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 0 201. 00		1		0		0		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 201.00				0		0		
201.00 Negative Cost Centers 0 0 0 201.00					١	U		
				ი	0	0		
		1 1 9	66, 475, 409	6, 335, 349	3, 048, 458	3, 503, 548		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150133

					7/30/2015 3: 1	4 pm
Cost Center Description	OTHER ADMI NI STRATI VE	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	AND GENERAL		AND GENERAL	FLAINI	LINEN SERVICE	
	5. 01	5A. 01	5. 02	7. 00	8. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS - MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 OTHER ADMINISTRATIVE AND GENERAL	12, 722, 372					5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	843, 984	4, 411, 980				5. 02
7. 00 00700 OPERATION OF PLANT	709, 156	3, 707, 156		3, 989, 093		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	79, 824	417, 285			457, 157	8. 00
9. 00 00900 HOUSEKEEPI NG	223, 636	1, 169, 070			l	9.00
10. 00 01000 DI ETARY	89, 172 185, 152	466, 153			l .	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON	345, 067	967, 895 1, 803, 859			l e	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	158, 086	826, 403			l e	14. 00
15. 00 01500 PHARMACY	306, 761	1, 603, 610			l	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	237, 812	1, 243, 177			l e	16. 00
17. 00 01700 SOCI AL SERVI CE	237,012	1, 243, 177		37, 309	ĺ	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS			<u>, </u>	0		17.00
30. 00 03000 ADULTS & PEDIATRICS	1, 268, 583	6, 631, 595	504, 346	570, 359	151, 658	30. 00
31. 00 03100 NTENSI VE CARE UNI T	401, 404	2, 098, 364		127, 489		31. 00
43. 00 04300 NURSERY	64, 893	339, 232		-		43.00
45.00 04500 NURSING FACILITY	0	0		0	0	45. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	685, 768	3, 584, 895	272, 638	237, 390	101, 771	50.00
51.00 05100 RECOVERY ROOM	210, 925	1, 102, 622	83, 857	11, 188	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	150, 425	786, 357	59, 804	46, 678	0	52.00
53. 00 05300 ANESTHESI OLOGY	110	574		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	676, 929	3, 538, 689	269, 124	176, 811	0	54.00
54. 01 05401 ULTRASOUND	0	1	0	0	0	54. 01
54. 02 05402 ONCOLOGY	453, 083	2, 368, 520		160, 050		54. 02
56. 00 05600 RADI OI SOTOPE	73, 353	383, 458			1	56. 00
57. 00 05700 CT SCAN	139, 657	730, 066		•	l	57. 00
58. 00 05800 MRI	148, 890	778, 333			l	58. 00
60. 00 06000 LABORATORY	817, 234	4, 272, 141				60.00
65. 00 06500 RESPI RATORY THERAPY	178, 994	935, 700				65. 00
66. 00 06600 PHYSI CAL THERAPY	516, 904	2, 702, 147			27, 239 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	57, 540	300, 794				67. 00 68. 00
69. 00 06900 SPEECH PATHOLOGY	6, 143 41, 480	32, 112 216, 839		678	l e	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	115, 949	606, 132				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	548, 811	2, 868, 945			0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 271, 093	6, 644, 613		0	ĺ	73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1,2,1,0,0	0, 011, 010	0 000, 020	0	Ö	76. 00
76. 01 03610 SLEEP LAB		0	o o	0	Ö	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	0	0	0	0	76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	O	0	o	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u>. </u>					
90. 00 09000 CLI NI C	186, 856	976, 802	74, 288	51, 641	7, 982	90.00
91. 00 09100 EMERGENCY	532, 241	2, 782, 322	211, 601	181, 721	55, 874	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0)			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0			l	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0	0			116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	11, 725, 915	61, 297, 841	4, 326, 275	2, 123, 110	435, 723	118.00
NONREI MBURSABLE COST CENTERS	10 017	05.000	7 242	0.240		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	18, 217	95, 232			0	190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 WELLNESS CENTER	780, 885 70, 399	4, 082, 126 368, 014				192. 00 192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	70, 399	300, 014	21, 900	139, 920		194. 00
194.00 07930 0THER NONRETMBURSABLE COST CENTERS	126, 956	663, 672	50, 474	28, 357		194. 00 194. 01
194. 02 07952 SENI OR CI RCLE	120, 730	-31, 476		∠0, 357 ∩	l e	194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS		-51, 470 O		0	l e	194. 02
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS		0		0		194. 03
194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS		0		n	11, 988	
200.00 Cross Foot Adjustments		0)		, ,00	200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	12, 722, 372	66, 475, 409	4, 411, 980	3, 989, 093	ł	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133 Period:

| Period: | Worksheet B | From 03/01/2014 | Part | To 02/28/2015 | Date/Time Prepared: | 7/30/2015 3:14 pm

					7/30/2015 3:1	4 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				ADMI NI STRATI ON	SERVICES &	
	2.22	10.00		10.00	SUPPLY	
CENEDAL CEDALOE COCT CENTEDO	9. 00	10. 00	11. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-BLDG & FIXT						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						
						4.00
5. 01 00540 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1 275 140					8. 00
9. 00 00900 HOUSEKEEPI NG	1, 275, 149	F74 000				9. 00
10. 00 01000 DI ETARY	26, 228	574, 999	4 400 4/-			10.00
11. 00 01100 CAFETERI A	22, 036	0	1, 103, 167	1		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 709	0	51, 485		4 04/ 440	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	15, 158	0	25, 494		1, 016, 442	14. 00
15. 00 01500 PHARMACY	18, 929	0	34, 279	1	17, 456	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	20, 889	U	43, 728	1	1, 278	16.00
17. 00 01700 SOCIAL SERVICE	0	U)J U	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	317, 168	210 000	218, 637	557, 596	40.021	30. 00
31. 00 03000 ADULTS & PEDIATRICS		310, 000			60, 031	30.00
43. 00 04300 NURSERY	70, 895	46, 113 0	63, 950		15, 535 0	43. 00
45.00 04500 NURSING FACILITY	6, 787 0	0	9, 249	1	0	45. 00 45. 00
ANCI LLARY SERVICE COST CENTERS	U	U _I) U	0	43.00
50. 00 05000 OPERATI NG ROOM	132, 009	14, 245	68, 824	218, 198	155, 448	50. 00
51. 00 05100 RECOVERY ROOM	6, 222	14, 243	34, 346		9, 995	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	25, 957	55, 395	20, 190		0, 7,7	52. 00
53. 00 05300 ANESTHESI OLOGY	20, 707	00, 070	20, 170	1	89	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	98, 323	Ö	109, 534	-1	20, 125	54. 00
54. 01 05401 ULTRASOUND	0	0	.07,00		0	54. 01
54. 02 05402 0NCOLOGY	89, 002	o	41, 506	130, 570	8, 757	54. 02
56. 00 05600 RADI OI SOTOPE	3, 854	o	6, 862		272	56. 00
57. 00 05700 CT SCAN	14, 607	o	15, 449		14, 318	57. 00
58. 00 05800 MRI	26, 523	o	13, 427		685	58. 00
60. 00 06000 LABORATORY	45, 964	o	107, 645		90, 728	60. 00
65. 00 06500 RESPIRATORY THERAPY	22, 797	o	32, 688		5, 784	65. 00
66. 00 06600 PHYSI CAL THERAPY	66, 604	o	55, 563		4, 549	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	o	2, 718	1	857	67. 00
68.00 06800 SPEECH PATHOLOGY	754	o	. (1	2	68. 00
69. 00 06900 ELECTROCARDI OLOGY	377	o	11, 736	23, 865	513	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	О	o	C	o	85, 676	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	О	o	C	o	444, 843	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	(o	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76.00
76. 01 03610 SLEEP LAB	0	0	C	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	27, 963	0	·		21, 447	
91. 00 09100 EMERGENCY	101, 053	0	83, 67 <i>6</i>	232, 863	50, 651	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS		_1				
95. 00 09500 AMBULANCE SERVICES	0	0	(0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	96. 00
SPECIAL PURPOSE COST CENTERS		ما				444 00
116. 00 11600 HOSPI CE	0	0	1 001 006	1		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 165, 808	425, 753	1, 091, 398	2, 008, 506	1, 009, 039	118.00
NONREI MBURSABLE COST CENTERS	4 (20	ما	2.21/		4 010	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 638 0	U	3, 216	1		190. 00 192. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 WELLNESS CENTER	88, 934	0	(192. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	00, 934	0				194. 00
194. 01 07951 MARKETI NG	15, 769	0	8, 553			194. 00
194. 02 07952 SENI OR CI RCLE	13, 709	52, 196	0, 555			194. 01
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	97, 050	(194. 02 194. 03
194.04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	77, USU	(1 1		194. 03
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	٥	(194. 04
200.00 Cross Foot Adjustments		4	(7	Ü	200. 00
201.00 Negative Cost Centers	U	٨	r	ار	Λ	200.00
202.00 TOTAL (sum lines 118-201)	1, 275, 149	574, 999	1, 103, 167	2, 008, 506	1, 016, 442	
(22	., =, 0, , ,	2	., .00, 107	_, 555, 566	., 0.0, .12	

Provi der CCN: 150133

				To	02/28/2015	Date/Time Prep 7/30/2015 3:14	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	Intern &	трііі
			RECORDS & LI BRARY			Residents Cost & Post	
			LIBRAKI			Stepdown	
						Adjustments	
	CENEDAL SEDVICE COST CENTEDS	15. 00	16. 00	17. 00	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02 7. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	1, 830, 271					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 441, 183	3			16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0			17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		124 704		0 440 174	0	30. 00
30. 00 31. 00	03100 I NTENSI VE CARE UNI T	0 0	126, 786 8, 603		9, 448, 176 2, 811, 705		31. 00
43. 00	04300 NURSERY	l o	4, 301		429, 861	Ö	43. 00
45.00	04500 NURSING FACILITY	0	. 0	1	0	0	45. 00
	ANCILLARY SERVICE COST CENTERS		440 704	1 -			
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0 0	160, 731 15, 323	1	4, 946, 149 1, 373, 296	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		9, 386		1, 373, 296	0	52.00
53. 00	05300 ANESTHESI OLOGY	l o	0	Ö	707	Ö	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	51, 887	0	4, 264, 493	0	54.00
54. 01	05401 ULTRASOUND	0	0	0	1	0	54. 01
54. 02 56. 00	05402 ONCOLOGY 05600 RADI OI SOTOPE	0	43, 611 18, 189		3, 027, 333 490, 839	0	54. 02 56. 00
57. 00	05700 CT SCAN		155, 684		1, 011, 915	0	57. 00
58. 00	05800 MRI	0	39, 739		965, 596	Ō	58. 00
60.00	06000 LABORATORY	0	158, 823		5, 299, 436		60.00
65. 00	06500 RESPI RATORY THERAPY	0	28, 825		1, 222, 407	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 0	21, 413 4, 210		3, 202, 792 331, 455	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		488		37, 154	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	9, 058		279, 557	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	41, 935		779, 841	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	45, 573		3, 577, 550		72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTERS	1, 830, 271	382, 855	0	9, 363, 065	0	73. 00 76. 00
76. 01	03610 SLEEP LAB		O		0	Ö	76. 00
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 02
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	15 410	o	1, 311, 297	0	90. 00
91.00	09100 EMERGENCY	0	15, 410 98, 353		3, 798, 114		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		70,000		0,7,0,1.1	Ö	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	0	1	0		95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	96. 00
116. 00	11600 HOSPI CE	0	0	0	0	0	116. 00
118. 00		1, 830, 271	1, 441, 183		59, 046, 960		118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	123, 487		190.00
) 19200 PHYSICIANS' PRIVATE OFFICES 19201 WELLNESS CENTER	0	0		5, 752, 042 644, 864		192. 00 192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS		Ö		9, 446		194. 00
	07951 MARKETI NG	0	0	0	768, 852		194. 01
	2 07952 SENI OR CI RCLE		0		20, 720		194. 02
	3 07953 OTHER NONREI MBURSABLE COST CENTERS	0	0		97, 050		194. 03 194. 04
	107954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS		0		11, 988		194. 04 194. 05
200.00			O		0		200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	1, 830, 271	1, 441, 183	0	66, 475, 409	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150133

		7/30/2015 3:1	
Cost Center Description	Total		
GENERAL SERVICE COST CENTERS	26. 00		
1.00 O0100 CAP REL COSTS-BLDG & FIXT			1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01 00540 OTHER ADMINISTRATIVE AND GENERAL			5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL			5. 02
7.00 OO700 OPERATION OF PLANT			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11. 00
13.00 O1300 NURSING ADMINISTRATION			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 01700 SOCIAL SERVICE			17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	9, 448, 176		30.00
31. 00 03000 ADULTS & PEDIATRICS	2, 811, 705		31.00
43. 00 04300 NURSERY	429, 861		43. 00
45. 00 04500 NURSING FACILITY	427, 001		45. 00
ANCI LLARY SERVI CE COST CENTERS	5		43.00
50. 00 05000 OPERATI NG ROOM	4, 946, 149		50.00
51. 00 05100 RECOVERY ROOM	1, 373, 296		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 074, 221		52. 00
53. 00 05300 ANESTHESI OLOGY	707		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 264, 493		54. 00
54. 01 05401 ULTRASOUND	1		54. 01
54. 02 05402 ONCOLOGY	3, 027, 333		54. 02
56. 00 05600 RADI 0I SOTOPE	490, 839		56. 00
57. 00 05700 CT SCAN	1, 011, 915		57. 00
58. 00 05800 MRI	965, 596		58. 00
60. 00 06000 LABORATORY	5, 299, 436		60.00
65. 00 06500 RESPI RATORY THERAPY	1, 222, 407		65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 202, 792		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	331, 455		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	37, 154		68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	279, 557 779, 841		71. 00
72. 00 07100 IMPL. DEV. CHARGED TO PATIENTS	3, 577, 550		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 363, 065		73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	7, 303, 003		76.00
76. 01 03610 SLEEP LAB	0		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 03
OUTPATIENT SERVICE COST CENTERS			
90. 00 09000 CLI NI C	1, 311, 297		90. 00
91. 00 09100 EMERGENCY	3, 798, 114		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
OTHER REIMBURSABLE COST CENTERS			
95. 00 09500 AMBULANCE SERVICES	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		96. 00
SPECIAL PURPOSE COST CENTERS	0		11/ 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	59, 046, 960		118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	123, 487		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 752, 042		192.00
192. 01 19201 WELLNESS CENTER	644, 864		192. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	9, 446		194. 00
194. 01 07951 MARKETI NG	768, 852		194. 01
194. 02 07952 SENI OR CI RCLE	20, 720		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	97, 050		194. 03
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0		194. 04
194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS	11, 988		194. 05
200.00 Cross Foot Adjustments	0		200.00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118-201)	66, 475, 409		202. 00

| Peri od: | Worksheet B | From 03/01/2014 | Part II | To 02/28/2015 | Date/Time Prepared: Provi der CCN: 150133

					То	02/28/2015	Date/Time Prep 7/30/2015 3:14	
				CAPI TAL REI	LATED COSTS		773072013 3.1	трііі
		0 1 0 1 0 1 1	D: 11	DIDO A FLVT	MANUE FOLLIE		EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	16, 476		24, 404	24, 404	4. 00
5. 01 5. 02		OTHER ADMINISTRATIVE AND GENERAL OTHER ADMINISTRATIVE AND GENERAL	0	307, 914 494, 584		456, 077 732, 569	2, 517 2, 002	5. 01 5. 02
7. 00		OPERATION OF PLANT	0	504, 534		747, 307	539	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	10, 223		15, 142	0	8. 00
9.00		HOUSEKEEPI NG	0	21, 570		31, 949	609	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	0	59, 259 49, 785		87, 773 73, 741	133 487	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	0	12, 898		19, 104	1, 203	
14. 00		CENTRAL SERVICES & SUPPLY	0	34, 247		50, 726	265	14. 00
15. 00		PHARMACY	0	42, 766		63, 344	850	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	47, 196 0		69, 906 0	477 0	16. 00 17. 00
17.00		IENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	<u> </u>	0	17.00
30. 00		ADULTS & PEDIATRICS	0	716, 591	344, 811	1, 061, 402	3, 413	30. 00
31.00	1	INTENSIVE CARE UNIT	0	160, 176		237, 250	1, 181	31. 00
43. 00 45. 00		NURSERY NURSING FACILITY	0	15, 334 0		22, 713 0	197 0	43. 00 45. 00
45.00		LARY SERVICE COST CENTERS	0	0	ıj U	<u>U</u>	U	45.00
50.00		OPERATING ROOM	0	298, 253	143, 514	441, 767	1, 334	50. 00
51.00		RECOVERY ROOM	0	14, 056		20, 820	671	51. 00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	58, 645 0		86, 864 0	431 0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	222, 143		329, 035	1, 796	
54. 01		ULTRASOUND	0	0		0	0	54. 01
54. 02	1	ONCOLOGY	0	201, 084		297, 842	798	54. 02
56.00	1	RADI OI SOTOPE	0	8, 706		12, 895	150	
57. 00 58. 00	05800	CT SCAN MRI	0	33, 003 59, 923		48, 883 88, 757	259 246	57. 00 58. 00
60.00	1	LABORATORY	0	103, 848		153, 818	1, 324	60. 00
65. 00		RESPI RATORY THERAPY	0	51, 506	24, 784	76, 290	516	65. 00
66.00	1	PHYSI CAL THERAPY	0	150, 481		222, 890 0	659	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0 1, 704	-	2, 524	23	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	0	852		1, 262	146	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS OTHER ANCILLARY SERVICE COST CENTERS	0) 0		0	0	73. 00 76. 00
76. 01		SLEEP LAB	0	Ö	Ö	o	0	76. 01
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	O	0	
76. 03		OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 03
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	64, 881	31, 220	96, 101	583	90. 00
91. 00		EMERGENCY	0	228, 311		338, 170	1, 423	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
05 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	Ι ο	0		ما		05 00
95. 00 96. 00		DURABLE MEDICAL EQUIP-RENTED	0			0	0	
70.00		AL PURPOSE COST CENTERS			<u> </u>	<u> </u>	J	70.00
		HOSPI CE	0			0		116. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	0	3, 990, 949	1, 920, 376	5, 911, 325	24, 232	118. 00
190 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 478	5, 042	15, 520	33	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	2, 097, 364		3, 106, 577		192. 00
		WELLNESS CENTER	0	200, 931	96, 684	297, 615		192. 01
	1	OTHER NONREIMBURSABLE COST CENTERS	0	0	-	0		194. 00
		MARKETING SENIOR CIRCLE	0	35, 627 0	17, 143	52, 770 0		194. 01 194. 02
		OTHER NONREIMBURSABLE COST CENTERS	0	Ö		o		194. 02
		OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o		194. 04
194. 05 200. 00		OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 05 200. 00
200.00		Cross Foot Adjustments Negative Cost Centers		n	n	ol Ol		200. 00 201. 00
202.00		TOTAL (sum lines 118-201)	0	6, 335, 349	3, 048, 458	9, 383, 807	24, 404	
					,	·	·	

Provider CCN: 150133

Peri od:

From 03/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Cost Center Description OTHER OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE ADMI NI STRATI VE LINEN SERVICE **PLANT** AND GENERAL AND GENERAL 7.00 8. 00 9. 00 5.01 5.02 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 OTHER ADMINISTRATIVE AND GENERAL 458, 594 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 30, 424 764, 995 5.02 5.02 7.00 00700 OPERATION OF PLANT 25, 564 48, 886 822, 296 7.00 00800 LAUNDRY & LINEN SERVICE 2.878 8.00 5. 503 1.677 25, 200 8 00 9.00 00900 HOUSEKEEPI NG 8,062 15, 417 3, 539 59, 576 9.00 10.00 01000 DI ETARY 3, 215 6, 147 9, 723 0 1, 225 10.00 01100 CAFETERI A 12, 764 6,674 8, 168 1,030 11.00 11.00 0 01300 NURSING ADMINISTRATION 13.00 12, 439 23, 787 2, 116 0 267 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 699 10, 898 5, 619 880 708 14.00 15.00 01500 PHARMACY 11,058 21, 147 7,017 884 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 394 o 16.00 8,573 976 7, 743 01700 SOCIAL SERVICE 17.00 C 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 45, 730 87, 451 117, 571 8, 360 14, 819 30.00 03100 INTENSIVE CARE UNIT 31.00 14.470 27, 671 26, 280 31.00 1,540 3, 312 43.00 04300 NURSERY 2, 339 4, 473 2,516 317 43.00 04500 NURSING FACILITY 45.00 45.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 721 47, 274 48, 935 5, 610 6, 168 50.00 05100 RECOVERY ROOM 51.00 7,604 14, 540 2, 306 291 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 213 52.00 5, 423 10, 370 9,622 0 52.00 o 53 00 05300 ANESTHESI OLOGY 0 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 24, 402 46, 665 36, 447 0 4, 594 54.00 05401 ULTRASOUND 0 0 54.01 54.01 05402 ONCOLOGY 54.02 16, 333 31, 234 32, 992 286 4, 158 54.02 05600 RADI OI SOTOPE 56.00 2,644 5, 057 1, 428 2, 321 180 56.00 57.00 05700 CT SCAN 5,034 9, 627 5, 415 0 682 57.00 05800 MRI 58.00 5, 367 10, 264 9,832 0 1, 239 58.00 60 00 06000 LABORATORY 29 460 56.337 17 038 0 2 147 60 00 06500 RESPIRATORY THERAPY 65.00 6, 452 12, 339 8, 451 0 1,065 65.00 06600 PHYSI CAL THERAPY 18, 634 24, 690 1,501 3, 112 66.00 35, 633 66.00 06700 OCCUPATIONAL THERAPY 3, 967 67.00 2,074 0 67.00 C 0 06800 SPEECH PATHOLOGY 423 280 0 35 68 00 68 00 221 69.00 06900 ELECTROCARDI OLOGY 1, 495 2,859 140 0 18 69.00 4, 180 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 993 o 71.00 71.00 C 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 784 37, 833 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 45.793 0 73.00 73.00 87, 602 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76.00 76.01 03610 SLEEP LAB 0 0 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 0 0 76.02 C 0 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 6, 736 12, 881 10, 645 440 1, 306 90.00 09100 EMERGENCY 4, 721 91.00 36, 690 37, 459 3,080 91.00 19, 186 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0 n 95.00 09600 DURABLE MEDICAL FOULP-RENTED 96.00 0 0 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1-117) 54, 467 118. 00 422, 672 750, 134 437, 649 24, 018 118.00 NONREI MBURSABLE COST CENTERS 1, 719 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 217 190. 00 657 1, 256 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 28, 150 0 0 192.00 344, 116 192. 01 19201 WELLNESS CENTER 4, 853 2, 538 32, 967 0 4, 155 192. 01 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 521 0 194. 00 C 194. 01 07951 MARKETI NG 4.577 8, 752 5,845 737 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 0 C 0 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 194, 03 0 C 0 0 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 C 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 194. 05 0 C 0 661 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 458, 594 764, 995 822, 296 25, 200 59, 576 202. 00 Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150133 Peri od: Worksheet B From 03/01/2014 Part II 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** SERVICES & ADMI NI STRATI ON **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 OTHER ADMINISTRATIVE AND GENERAL 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 108, 216 10 00 01100 CAFETERI A 102, 864 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 0 4, 801 63.717 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 2, 377 1, 374 78, 546 14.00 15.00 01500 PHARMACY 0 3, 196 1, 349 108, 845 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 0 4,077 0 99 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 58, 343 20, 388 17, 688 4, 639 0 30.00 03100 INTENSIVE CARE UNIT 8,679 6, 130 31.00 5, 963 1, 200 0 31.00 43.00 04300 NURSERY 862 1,024 0 43.00 04500 NURSING FACILITY 45.00 45.00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 681 6, 417 6, 922 12,012 0 50.00 51.00 05100 RECOVERY ROOM 3, 203 3, 482 772 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 10, 425 1,883 2, 235 0 0 52.00 53 00 05300 ANESTHESI OLOGY 53 00 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 10, 213 0 1,555 0 54.00 05401 ULTRASOUND 0 0 54.01 54.01 54.02 05402 ONCOLOGY 0 3,870 677 0 54.02 4, 142 05600 RADI OI SOTOPE 56.00 640 C 21 0 56.00 57.00 05700 CT SCAN 1, 441 0 1, 106 0 57.00 05800 MRI 58.00 000000000000 1, 252 C 53 0 58.00 60 00 06000 LABORATORY 10 037 6 871 7 011 0 60 00 06500 RESPIRATORY THERAPY 65.00 3,048 2,679 447 0 65.00 06600 PHYSI CAL THERAPY 5, 181 351 0 66.00 C 66.00 06700 OCCUPATIONAL THERAPY 67.00 253 0 0 67.00 66 06800 SPEECH PATHOLOGY 68 00 0 0 68 00 0 69.00 06900 ELECTROCARDI OLOGY 1,094 757 40 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 6.621 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 34, 377 0 72.00 07300 DRUGS CHARGED TO PATIENTS 108, 845 0 73 00 C 0 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 76.00 76.01 03610 SLEEP LAB 0 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 0 0 76.02 0 0 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 3, 768 3, 025 1, 657 90.00 09100 EMERGENCY 91.00 0 7, 802 7,388 0 91.00 3, 914 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0 95.00 09600 DURABLE MEDICAL FOULP-RENTED 96.00 0 0 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116, 00 80, 128 SUBTOTALS (SUM OF LINES 1-117) <u>63, 7</u>17 77, 974 108, 845 118. 00 101, 766 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 300 0 372 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 43 0 192, 01 192. 01 19201 WELLNESS CENTER 0 C 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 r 0 0 0 194.00 194. 01 07951 MARKETI NG 0 798 0 157 0 194. 01

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108, 845 202. 00

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194. 02 07952 SENI OR CIRCLE

194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS

194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS

194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Design Company Compa	Heal th Finan		KOSCIUSKO COMMUN				u of Form CMS-	<u>2552-10</u>
COST Centrer Prescription	ALLOCATION C	OF CAPITAL RELATED COSTS		Provi der	1	From 03/01/2014	Part II Date/Time Pre	
SHERMEN, SERVICE COST CENTERS		Cost Center Description	RECORDS &	SOCI AL SERVICE	Subtotal	Residents Cost & Post Stepdown	Total	•
1.00	CENED	AL SEDVICE COST CENTEDS	16. 00	17. 00	24. 00	25. 00	26. 00	
4.00 00000 DOLOGO DOLOGO			T	I				1.00
5.01 00540 OTHER ADMINISTRATIVE AND CEMERAL 5.02 0050 OTHER ADMINISTRATIVE AND CEMERAL 7.00 0050 OTHER ADMINISTRATION 10.00	•							1
5.02 0.0560 OTHER ABIN ISTRATI VE AND GENERAL								1
0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000								1
9.00 0.000	7. 00 00700	OPERATION OF PLANT						7. 00
10.00 01000 ETARY								1
11.00 01100 CAFETERIA 11.00 13.00								•
14.00 01400 CENTRAL SERVICES & SUPPLY 108,245 15.00 01500 HERIARCHY 108,245 17.00 10700 01400 HERIARCHY 108,245 17.00 10700 01400 HERIARCHY 108,245 17.00 10700 01400 HERIARCHY 108,245 17.00 10700 014,449,322 0.0 1,449,322 0.0 30.00 30.00 MITERISTRY GUITTE SERVICE COST CENTERS 0.0 1,449,322 0.0 334,322 0.334,322 31.00 30.00 30.00 MITERISTRY CARE UNIT 25.00 0.0								1
15.00								1
16.00 1000 MEDICAL RECORDS & LIBRARY 108.245 0 1.00			1					
IMPATI ENT ROUTINE SERVICE COST CENTERS			108, 245					1
30.00	17. 00 01700	SOCIAL SERVICE	0	0				17. 00
31.0 0 3300 MISTERS IVE CARE LIMIT 646 0 334, 322 0 34, 764 0 34, 76			0.510	ام	1 440 22	0	1 440 222	20.00
43.00 04300 NURSIERY 10 0 0 0 0 0 0 0 0			1 1					1
*** *** ******************************	43. 00 04300	NURSERY	323	О	34, 76	4 0		43. 00
50.00			0	0	(0	0	45. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 1, 150 0 54, 839 0 54, 839 51.00 520.00 05200 DELIVERY ROOM & LABOR ROOM 705 0 12,171 0 12,9171 52.00 53.00 05300 ARESTHESIOLOGY 0 0 0 0 19 53.00 054.01 054.01 ULTRASOUND 0 0 0 0 0 0 0 0 0			12 066	O	615 90	7 0	615 907	50.00
53.00 05300 ANESTHESI OLOGY 0 0 19 53.00				•	·			1
54. 00 05400 RADI DLOGY-DI ACNOSTIC 3,895 0 458,602 0 458,602 54. 00 54. 01 05401 ULTRASOUND 0 0 0 0 0 54. 01 54. 02 05402 ONCOLOGY 3,274 0 395,606 0 395,606 54. 01 54. 02 05402 ONCOLOGY 3,274 0 395,606 0 395,606 54. 02 56. 00 05600 RADI DI STOTPE 1,366 0 26,702 0 26,702 56. 00 05600 RADI DI STOTPE 1,366 0 26,702 0 226,702 56. 00 05600 RADI DI STOTPE 1,366 0 246,702 0 2119,993 58. 00 05800 MRI 2,2983 0 119,993 0 119,993 58. 00 05800 MRI PARTON PHERAPY 2,164 0 113,451 0 113,451 0 113,451 0 0 113,451 0 0 0 0 0 0 0 0 0	1		1	•				1
54. 01 05401 ULTRASQUIND	1		1 -1					1
56.00 05600 RADIO I SOTOPE	•		1	•				1
57.00 05700 CT SCAN	•		1	•				1
58.00 05800 MR 2, 983 0 119, 993 0 119, 993 58.00 0 00 000			1	-				•
65 00 06500 RESPI RATORY THERAPY 1,608 0 314,259 0 314,259 66.00	•		1	-				•
66 00 06600 0670	1		1	•				•
67. 00 66700 0CCUPATI ONAL THERAPY 316 0 6,699 0 6,699 67. 00 68. 00 06800 SPEECH PATHOLOGY 37 0 3,520 0 3,520 68. 00 69. 00 06900 ELECTROCARDIOLOGY 680 0 8,491 0 8,491 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3,148 0 21,942 0 21,942 10 02,100 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3,421 0 95,415 0 95,415 72. 00 73. 00 07300 IMPL. DEV. CHARGED TO PATIENTS 28,793 0 271,033 0 271,033 73. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 01 03610 SLEEP LAB 0 0 0 0 0 0 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 0 0 0 0 0 76. 03 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 00000 00000 0 0 0 0 0	1		1	•				•
68.00 06800 06900 ELECTROCARDIOLOGY 37 0 3,520 0 3,520 68.00				-				•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 148 0 21, 942 0 21, 942 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 421 0 95, 415 0 95, 415 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 793 0 271, 033 0 271, 033 73.00 76.00 07300 DRUGS CHARGED TO PATIENTS 28, 793 0 271, 033 0 271, 033 73.00 76.01 07301 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.01 076.01 076.01 76.02 07502 PSYCHIATRI C/PSYCHOLOGI CAL SERVICES 0 0 0 0 0 0 0 76.02 07503 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.03 07503 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76.04 07504 OTHER REVICE COST CENTERS 76.00 07500 OTHER REVICE COST CENTERS 0 0 0 0 0 76.01 07504 OTHER REVICE COST CENTERS 77.00 07500 OTHER REVICE COST CENTERS 77.00 07500 OTHER REVIDENCE COST CENTERS 77.00 0 0 0 0 0 0 77.00 07500 OTHER REVIDENCE COST CENTERS 77.00			1		3, 520	0		•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 421 0 95, 415 0 95, 415 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 28, 793 0 271, 033 0 271, 033 73. 00 0 0 0 0 0 0 0 0 0			1	-				•
73.00 07300 DRUGS CHARCED TO PATI ENTS 28,793 0 271,033 0 271,033 73.00 76.00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76.01 03610 SLEEP LAB 0 0 0 0 0 0 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76.03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76.04 00 00 0 0 0 0 76.05 00 00 0 0 0 0 76.06 00 0 0 0 0 76.07 00 00 0 0 0 0 76.08 00 00 0 0 0 76.09 00 00 0 0 0 76.01 00 00 0 0 76.02 00 00 0 0 76.03 00 00 0 0 76.04 00 00 0 0 76.05 00 00 0 0 76.06 00 00 0 76.07 00 00 0 76.08 00 00 0 0 76.09 00 00 0 76.00 00 00 0								•
76. 01 03610 SLEEP LAB 0 0 0 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 76. 02 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 03 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 1, 1, 157 0 138, 299 0 138, 299 90. 00 91. 00 09100 EMBRGENCY 7, 384 0 467, 217 0 467, 217 91. 00 92. 00 09200 DSSERVATI ON BEDS (NON-DISTI NCT PART OTHER REI MBURSABLE COST CENTERS) 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	ō				•
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 76. 02 76. 03 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	(0		
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76. 03			1	0	(0 0		•
90. 00 09000 CLINIC 1,157 0 138,299 0 138,299 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 95. 00 95. 00 96.			1	Ö	(1
91. 00 09100 EMERGENCY 7, 384 0 467, 217 0 467, 217 91. 00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 0 0 0 0 0 0 0 0 0			1 157	ما	120, 200		120 200	00.00
92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES O O O O O O O O O O O O O O O O O O O								1
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 96. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 96. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 108, 245 0 5, 439, 674 0 5, 439, 674 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 20, 074 0 20, 074 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 478, 886 0 3, 478, 886 192. 00 192. 01 19201 WELLNESS CENTER 0 0 342, 128 192. 01 194. 01 07951 MARKETI NG 0 0 521 0 521 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 73, 775 0 73, 775 194. 01 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 9, 823 0 9, 823 194. 02 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 0 18, 265 194. 03 194. 04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 06 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 06 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 08 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 09 00 00 00 0 0 0 194. 09 00 00 0 0 0 0 194. 09 00 00 00 0 0 0 194. 09 00 00 0 0 0 0 0 194. 09 00 00 0 0 0 0 195. 00 00 00 0 0 0 0 195. 00 00 00 00 0 0	92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	7,001	S ₁	107, 21	-	107,217	
96. 00			1	ام		1		
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE								
118. 00	SPECI /	AL PURPOSE COST CENTERS	1 9			51 0		70.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 20, 074 0 20, 074 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 478, 886 0 3, 478, 886 192. 00 192. 01 19201 WELLNESS CENTER 0 0 0 342, 128 0 342, 128 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 521 0 521 194. 00 194. 01 07951 MARKETI NG 0 0 73, 775 0 73, 775 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 0 18, 265 194. 04 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 04 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 661 0 661 194. 05 200. 00 0 0 0 0 0 0 0 0	1							
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 20, 074 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 478, 886 192. 00 192. 01 192. 01 19201 WELLNESS CENTER 0 0 342, 128 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 521 194. 00 194. 01 07951 MARKETI NG 0 0 73, 775 0 73, 775 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 194. 02 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 661 0 661 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 661 0 661 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 661 0 0 661 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			108, 245	0	5, 439, 674	4 0	5, 439, 674]118. 00]
192. 01 19201 WELLNESS CENTER 0 0 342, 128 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 521 194. 00 194. 01 07951 MARKETI NG 0 0 73, 775 0 73, 775 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 18, 265 194. 03 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	20, 074	4 0	20, 074	190. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 521 0 521 194. 00 194. 01 07951 MARKETI NG 0 0 73, 775 0 73, 775 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 00 19200	PHYSICIANS' PRIVATE OFFICES	1	О			3, 478, 886	192. 00
194. 01 07951 MARKETING 0 0 73, 775 0 73, 775 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 18, 265 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 661 0 0 661 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				•
194. 02 07952 SENI OR CIRCLE 0 0 9, 823 0 9, 823 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 18, 265 0 18, 265 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 661 0 661 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0				ol				1
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 661 0 661 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0	194. 02 07952	SENIOR CIRCLE	O	o	9, 823	3 0	9, 823	194. 02
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 661 0 0 661 194. 05 200. 00 201. 00 Cross Foot Adjustments 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>18, 26</td><td>0</td><td></td><td></td></t<>			0	0	18, 26	0		
200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00				0 0	66°			
201.00 Negative Cost Centers 0 0 0 0 0 201.00 202.00 TOTAL (sum lines 118-201) 108,245 0 9,383,807 0 9,383,807 202.00				Ĭ	(o o	0	200.00
202.00 TOTAL (Sum Tines T18-201) T08, 245 0 9, 383, 807 0 9, 383, 807 202.00			0	0	0.000.000	-		
	202.00	IUIAL (SUM IINES II8-201)	108, 245	O	9, 383, 80	/ 0	9, 383, 807	J202. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	KOSCIUSKO COMML			In Li∈ Period:	worksheet B-1	
					From 03/01/2014 To 02/28/2015	Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			7/30/2015 3:1	4 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A. 01	5. 01	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	371, 833	.1				1.00
2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	00200 CAP REL COSTS-BLDG A FIAT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00540 OTHER ADMINISTRATI VE AND GENERAL 00560 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVI CES & SUPPLY	967 18, 072 29, 028 29, 612 600 1, 266 3, 478 2, 922 757 2, 010	371, 8: 96: 18, 0: 29, 0: 29, 6: 60: 1, 26: 3, 4: 2, 9: 75:	23, 236, 90 72 2, 396, 74 28 1, 906, 53 512, 94 500 566 580, 33 78 126, 46 22 464, 23 57 1, 145, 80	7 -12, 722, 372 6 0 4 0 0 0 2 0 5 0 0 0 3 0	3, 567, 996 2, 998, 000 337, 461 945, 434 376, 981 782, 743	2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
15. 00 16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 510 2, 770 0	2, 7	70 454, 13		1, 005, 365	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	42,058	42, 05	3, 245, 84	2 0	5, 363, 012	30.00
31. 00 43. 00 45. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY 04500 NURSING FACILITY	9, 401	9, 40	01 1, 124, 83 00 187, 95	3 0	1, 696, 960 274, 339	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS		1	<u> </u>	0		43.00
50. 00 51. 00 52. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	17, 505 825 3, 442	82	25 638, 83	1 0	891, 697	51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	13, 038		0	0	464	53.00
54. 01 54. 02	05401 ULTRASOUND 05402 ONCOLOGY	11, 802	11, 80	0 02 760, 06	0 0		
56.00	05600 RADI OI SOTOPE	511	51	11 143, 13	5 0	310, 105	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	1, 937 3, 517				590, 409 629, 443	
60. 00 65. 00	06000 LABORATORY 06500 RESPIRATORY THERAPY	6, 095 3, 023	1				1
66. 00	06600 PHYSI CAL THERAPY	8, 832		32 627, 67	6 0	2, 185, 243	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	100	1	0 22, 28 00	3 0	243, 254 25, 969	1
69. 00	06900 ELECTROCARDI OLOGY	50) [50 138, 91	9 0	175, 359	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	I I		0 0		
	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0 0	5, 373, 520 0	1
76. 01	03610 SLEEP LAB	0		Ö	0 0	Ō	76. 01
76. 02 76. 03	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03951 OTHER ANCI LLARY SERVI CE COST CENTERS	0			0 0	0	
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	3, 808	3, 80	08 555, 05	4	789, 946	90.00
91.00	09100 EMERGENCY	13, 400					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 96. 00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	000	l l		0 0		
116. 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0		0	0 0	0	116. 00
118.00	NONREI MBURSABLE COST CENTERS	234, 236					
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	615 123, 098	l l	15 31, 07 98	0 0	3, 301, 241	190. 00 192. 00
	19201 WELLNESS CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	11, 793	11, 79	93 0	0 0	297, 615 0	192. 01 194. 00
194. 01	07951 MARKETI NG	2, 091	2, 09	132, 40		536, 716	194. 01
	07952 SENIOR CIRCLE 07953 OTHER NONREIMBURSABLE COST CENTERS	0		0	0 31, 476 0 0		194. 02 194. 03
194. 04	07954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0		0	0 0	l .	194. 04 194. 05
200.00	Cross Foot Adjustments						200. 00
201. 00 202. 00		6, 335, 349	3, 048, 45	3, 503, 54	8	12, 722, 372	201. 00

Health Financial Syst	ems	KOSCI USKO COMMU	INITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STA	ATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 03/01/2014 To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
		CAPITAL REI	LATED COSTS				
Cost Cen	ter Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A. 01	5. 01	
203. 00 Uni t cos	t multiplier (Wkst. B, Part I)	17. 038157	8. 198460	0. 150775	5	0. 236543	203. 00
204.00 Cost to Part II)	be allocated (per Wkst. B,			24, 404	1	458, 594	204. 00
205.00 Unit cos	t multiplier (Wkst. B, Part			0. 001050	D	0. 008527	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150133 Peri od: Worksheet B-1 From 03/01/2014 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm Cost Center Description Reconciliation OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE LINEN SERVICE **PLANT** (SOUARE FEET) AND GENERAL (SQUARE FEET) (POUNDS OF (ACCUM. COST) LAUNDRY) 7.00 9.00 5A. 02 5.02 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00540 OTHER ADMINISTRATIVE AND GENERAL 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 -4, 411, 980 58, 012, 779 5.02 00700 OPERATION OF PLANT 3, 707, 156 7.00 7.00 294, 154 00800 LAUNDRY & LINEN SERVICE 8.00 0 417, 285 600 531, 717 8.00 169, 090 9.00 00900 HOUSEKEEPI NG 0 1, 169, 070 1, 266 9.00 01000 DI ETARY 00000 466, 153 3, 478 3, 478 10.00 10.00 0 01100 CAFETERI A 2, 922 967, 895 2, 922 11.00 0 11.00 01300 NURSING ADMINISTRATION 13.00 1,803,859 757 0 757 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 826, 403 2,010 18, 568 2,010 14.00 01500 PHARMACY 15.00 1,603,610 2,510 2.510 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16,00 1, 243, 177 2,770 0 2,770 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 6 631 595 42 058 176 393 42 058 30.00 0 31.00 03100 INTENSIVE CARE UNIT 2,098,364 9, 401 32, 494 9, 401 31.00 43.00 04300 NURSERY 0 339, 232 900 900 43.00 45.00 04500 NURSING FACILITY 0 45.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 584, 895 17,505 118, 369 17,505 50.00 51.00 05100 RECOVERY ROOM 0 0 0 1, 102, 622 825 825 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 786, 357 3, 442 O 3.442 52 00 53.00 05300 ANESTHESI OLOGY 574 C 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 538, 689 13, 038 0 13, 038 54.00 54.00 54.01 05401 ULTRASOUND 000000000000000 0 54.01 0 05402 ONCOLOGY 54 02 2, 368, 520 11, 802 6. 032 11,802 54 02 56.00 05600 RADI OI SOTOPE 383, 458 511 48, 979 511 56.00 05700 CT SCAN 730, 066 1, 937 1, 937 57.00 0 57.00 05800 MRI 58.00 778, 333 3, 517 0 3, 517 58.00 6, 095 6, 095 06000 LABORATORY 0 60.00 4, 272, 141 60 00 65.00 06500 RESPIRATORY THERAPY 935, 700 3,023 0 3,023 65.00 06600 PHYSI CAL THERAPY 66.00 2, 702, 147 8,832 31, 681 8,832 66.00 67.00 06700 OCCUPATIONAL THERAPY 300, 794 67.00 C 0 0 06800 SPEECH PATHOLOGY 100 68.00 32, 112 100 0 68.00 69.00 06900 ELECTROCARDI OLOGY 216, 839 0 50 69.00 50 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 606, 132 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 2, 868, 945 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 6, 644, 613 0 0 73.00 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76.00 76. 01 03610 SLEEP LAB 0 o 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 C 0 0 0 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 976, 802 3, 808 9, 284 3, 708 90.00 09100 EMERGENCY 0 91.00 2, 782, 322 13, 400 64, 987 13, 400 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116, 00 1<u>54, 591</u> 118. 00 SUBTOTALS (SUM OF LINES 1-117) 56, 885, 861 506, 787 118.00 -4, 411, 980 156, 557 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 615 190. 00 95, 232 615 192. 00 19200 PHYSICIANS' PRIVATE OFFICES -4, 082, 126 123.098 ol 0 192.00 192. 01 19201 WELLNESS CENTER 368, 014 11, 793 0 11, 793 192. 01 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 10, 987 0 194.00 194. 01 07951 MARKETI NG 0 663, 672 2,091 2, 091 194. 01 0 194. 02 07952 SENI OR CIRCLE 31, 476 0 0 194.02 C 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 03 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 04 C 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 13, 943 0 194. 05 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 3, 989, 093 1, 275, 149 202. 00 202.00 Cost to be allocated (per Wkst. B, 4, 411, 980 457, 157 Part I)

0.076052

764, 995

13.561240

822, 296

0.859775

25, 200

7. 541244 203. 00

59, 576 204. 00

Part II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

203.00

204.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 03/01/2014	Worksheet B-1	
Cost Center Description	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF		
		(ACCUM. COST)		LAUNDRY)		
	5A. 02	5. 02	7.00	8. 00	9. 00	
205.00 Unit cost multiplier (Wkst. B, Part		0. 013187	2. 795461	0. 047394	0. 352333	205. 00

			KOSCIUSKO COMMUN		CCN: 150122 D	<u> </u>	u of Form CMS-2	
CUST A	ILLUCA	FION - STATISTICAL BASIS		Provider		rom 03/01/2014	Worksheet B-1 Date/Time Pre 7/30/2015 3:1	pared:
		Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY (COSTED REQUIS.)	
					(NURSI NG SALARI ES)	(COSTED REQUIS.)		
	OENED	AL CERVILOR COCT OFFITERS	10.00	11. 00	13.00	14. 00	15. 00	
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE AND GENERAL						4. 00 5. 01
5. 01		OTHER ADMINISTRATIVE AND GENERAL						5. 02
7.00	1	OPERATION OF PLANT						7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	01000	DI ETARY	102, 285					10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMINI STRATI ON	0	33, 276 1, 553				11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	769		5, 301, 357		14. 00
15. 00	1	PHARMACY	0	1, 034	1	91, 042	5, 373, 520	
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	1, 319	1	6, 665 0	0	
17.00	I NPAT	ENT ROUTINE SERVICE COST CENTERS	,					
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	55, 145 8, 203	6, 595 1, 929		313, 097 81, 022	0	
43. 00		NURSERY	0, 203	279		01,022	0	1
45. 00	04500	NURSING FACILITY	0	0	0	0	0	45. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	2, 534	2, 076	1, 270, 158	810, 759	0	50.00
51.00	05100	RECOVERY ROOM	0	1, 036	638, 831	52, 131	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	9, 854	609	410, 121	0 464	0	
54. 00		RADI OLOGY-DI AGNOSTI C		3, 304		104, 962	0	
54. 01		ULTRASOUND	0	0	0	0	0	
54. 02 56. 00	1	ONCOLOGY RADI OI SOTOPE	0	1, 252 207	1	45, 674 1, 417	0	
57. 00	05700	CT SCAN	0	466	0	74, 677	0	57. 00
58. 00 60. 00	05800	MRI LABORATORY	0	405 3, 247	1	3, 571 473, 203	0	58. 00 60. 00
65. 00	1	RESPIRATORY THERAPY		986		30, 167	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	1, 676		23, 724	0	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	82 0	0 0	4, 471 8	0	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	354	138, 919		0	69. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	446, 851 2, 320, 135	0	
		DRUGS CHARGED TO PATTENTS	0	0	0	2, 320, 133	5, 373, 520	
		OTHER ANCILLARY SERVICE COST CENTERS	0	0		0		76. 00
76. 01 76. 02		SLEEP LAB PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	
76. 03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	1
90. 00		TIENT SERVICE COST CENTERS CLINIC	O	1, 219	555, 054	111, 857	0	90.00
91. 00	09100	EMERGENCY	o o	2, 524	1		0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
95. 00		AMBULANCE SERVICES	0	O	0	0	0	95. 00
96. 00		DURABLE MEDICAL EQUIP-RENTED	0	0			0	96. 00
116 00		AL PURPOSE COST CENTERS HOSPICE	0	0	0	O	0	116. 00
118.00)	SUBTOTALS (SUM OF LINES 1-117)	75, 736	32, 921			5, 373, 520	
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN		97	7	25 120	0	100.00
	1	PHYSICIANS' PRIVATE OFFICES	0	97		25, 129 2, 911		190. 00 192. 00
		WELLNESS CENTER	0	0	0	0		192. 01
		OTHER NONREIMBURSABLE COST CENTERS MARKETING	0	258	0	0 10, 572		194. 00 194. 01
194. 02	07952	SENI OR CIRCLE	9, 285	0	o o	0	0	194. 02
		OTHER NONREIMBURSABLE COST CENTERS OTHER NONREIMBURSABLE COST CENTERS	17, 264	0	0	0		194. 03 194. 04
	1	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
200.00	1	Cross Foot Adjustments						200.00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	574, 999	1, 103, 167	2, 008, 506	1, 016, 442	1, 830, 271	201. 00
		Part I)						
203.00	P	Unit cost multiplier (Wkst. B, Part I)	5. 621538	33. 152031	0. 171788	0. 191732	0. 340609	J203. 00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 03/01/2014 To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	
				SUPPLY	REQUIS.)	
			(NURSI NG	(COSTED		
			SALARI ES)	REQUIS.)		
	10.00	11. 00	13.00	14.00	15. 00	
204.00 Cost to be allocated (per Wkst. B, Part II)	108, 216	102, 864	63, 717	78, 546	108, 845	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	1. 057985	3. 091237	0. 005450	0. 014816	0. 020256	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150133

				To 02/28/2015 Date/lime Pre	
	Cost Center Description		SOCIAL SERVICE		
		RECORDS &	(TIME CDENT)		
		LI BRARY (GROSS	(TIME SPENT)		
		CHARGES)			
		16.00	17. 00		
	GENERAL SERVICE COST CENTERS	T			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL				5. 01
5. 02 7. 00	OO560 OTHER ADMINISTRATIVE AND GENERAL OO700 OPERATION OF PLANT				5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13.00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	462, 338, 280	1		16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	40 475 577	O		30.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	40, 675, 577 2, 759, 991			31. 00
43. 00	04300 NURSERY	1, 380, 008			43. 00
45. 00	04500 NURSING FACILITY	0	1		45. 00
	ANCILLARY SERVICE COST CENTERS		-1		1
50.00	05000 OPERATING ROOM	51, 565, 948	0		50. 00
51. 00	05100 RECOVERY ROOM	4, 915, 853	0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 011, 285	1		52. 00
53.00	05300 ANESTHESI OLOGY	0	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 646, 427	0		54.00
54. 01 54. 02	05401 ULTRASOUND 05402 ONCOLOGY	0 13, 991, 219	0		54. 01 54. 02
56. 00	05600 RADI OI SOTOPE	5, 835, 527			56. 00
57. 00	05700 CT SCAN	49, 946, 657			57. 00
58. 00	05800 MRI	12, 749, 234			58. 00
60.00	06000 LABORATORY	50, 953, 863	o		60.00
65.00	06500 RESPI RATORY THERAPY	9, 247, 713	o		65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 869, 755	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 350, 592			67. 00
68. 00	06800 SPEECH PATHOLOGY	156, 588			68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY	2, 906, 092	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 453, 710 14, 620, 701	0 0		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	122, 803, 864			73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	122, 003, 004			76.00
76. 01	03610 SLEEP LAB	0	l o		76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	o		76. 02
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	4, 943, 849			90.00
91. 00	09100 EMERGENCY	31, 553, 827	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				92. 00
95. 00	09500 AMBULANCE SERVICES	0	O		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
	SPECIAL PURPOSE COST CENTERS		- 1		
116.00	11600 H0SPI CE	0	0		116. 00
118.00		462, 338, 280	0		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	19201 WELLNESS CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		192. 01 194. 00
	07951 MARKETI NG	0			194. 00
	07952 SENI OR CI RCLE	0			194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	l ol		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	o		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 05
200.00	, ,				200. 00
201.00	9				201. 00
202.00		1, 441, 183	0		202. 00
202 00	Part I)	0 002117	0 000000		202 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 003117	0. 000000	I	203. 00

Health Financial Systems	KOSCIUSKO COMMUNIT	Y HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 15		Worksheet B-1
			From 03/01/2014 To 02/28/2015	Date/Time Prepared: 7/30/2015 3:14 pm
Cost Center Description		CLAL SERVICE		
	RECORDS &			
	LI BRARY (T	IME SPENT)		
	(GROSS			
	CHARGES)			
	16.00	17. 00		
204.00 Cost to be allocated (per Wkst. B,	108, 245	0		204. 00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	0. 000234	0. 000000		205. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15013	From 03/01/2014	Worksheet C Part I Date/Time Prepared:

				Т	o 02/28/2015	Date/Time Pre 7/30/2015 3:1	pared:
			Ti †l	e XVIII	Hospi tal	PPS	т рііі
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	505t 5011tol 55551 pt on	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance		
		Part I, col.	7.09		Di Gai i Gilanos		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30.00	03000 ADULTS & PEDI ATRI CS	9, 448, 176		9, 448, 176	0	9, 448, 176	30.00
	03100 NTENSI VE CARE UNI T	2, 811, 705		2, 811, 705		2, 811, 705	
	04300 NURSERY	429, 861		429, 861	0	429, 861	
	04500 NURSING FACILITY	427,001		427,001	-	427, 001	1
45.00	ANCI LLARY SERVI CE COST CENTERS				U	0	45.00
50. 00	05000 OPERATING ROOM	4, 946, 149		4, 946, 149	O	4, 946, 149	50.00
51. 00	05100 RECOVERY ROOM	1, 373, 296		1, 373, 296		1, 373, 296	1
51.00	05200 DELIVERY ROOM & LABOR ROOM	1, 074, 221		1, 074, 221	0	1, 373, 290	
					-		
53.00	05300 ANESTHESI OLOGY	707		707		707	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 264, 493		4, 264, 493		4, 264, 493	
	05401 ULTRASOUND	1			0	1	54. 01
	05402 ONCOLOGY	3, 027, 333		3, 027, 333		3, 027, 333	
56. 00	05600 RADI OI SOTOPE	490, 839		490, 839		490, 839	1
57. 00	05700 CT SCAN	1, 011, 915		1, 011, 915		1, 011, 915	
58. 00	05800 MRI	965, 596		965, 596		965, 596	
60.00	06000 LABORATORY	5, 299, 436		5, 299, 436		5, 299, 436	
65. 00	06500 RESPI RATORY THERAPY	1, 222, 407	0	., ===,		1, 222, 407	
66.00	06600 PHYSI CAL THERAPY	3, 202, 792	0	3, 202, 792	0	3, 202, 792	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	331, 455	0	331, 455	0	331, 455	67.00
68. 00	06800 SPEECH PATHOLOGY	37, 154	0	37, 154	0	37, 154	68. 00
69.00	06900 ELECTROCARDI OLOGY	279, 557		279, 557	0	279, 557	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	779, 841		779, 841	0	779, 841	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 577, 550		3, 577, 550	0	3, 577, 550	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 363, 065		9, 363, 065	0	9, 363, 065	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	o	0	76. 00
	03610 SLEEP LAB	0		1 0	0	0	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0		0	76. 02
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		1 0	0	0	
, 0. 00	OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.00
90.00	09000 CLINI C	1, 311, 297		1, 311, 297	0	1, 311, 297	90.00
	09100 EMERGENCY	3, 798, 114		3, 798, 114		3, 798, 114	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 271, 832		2, 271, 832		2, 271, 832	
72.00	OTHER REIMBURSABLE COST CENTERS	2,271,032		2, 271, 032		2, 271, 032	72.00
95. 00	09500 AMBULANCE SERVICES	T 0		Ιο	O	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED					0	
90.00	SPECIAL PURPOSE COST CENTERS				U	0	90.00
116 00	11600 HOSPI CE	1 0		1 0		0	116. 00
200.00		61, 318, 792	0	1		61, 318, 792	
	, ,						
201.00		2, 271, 832	_	2, 271, 832		2, 271, 832	
202. 00	Total (see instructions)	59, 046, 960	0	59, 046, 960	0	59, 046, 960	1202.00

Date/Time Prepared: 02/28/2015 7/30/2015 3:14 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 33, 034, 162 33, 034, 162 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 759, 991 2, 759, 991 31.00 04300 NURSERY 1, 380, 008 1, 380, 008 43.00 43.00 45.00 04500 NURSING FACILITY 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 15, 715, 456 35, 850, 492 51, 565, 948 0.095919 0.000000 50.00 51.00 05100 RECOVERY ROOM 1, 583, 302 3, 332, 551 4, 915, 853 0.279361 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 011, 285 0.356732 0.000000 52.00 52.00 2, 732, 861 278, 424 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 147, 235 13, 499, 192 16, 646, 427 0.256181 0.000000 54.00 54.01 05401 ULTRASOUND 0.000000 0.000000 54.01 13, 991, 219 05402 ONCOLOGY 0.000000 54.02 13, 915, 496 0.216374 54.02 75, 723 56.00 05600 RADI OI SOTOPE 464, 862 5, 370, 665 5, 835, 527 0.084112 0.000000 56.00 05700 CT SCAN 6, 765, 448 43, 181, 209 49, 946, 657 0. 020260 0.000000 57.00 57.00 58.00 05800 MRI 769, 644 11, 979, 590 12, 749, 234 0.075738 0.000000 58.00 06000 LABORATORY 13, 629, 629 37, 324, 234 50, 953, 863 0.104005 60.00 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 3, 951, 397 5, 296, 316 9, 247, 713 0. 132185 0.000000 65.00 06600 PHYSI CAL THERAPY 6,004,255 6, 869, 755 0.000000 66.00 865, 500 0.466216 66.00 1, 291, 634 06700 OCCUPATIONAL THERAPY 58, 958 1, 350, 592 0. 245415 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.492 88, 096 156, 588 0.237272 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 48,500 2, 857, 592 2, 906, 092 0.096197 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 888, 818 8, 564, 892 13, 453, 710 0.057965 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 8, 210, 976 6, 409, 725 14, 620, 701 0.000000 72 00 0 244691 73.00 07300 DRUGS CHARGED TO PATIENTS 42, 046, 524 80, 757, 340 122, 803, 864 0.076244 0.000000 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0.000000 76.00 76. 01 03610 SLEEP LAB 0 0 0 0.000000 0.000000 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 0 C 0.000000 0.000000 76.02 76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 588 597 4 355 252 4 943 849 0 265238 0.000000 90 00 91.00 09100 EMERGENCY 5, 488, 016 26, 065, 811 31, 553, 827 0. 120369 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 346, 894 5, 294, 521 7, 641, 415 0.297305 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0.000000 0.000000 95 00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0.000000 0.000000 96.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 H0SPI CE 116.00 Subtotal (see instructions) 150, 620, 993 311, 717, 287 462, 338, 280 200. 00 200.00

150, 620, 993

311, 717, 287

462, 338, 280

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150133	From 03/01/2014	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm

Cost Center Description					7/30/2015 3:14 pm
INPATIENT ROUTINE SERVICE COST CENTERS 11.00			Title XVIII	Hospi tal	PPS
NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 3300.00 ADULTS & PEDI ATRIC S 31.00 3300.0 ADULTS & PEDI ATRIC S 31.00 3300.0 NINESS RY 45.00 43.00 NINESS RY 45.00 45.00 45.00 07.00	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADUITS & PEDIATRIC S 31.00 31.00 ASTON ADUITS & PEDIATRIC S 31.00 31.00 ASTON ADUITS & PEDIATRIC S 42.00 31.00 ASTON ADUITS & PEDIATRIC S 45.00 ASTON ADUITS & ASTON ADUITS & ASTON ADUITS & ASTON ADUITS & ASTON AST					
30.00 30000 ADULTS & PEDI ATRICS 33.00 33.00 33.00 33.00 1 NTENSI VE CARE UNIT 42.00 43.00 43.00 NURSERY 45.00 45.00 45.00 MURSING FACI LITY 45.00		11. 00			
31.00 03100 INTENSIVE CARE UNIT					
43. 00 04300 NURSINE FACILITY 45. 00 45. 00 450. 00 NURSING FACILITY 450. 00 450. 00 NURSING FACILITY 450. 00 450. 00 NURSING FACILITY 450. 00 450	30. 00 03000 ADULTS & PEDIATRICS				
45. 00 ASCO NURSI NG FACILITY	31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS 50.00 50000 DEFRATI NG ROOM 0.095919 50.00 50000 DEFRATI NG ROOM 0.279361 51.00 51.00 520.00 520.00 ELU VERY ROOM & LABOR ROOM 0.356732 52.00 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 54.01 53.00 55.00 55.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 67.00	43. 00 04300 NURSERY				43.00
50.00 05000 05000 05000 05000 05000 05000 0500 050000 050000 05000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 050000000 05000000 050000000 05000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 0500000000	45.00 04500 NURSING FACILITY				45. 00
51.00 05100 RECOVERY ROOM 0.279361 55.00	ANCILLARY SERVICE COST CENTERS				
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0.356732 52.00 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05400 RADI OLOGY-DI AGNOSTI C 0.256181 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.265181 54.01 05401 ULTRASOUND 0.000000 54.01 05402 00COLOGY 0.216374 56.00 05402 00COLOGY 0.216374 56.00 05700 CT SCAN 0.020260 05700 CT SCAN 0.020260 05700 CT SCAN 0.075738 58.00 05800 MRI 0.075738 58.00 05800 MRI 0.075738 58.00 05800 RSPI RATORY THERAPY 0.104005 0.00000 0.00000 LABORATORY 0.104005 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	50. 00 05000 OPERATING ROOM	0. 095919			50.00
S3. 00 05400 055	51.00 05100 RECOVERY ROOM	0. 279361			51.00
54. 00 05400 ABDI OLOGY - DI AGNOSTI C 0. 256181 54. 00 54. 01 05401 ULTRASOUND 0. 000000 54. 01 05402 ONCOLOGY 0. 216374 54. 02 56. 00 05402 ONCOLOGY 0. 216374 54. 02 56. 00 05402 ONCOLOGY 0. 216374 54. 02 56. 00 05402 ONCOLOGY 0. 201412 56. 00 57. 00 05700 CT SCAN 0. 020260 57. 00 05700 CT SCAN 0. 020260 57. 00 05600 MRI 0. 075738 58. 00 06900 LABORATORY 0. 132185 06. 00 06500 RESPI RATORY THERAPY 0. 132185 06. 00 06500 RESPI RATORY THERAPY 0. 132185 06. 00 06600 PHYSI CAL THERAPY 0. 466216 06. 00 06600 PHYSI CAL THERAPY 0. 245415 07. 00 06900 ELECTROCARDI OLOGY 0. 237272 06. 00 06900 ELECTROCARDI OLOGY 0. 237272 0. 00 06900 ELECTROCARDI OLOGY 0. 096197 0. 096197 0. 097100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 71. 00 07300 PRUSC CHARGED TO PATI ENTS 0. 244691 72. 00 07300 PRUSC CHARGED TO PATI ENTS 0. 244691 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07900 DRUGS CHARGED TO PATI ENTS 0. 000000 76. 01 03610 SLEEP LAB 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 356732			52.00
54.01 05401 ULTRASOUND 0.000000 54.01 54.02 05402 ONCOLOGY 0.216374 54.02 56.00 05600 RADI DI SOTOPE 0.084112 56.00 57.00 05700 CT SCAN 0.020260 57.00 58.00 05800 MRI 0.075738 58.00 60.00 06600 LABORATORY 0.104005 65.00 65.00 056500 REPI RATORY THERAPY 0.132185 65.00 66.00 06600 PHYSI CAL THERAPY 0.146216 66.00 67.00 06600 PHYSI CAL THERAPY 0.245415 66.00 68.00 06600 SPECPH PATHOLOGY 0.237272 68.00 68.00 06600 SELECTROCARDI OLOGY 0.237272 68.00 69.00 06900 ELECTROCARDI OLOGY 0.096197 0.096197 0.00000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.244691 72.00 72.00 07200 IMPLE DV. CHARGED TO PATI ENTS 0.244691 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.244691 72.00 76.01 03610 SLEEP LAB 0.000000 76.00 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 76.00 76.03 03991 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76.00 76.03 03991 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76.00 76.03 03991 OTHER ANCI LLARY SERVI CE ST CENTERS 0.000000 76.00 76.01 03610 SLEEP LAB 0.000000 76.00 76.02 03950 07900 CLINI C 0.265238 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 02 05400 0KOLOGY 0. 216374 54. 02 56. 00 05600 RADI OI STOPE 0. 084112 56. 00 57. 00 05700 CT SCAN 0. 020260 57. 00 58. 00 05800 MRI 0. 075738 58. 00 66. 00 06600 LABORATORY 0. 104005 66. 00 66. 00 06500 RESPI RATORY THERAPY 0. 132185 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 466216 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 245415 67. 00 68. 00 06600 SPEECH PATHOLOGY 0. 237272 68. 00 68. 00 06600 SPEECH PATHOLOGY 0. 096197 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 096197 69. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 076244 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 076244 73. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 01 76. 03 03951 OTHER ANCILLARY SERVI CE COST CENTERS 0. 000000 76. 02 79. 00 09000 CLINI C 0. 025238 0. 000000 76. 03 79. 00 09000 CLINI C 0. 025238 0. 000000 0. 000000 0. 000000 0. 000000 76. 01 07600 07600 07600 07600 07600 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 256181			54. 00
56. 00 05600 R3DI OI SOTOPE 0.084112 56. 00	54. 01 05401 ULTRASOUND	0. 000000			54. 01
57. 00 05700 CT SCAN 0.020260 57. 00 58. 00 05800 MRI 0.075738 58. 00 06. 00 0	54. 02 05402 ONCOLOGY	0. 216374			54. 02
58.00 05800 MRI 0.075738 58.00 60.00 06000 LABORATORY 0.104005 60.00 65.00 06500 RESPI RATORY THERAPY 0.132185 65.00 66.00 06600 PHYSI CAL THERAPY 0.466216 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.245415 67.00 68.00 06800 SPEECH PATHOLOGY 0.237272 68.00 69.00 06900 ELECTROCARDI OLOGY 0.096197 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.096197 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.244691 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.076244 73.00 76.01 03550 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 76.02 76.03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76.03 90.00 09000 CLI NI C 0.265238 90.00 91.00 09100 EMERGENCY 0.120369 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART D.297305	56. 00 05600 RADI 0I SOTOPE	0. 084112			56.00
60. 00 06000 LABORATORY 0. 104005 65. 00 06500 RESPI RATORY THERAPY 0. 132185 65. 00 06500 RESPI RATORY THERAPY 0. 466216 66. 00 06600 PHYSI CAL THERAPY 0. 245415 67. 00 06700 OCCUPATI ONAL THERAPY 0. 245415 67. 00 06800 SPECCH PATHOLOGY 0. 237272 68. 00 06800 SPECCH PATHOLOGY 0. 237272 68. 00 06900 ELECTROCARDI OLOGY 0. 906197 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 244691 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 244691 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 76. 01 03510 SLEEP LAB 0. 000000 76. 01 03510 SLEEP LAB 0. 000000 76. 01 03500 DRUGS CHARGED TO PATI ENTS 0. 0000000 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 076. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 076. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 076. 02 076. 0	57. 00 05700 CT SCAN	0. 020260			57. 00
65. 00 06500 RESPI RATORY THERAPY 0. 132185 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 466216 66. 00 67. 00 06700 0502PATI ONAL THERAPY 0. 245415 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 237272 68. 00 06900 ELECTROCARDI OLOGY 0. 096197 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 075965 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 244691 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 76. 01 03610 SLEEP LAB 0. 000000 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 000000 000000 000000 0000000 000000	58. 00 05800 MRI	0. 075738			58.00
66. 00 06600 PHYSI CAL THERAPY 0. 466216 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 245415 67. 00 68. 00 06800 SPECCH PATHOLOGY 0. 237272 69. 00 06900 ELECTROCARDI OLOGY 0. 096197 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 244691 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 244691 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 73. 00 76. 00 76. 01 03610 SLEEP LAB 0. 000000 76. 01 03610 SLEEP LAB 0. 000000 76. 01 03610 SLEEP LAB 0. 000000 76. 01 03650 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 09000 CLI NI C 0. 265238 91. 00 09100 EMERGENCY 0. 120369 91. 00 09100 EMERGENCY 0. 120369 91. 00 09100 EMERGENCY 0. 120369 92. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 09600 09600 09600 09600	60. 00 06000 LABORATORY	0. 104005			60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0.245415 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.237272 68. 00 06900 ELECTROCARDI OLOGY 0.996197 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.057965 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.244691 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.244691 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.076244 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76. 01 03610 SLEEP LAB 0.000000 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0.000000 76. 03 001704TI ENT SERVI CE COST CENTERS 0.000000 76. 03 001704TI ENT SERVI CE COST CENTERS 0.000000 76. 03 001704TI ENT SERVI CE COST CENTERS 0.000000 09000 CLI NI C 0.265238 90. 000000 09000 CLI NI C 0.297305 92. 00 09000 BERGRENCY 0.120369 92. 00 09000 MBULANCE SERVI CES 0.000000 95. 00 09000 MBULANCE SERVI CES 0.000000 96. 00 09000 MBULANCE SERVI CES 0.000000 96. 00 09000 DIRBABLE MEDI CAL EQUI P-RENTED 0.000000 96. 00 09000 DIRBABLE MEDI CAL EQUI P-RENTED 0.000000 09000 000000 090000 0000000 0000000 00000000	65. 00 06500 RESPIRATORY THERAPY	0. 132185			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 466216			66.00
69. 00 06900 ELECTROCARDIOLOGY 0. 096197 0. 096197 71. 00 71100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 057965 71. 00 7200 1MPL. DEV. CHARGED TO PATIENTS 0. 244691 72. 00 7300 DRUGS CHARGED TO PATIENTS 0. 076244 73. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 01 03610 SLEEP LAB 0. 000000 76. 01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0. 000000 76. 02 03550 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 03 09000 CLINIC 0. 0265238 90. 000000 91. 00 09100 EMERGENCY 0. 120369 91. 00 09100 EMERGENCY 0. 120369 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 297305 0710 DTHER REIMBURSABLE COST CENTERS 0. 000000 99. 00 09000 DURABLE MEDICAL EQUIP-RENTED 0. 000000 99. 00 00000 00000 00000 00000 00000 00000 0000	67. 00 06700 OCCUPATI ONAL THERAPY	0. 245415			67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY	0. 237272			68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 096197			69.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 057965			71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 244691			72. 00
76. 01	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 076244			73.00
76. 02	76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76.00
76. 03	76. 01 03610 SLEEP LAB	0. 000000			76. 01
OUTPATI ENT SERVI CE COST CENTERS O	76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
90. 00 09000 CLINI C 0. 265238 90. 00 91. 00 09100 EMERGENCY 0. 120369 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 297305 92. 00 OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 0. 000000 96. 00 ODHABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 ODHABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 ODHABLE MEDI CAL EQUI P-RENTED 0. 000000 ODHABLE MEDI CAL EQUI P-RENTED 0. 0000000 ODHABLE MEDI CAL EQUI P-RENTED 0. 0000000 ODHABLE MEDI CAL EQUI P-RENTED 0. 0000000 ODHABLE MEDI CAL EQUI P-RENTED ODHABLE MEDI CAL	76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 03
91. 00					
92. 00		0. 265238			90.00
OTHER REI MBURSABLE COST CENTERS O 09500 AMBULANCE SERVI CES O 000000 O 09600 DURABLE MEDI CAL EQUI P-RENTED O 000000 O 0000000 O 000000 O 0 0	91. 00 09100 EMERGENCY				91.00
95. 00 09500 AMBULANCE SERVICES 0.000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96. 00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 297305			92. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 9600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 116.00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
116.00	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				
	202.00 Total (see instructions)				202.00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150133	Period: Worksheet C From 03/01/2014 Part I

			Ť	02/28/2015	Date/Time Pre 7/30/2015 3:1	pared:
		Ti t	le XIX	Hospi tal	Cost	т рііі
			, , , , , , , , , , , , , , , , , , ,	Costs	0001	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 448, 176		9, 448, 176	0	9, 448, 176	
31.00 03100 INTENSIVE CARE UNIT	2, 811, 705		2, 811, 705	0	2, 811, 705	
43. 00 04300 NURSERY	429, 861		429, 861	0	429, 861	
45.00 O4500 NURSING FACILITY	0		0	0	0	45. 00
ANCILLARY SERVICE COST CENTERS	1	T	,			
50.00 05000 OPERATING ROOM	4, 946, 149		4, 946, 149	0	4, 946, 149	50.00
51.00 05100 RECOVERY ROOM	1, 373, 296		1, 373, 296	0	1, 373, 296	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 074, 221		1, 074, 221	0	1, 074, 221	
53. 00 05300 ANESTHESI OLOGY	707		707	0	707	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 264, 493		4, 264, 493	0	4, 264, 493	
54. 01 05401 ULTRASOUND	1		1	0	1	54. 01
54. 02 05402 ONCOLOGY	3, 027, 333		3, 027, 333	0	3, 027, 333	
56. 00 05600 RADI 0I SOTOPE	490, 839		490, 839	0	490, 839	
57. 00 05700 CT SCAN	1, 011, 915		1, 011, 915	0	1, 011, 915	1
58. 00 05800 MRI	965, 596		965, 596	0	965, 596	
60. 00 06000 LABORATORY	5, 299, 436		5, 299, 436	0	5, 299, 436	
65. 00 06500 RESPIRATORY THERAPY	1, 222, 407		., ===,	0	1, 222, 407	
66. 00 06600 PHYSI CAL THERAPY	3, 202, 792	0	3, 202, 792	0	3, 202, 792	66. 00
67. 00 06700 0CCUPATIONAL THERAPY	331, 455	0	331, 455	0	331, 455	67. 00
68. 00 06800 SPEECH PATHOLOGY	37, 154		37, 154	0	37, 154	
69. 00 06900 ELECTROCARDI OLOGY	279, 557		279, 557	0	279, 557	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	779, 841		779, 841	0	779, 841	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 577, 550		3, 577, 550	0	3, 577, 550	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 363, 065		9, 363, 065	0	9, 363, 065	73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 00
76. 01 03610 SLEEP LAB	0		0	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0	0	0	76. 02
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 311, 297		1, 311, 297	0	1, 311, 297	
91. 00 09100 EMERGENCY	3, 798, 114		3, 798, 114	0	3, 798, 114	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 271, 832		2, 271, 832		2, 271, 832	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 H0SPI CE	0		0			116. 00
200.00 Subtotal (see instructions)	61, 318, 792		,,	0	61, 318, 792	
201.00 Less Observation Beds	2, 271, 832		2, 271, 832		2, 271, 832	
202.00 Total (see instructions)	59, 046, 960	0	59, 046, 960	0	59, 046, 960	202. 00

						7/30/2015 3:1	4 pm
				le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
				·		Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	33, 034, 162		33, 034, 16	2		30.00
31.00	03100 INTENSIVE CARE UNIT	2, 759, 991		2, 759, 99	1		31.00
43.00	04300 NURSERY	1, 380, 008		1, 380, 00			43.00
	04500 NURSING FACILITY	0			0		45. 00
10.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		10.00
50.00	05000 OPERATING ROOM	15, 715, 456	35, 850, 492	51, 565, 94	8 0. 095919	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	1, 583, 302	3, 332, 551			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 732, 861	278, 424			0. 000000	
53. 00	05300 ANESTHESI OLOGY	2, 732, 001	270, 424		0. 000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 147, 235	13, 499, 192	1		0.00000	
54. 00	05401 ULTRASOUND	3, 147, 233	13, 477, 172	10, 040, 42	0. 230181	0.000000	
54. 01	05402 ONCOLOGY	75 722	12 015 404	12 001 21			
		75, 723	13, 915, 496			0.000000	
56. 00	05600 RADI OI SOTOPE	464, 862	5, 370, 665			0.000000	
57. 00	05700 CT SCAN	6, 765, 448	43, 181, 209			0. 000000	
58. 00	05800 MRI	769, 644	11, 979, 590				
60.00	06000 LABORATORY	13, 629, 629	37, 324, 234			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	3, 951, 397	5, 296, 316			0. 000000	
66.00	06600 PHYSI CAL THERAPY	865, 500	6, 004, 255			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	58, 958	1, 291, 634	1, 350, 59	2 0. 245415	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	68, 492	88, 096	156, 58	8 0. 237272	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	48, 500	2, 857, 592	2, 906, 09	2 0. 096197	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 888, 818	8, 564, 892	13, 453, 71	0. 057965	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 210, 976	6, 409, 725	14, 620, 70	1 0. 244691	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	42, 046, 524	80, 757, 340	122, 803, 86	4 0. 076244	0. 000000	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	, ,	0. 000000	0. 000000	
76. 01	03610 SLEEP LAB	0	0		0. 000000	0. 000000	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0. 000000		
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0.000000	0. 000000	
70.03	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0.00000	0.000000	70.03
90. 00	09000 CLINIC	588, 597	4, 355, 252	4, 943, 84	9 0. 265238	0. 000000	90.00
91.00	09100 EMERGENCY						
		5, 488, 016	26, 065, 811				1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 346, 894	5, 294, 521	7, 641, 41	5 0. 297305	0.000000	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	1 2			0 000000	0.000000	05.00
95. 00	09500 AMBULANCE SERVI CES	0	0	•	0. 000000		
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0. 000000	0. 000000	96. 00
	SPECIAL PURPOSE COST CENTERS	T T		ı	T		
	11600 HOSPI CE	0	0	1	0		116. 00
200.00		150, 620, 993	311, 717, 287	462, 338, 28	0		200. 00
201.00							201. 00
202.00	Total (see instructions)	150, 620, 993	311, 717, 287	462, 338, 28	0		202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150133	From 03/01/2014	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm

				7/30/2015 3:14 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
45.00 04500 NURSING FACILITY				45. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
54. 02 05402 ONCOLOGY	0. 000000			54. 02
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 00
76. 01 03610 SLEEP LAB	0. 000000			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150133	Period: Worksheet C From 03/01/2014 Part I

			T	0 02/28/2015	Date/Time Pre 7/30/2015 3:1	
		Ti	tle V	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	9, 448, 176		9, 448, 176	0	9, 448, 176	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 811, 705		2, 811, 705	0	2, 811, 705	31.00
43. 00 04300 NURSERY	429, 861		429, 861	0	429, 861	43.00
45.00 04500 NURSING FACILITY	0		0	0	0	45. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 946, 149		4, 946, 149	0	4, 946, 149	50.00
51.00 05100 RECOVERY ROOM	1, 373, 296		1, 373, 296	0	1, 373, 296	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 074, 221		1, 074, 221	0	1, 074, 221	52.00
53. 00 05300 ANESTHESI OLOGY	707		707	0	707	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 264, 493		4, 264, 493	0	4, 264, 493	54.00
54. 01 05401 ULTRASOUND	1		1	0	1	54. 01
54. 02 05402 ONCOLOGY	3, 027, 333		3, 027, 333	0	3, 027, 333	54. 02
56. 00 05600 RADI 0I SOTOPE	490, 839		490, 839	0	490, 839	56.00
57. 00 05700 CT SCAN	1, 011, 915		1, 011, 915	0	1, 011, 915	57.00
58. 00 05800 MRI	965, 596		965, 596	0	965, 596	58. 00
60. 00 06000 LABORATORY	5, 299, 436		5, 299, 436	0	5, 299, 436	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 222, 407	0	1, 222, 407	0	1, 222, 407	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 202, 792	0	3, 202, 792	0	3, 202, 792	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	331, 455	0	331, 455	0	331, 455	67. 00
68. 00 06800 SPEECH PATHOLOGY	37, 154		37, 154	0	37, 154	68. 00
69. 00 06900 ELECTROCARDI OLOGY	279, 557		279, 557	0	279, 557	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	779, 841		779, 841	0	779, 841	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 577, 550		3, 577, 550	0	3, 577, 550	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 363, 065		9, 363, 065	0	9, 363, 065	73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0		1 0	0	0	76. 00
76. 01 03610 SLEEP LAB	0		1 0	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		l 0	0	0	76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0		l 0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C	1, 311, 297		1, 311, 297	0	1, 311, 297	90.00
91. 00 09100 EMERGENCY	3, 798, 114		3, 798, 114	0	3, 798, 114	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 271, 832		2, 271, 832		2, 271, 832	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0		0		0	116. 00
200.00 Subtotal (see instructions)	61, 318, 792	0	61, 318, 792	0	61, 318, 792	200.00
201.00 Less Observation Beds	2, 271, 832		2, 271, 832		2, 271, 832	201. 00
202.00 Total (see instructions)	59, 046, 960	O	59, 046, 960	0	59, 046, 960	202. 00
				·		

				Γ	o 02/28/2015	Date/Time Pre 7/30/2015 3:1	pared: 4 nm
-			Ti	tle V	Hospi tal	Cost	т р
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	•	+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	33, 034, 162		33, 034, 162	2		30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 759, 991		2, 759, 991			31. 00
43.00	04300 NURSERY	1, 380, 008		1, 380, 008			43.00
45. 00	04500 NURSING FACILITY	0					45. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	15, 715, 456	35, 850, 492			0. 000000	1
51.00	05100 RECOVERY ROOM	1, 583, 302	3, 332, 551			0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 732, 861	278, 424			0. 000000	1
53. 00	05300 ANESTHESI OLOGY	0	0	١ - `	0.00000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 147, 235	13, 499, 192	16, 646, 427		0. 000000	1
54. 01	05401 ULTRASOUND	0	0	(0. 000000	0. 000000	1
54. 02	05402 ONCOLOGY	75, 723	13, 915, 496			0. 000000	1
56. 00	05600 RADI OI SOTOPE	464, 862	5, 370, 665			0. 000000	1
57. 00	05700 CT SCAN	6, 765, 448	43, 181, 209			0. 000000	1
58. 00	05800 MRI	769, 644	11, 979, 590			0. 000000	1
60. 00	06000 LABORATORY	13, 629, 629	37, 324, 234			0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	3, 951, 397	5, 296, 316			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	865, 500	6, 004, 255			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	58, 958	1, 291, 634			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	68, 492	88, 096			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	48, 500	2, 857, 592			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 888, 818	8, 564, 892			0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 210, 976	6, 409, 725			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	42, 046, 524	80, 757, 340			0. 000000	1
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0.00000	0. 000000	
76. 01	03610 SLEEP LAB	0	0	C	0.00000	0. 000000	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0. 000000	
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0. 000000	0. 000000	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	588, 597	4, 355, 252			0. 000000	90.00
91. 00	09100 EMERGENCY	5, 488, 016	26, 065, 811			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 346, 894	5, 294, 521	7, 641, 415	0. 297305	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS			ı			
95. 00	09500 AMBULANCE SERVI CES	0	0			0. 000000	
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(0. 000000	0. 000000	96. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	150 (20 002	0				116. 00
200.00	,	150, 620, 993	311, 717, 287	462, 338, 280	'		200. 00
201.00	1	450 (00 000	044 747 007	4/0 000 000			201. 00
202.00	Total (see instructions)	150, 620, 993	311, 717, 287	462, 338, 280	ų l		202. 00

Неа	alth Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
CO	MPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN	: 150133	From 03/01/2014	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm

				7/30/2015 3:14 pm
		Title V	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
45. 00 04500 NURSING FACILITY				45. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
54. 02 05402 0NCOLOGY	0. 000000			54. 02
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 00
76. 01 03610 SLEEP LAB	0. 000000			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS	0.00000			7 5. 55
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			72.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
SPECIAL PURPOSE COST CENTERS	0.000000			70.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
202. 00 10tal (300 1113ti doti 0113)	ı			1202.00

Health Financial Systems	KOSCI USKO COMMU	INITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 03/01/2014 To 02/28/2015	Part I Date/Time Pre	narod:
				10 02/20/2015	7/30/2015 3:1	pareu. 4 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col	•		
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 440 000	1		10.405		
30. 00 ADULTS & PEDI ATRI CS	1, 449, 322		1, 117, 02.			
31. 00 INTENSIVE CARE UNIT	334, 322		334, 32	· ·		
43. 00 NURSERY	34, 764		34, 76			1
45. 00 NURSING FACILITY	0		1	0	0.00	1
200.00 Total (lines 30-199)	1, 818, 408		1, 818, 40	14, 996		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	4 00	6)	-			
INDATI ENT. DOUTINE CERVI OF COCT OFFITERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	2 502	410.7/4				1 20 00
30. 00 ADULTS & PEDI ATRI CS	3, 593					30.00
31. 00 INTENSIVE CARE UNIT	520	134, 040	2			31.00
43. 00 NURSERY	0		2			43.00
45. 00 NURSING FACILITY	0	550.004	'			45. 00
200.00 Total (lines 30-199)	4, 113	552, 804	1			200. 00

Health Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 150133	Peri od: From 03/01/2014	Worksheet D Part II

APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150133	Peri od: From 03/01/2014 To 02/28/2015	Worksheet D Part II Date/Time Pre	narod:
					10 02/28/2015	7/30/2015 3:1	pareu: 4 pm
			Ti t	le XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOULLABLY OF BUILDING CONTROL	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	/45.007	F4 F4F 044	0.0440	0 (00 (01	40.404	F0 00
50.00	05000 OPERATI NG ROOM	615, 907	51, 565, 948			43, 401	50.00
51.00	05100 RECOVERY ROOM	54, 839		•			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	129, 171	3, 011, 28			304	52. 00
53. 00	05300 ANESTHESI OLOGY	19	l .	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	458, 602	16, 646, 42			75, 168	1
54. 01	05401 ULTRASOUND	0	10.001.01	0.00000		0	54. 01
54. 02	05402 ONCOLOGY	395, 606					
56. 00	05600 RADI OI SOTOPE	26, 702					56. 00
57. 00	05700 CT SCAN	84, 135				6, 151	57. 00
58. 00	05800 MRI	119, 993					
60.00	06000 LABORATORY	295, 966					60.00
65. 00	06500 RESPI RATORY THERAPY	113, 451	9, 247, 71				
66. 00	06600 PHYSI CAL THERAPY	314, 259		•			
67. 00	06700 OCCUPATI ONAL THERAPY	6, 699					67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 520					
69. 00	06900 ELECTROCARDI OLOGY	8, 491					69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 942		•			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	95, 415					
73. 00	07300 DRUGS CHARGED TO PATIENTS	271, 033	1			35, 048	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0.00000		0	76. 00
76. 01	03610 SLEEP LAB	0	(0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0.0000		0	76. 02
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0.0000	00 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	138, 299					90.00
91.00	09100 EMERGENCY	467, 217					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	348, 492	7, 641, 41!	0. 04560	923, 650	42, 124	92.00
0= 0-	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	_			-	_	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0.00000		0	, 0. 00
200.00	Total (lines 50-199)	3, 969, 758	425, 164, 119	케	43, 441, 383	350, 393	J200. 00

Health Financial Systems	KOSCIUSKO COMML	INITY HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 03/01/2014 To 02/28/2015		narod:
				10 02/20/2013	7/30/2015 3: 14	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
45.00 04500 NURSING FACILITY	0	0		0	0	45. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				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	12, 435					30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 297	0.00	52	0 0		31.00
43. 00 04300 NURSERY	1, 264	0.00		0		43.00
45.00 04500 NURSING FACILITY	0	0.00		0		45. 00
200.00 Total (lines 30-199)	14, 996		4, 11	3 0		200. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATI THROUGH COSTS	ENT ANCILLARY SERVICE OTHER PASS Provider	Peri od: From 03/01/2014 To 02/28/2015	Worksheet D Part IV Date/Time Prepared:

				o 02/28/2015	Date/lime Pre 7/30/2015 3:1	pared: 4 nm
		Titl	e XVIII	Hospi tal	PPS	т рііі
Cost Center Description	Non Physician N	Nursing School	Allied Health	All Other	Total Cost	
· ·	Anesthetist	Ü		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
54. 01 05401 ULTRASOUND	0	0	C	0	0	54. 01
54. 02 05402 0NCOLOGY	0	0	C	0	0	54. 02
56. 00 05600 RADI OI SOTOPE	0	0	C	0	0	56. 00
57. 00 05700 CT SCAN	0	0	C	0	0	57.00
58. 00 05800 MRI	0	0	C	0	0	58. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76. 00
76. 01 03610 SLEEP LAB	o	0		0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	0		0	0	76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	o	0		0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>			
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
91. 00 09100 EMERGENCY	o	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-				
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	96. 00
200.00 Total (lines 50-199)	O	0	C	0	0	200.00
	1	- 1	'	•	•	

Heal th	Financial Systems		KOSCIUSKO COMMU	JNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT H COSTS	ANCILLARY SER	RVICE OTHER PAS	S	Provi der		Period: From 03/01/2014 To 02/28/2015	Worksheet D Part IV Date/Time Pre 7/30/2015 3:1	
					Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Total	Total	Charges	Ratio of Cost	t Outpatient	I npati ent	
			Outpati ent	(from	Wkst. C,	to Charges	Ratio of Cost	Program	
			Cost (sum of	Part	I, col.	(col. 5 ÷ col	. to Charges	Charges	
			col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
			4)				7)		
			6. 00		7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS		•	•			<u>.</u>		
50.00	05000 OPERATING ROOM		0	5	1, 565, 948	0.00000	0.000000	3, 633, 681	50.00
E1 00	DE100 DECOVEDY DOOM		1 0	J	4 O1E OE2	1 000000	ol o ooooool	200 000	E1 00

	Cost Center Description	Total		Ratio of Cost	Outpati ent	I npati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS			,	1		
	05000 OPERATING ROOM	0					50.00
	05100 RECOVERY ROOM	0	4, 915, 853				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	3, 011, 285				
	05300 ANESTHESI OLOGY	0	0	0. 000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	16, 646, 427	0.000000		2, 728, 433	54.00
	05401 ULTRASOUND	0	0	0.000000	0. 000000	0	54. 01
	05402 ONCOLOGY	0	13, 991, 219			38, 613	54. 02
56.00	05600 RADI 0I SOTOPE	0	5, 835, 527	0.000000	0.000000	254, 958	56.00
57.00	05700 CT SCAN	0	49, 946, 657	0.000000	0.000000	3, 652, 771	57.00
58.00	05800 MRI	0	12, 749, 234	0.000000	0. 000000	372, 386	58. 00
60.00	06000 LABORATORY	0	50, 953, 863	0.000000	0. 000000	6, 358, 597	60.00
65.00	06500 RESPI RATORY THERAPY	0	9, 247, 713	0.000000	0.000000	1, 995, 347	65.00
66.00	06600 PHYSI CAL THERAPY	0	6, 869, 755	0.000000	0.000000	347, 283	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1, 350, 592	0.000000	0.000000	33, 670	67.00
68.00	06800 SPEECH PATHOLOGY	0	156, 588	0.000000	0.000000	48, 499	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 906, 092	0.000000	0.000000	28, 002	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 453, 710	0.000000	0.000000	1, 530, 669	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 620, 701	0.000000	0.000000	2, 667, 112	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	122, 803, 864	0.000000	0.000000	15, 880, 414	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76. 01	03610 SLEEP LAB	0	0	0.000000	0.000000	ol	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.000000	0.000000	ol	76. 02
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	4, 943, 849	0.000000	0.000000	135, 187	90.00
91.00	09100 EMERGENCY	0	31, 553, 827	0.000000	0. 000000	2, 414, 112	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 641, 415	0.000000	0. 000000	923, 650	92.00
	OTHER REIMBURSABLE COST CENTERS	•		,			
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96. 00
200.00	Total (lines 50-199)	0	425, 164, 119			43, 441, 383	200. 00
	•	•	•	•			•

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	T ANCILLARY SERVICE OTHER PASS Provider CCN:	150133 Peri od: Worksheet D Part IV Part IV Date/Time Prepared: 7/20/2015 2:14 pm

				02/20/2013	7/30/2015 3: 1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	4, 182, 166	0			50.00
51.00 05100 RECOVERY ROOM	0	303, 580	0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	210	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 958, 079	0			54.00
54. 01 05401 ULTRASOUND	0	0	0			54. 01
54. 02 05402 ONCOLOGY	0	4, 030, 298	0			54. 02
56. 00 05600 RADI 0I SOTOPE	0	1, 333, 193	0			56. 00
57. 00 05700 CT SCAN	O	7, 203, 160	0			57. 00
58. 00 05800 MRI	O	2, 118, 534	0			58. 00
60. 00 06000 LABORATORY	O	4, 028, 731	0			60.00
65. 00 06500 RESPIRATORY THERAPY	O	1, 006, 739	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	O	13, 168	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	O	636	o			67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	o			68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	770, 724	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	855, 295	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	631, 290	o			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	18, 404, 076	o			73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	o		o			76. 00
76. 01 03610 SLEEP LAB	o	0	o			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	o			76. 02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	o	0	o			76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	580, 678	0			90.00
91. 00 09100 EMERGENCY	o	3, 670, 708	o			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	1, 039, 349	o			92.00
OTHER REIMBURSABLE COST CENTERS	•		,			
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	o			96. 00
200.00 Total (lines 50-199)	0	55, 130, 614	0			200. 00

Title XVII Hospital PPS Costs Cost Costs Cost Costs Cost Costs Cost Ratio From Worksheet C, Part I, col. 9 PS Reinbursed Services Services Cost Cos					10 02/28/2015	7/30/2015 3:1	pared: 4 pm
Cost Center Description			Ti tl	e XVIII	Hospi tal		
Ratio From Worksheet C, Part I, col. Part I,				Charges		Costs	
Morksheet C, Part I, col. 9	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
Part I, col. 9		Ratio From		Reimbursed	Rei mbursed	(see inst.)	
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS A		Part I, col. 9					
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50.00 05000 05000 05000 0 401.149 50.00	ANOLILIARY OFFICE COOT OFFITTED	1.00	2.00	3.00	4. 00	5. 00	
S1 00 05100 RECOVERY ROOM 0.279361 303,580 0 0 84,808 51.00				1			
S2.00 05.200 05.200 05.11 VERY ROOM & LABOR ROOM 0. 356732 210 0 0 0 75 52.00							
S3.00 05300 ABSTHESI OLOGY 0.000000 0 0 0 53.00							1
54.00 05400 RADIOLOGY-DI AGNOSTIC 0.256181 4,958,079 0 0 1,270,166 54.01					-		
54. 01 05401 ULTRASOUND 0.000000 0 0 0 0 54. 01					-	_	
54.02 05402 0NOLLOGY		l e			٥		1
56. 00 05600 RADI OI SOTOPE 0.084112 1,333,193 0 0 112,138 56. 00 57. 00 05700 0					-	-	
57. 00 05700 CT SCAN 0.020260 7, 203, 160 0 0 145, 936 57. 00 58. 00 05800 MRI 0.075738 2, 118, 534 0 0 160, 454 58. 00 0.0000 LABORATORY 0.104005 4, 028, 731 0 3, 994 419, 008 60. 00 65. 00 6							
58. 00 05800 MRI					-	· ·	1
60. 00 06000 LABORATORY 0. 104005 4, 028, 731 0 3, 994 419, 008 60. 00 65. 00 05500 RESPI RATORY THERAPY 0. 132185 1, 006, 739 0 0 133, 076 65. 00 06000 PHYSI CAL THERAPY 0. 245415 636 0 0 0 0 156 67. 00 06700 0CCUPATI ONAL THERAPY 0. 245415 636 0 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0. 237272 0 0 0 0 0 0 0 0 0							
65. 00 06500 RESPIRATORY THERAPY 0. 132185 1, 006, 739 0 0 133, 076 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 466216 13, 168 0 0 0 6, 139 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 245415 636 0 0 0 156 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 237272 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0. 096197 770, 724 0 0 74, 141 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 855, 295 0 0 49, 577 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 244691 631, 290 0 0 154, 471 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 18, 404, 076 0 54, 027 1, 403, 200 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 0 76. 03 00179ATI ENT SERVI CE COST CENTERS 0. 000000 0 0 0 0 76. 03 09000 CLI NI C 0 09000 0 0 0 0 76. 03 09000 DIRUGS CHARGED TO BESS 0. 0000000 0 0 0 76. 03 09000 09000 00 0 0 0 76. 03 00179ATI ENT SERVI CE COST CENTERS 0. 0000000 0 0 0 76. 03 09000 0018 001					-		
66. 00 06600 PHYSI CAL THERAPY 0. 466216 13, 168 0 0 6, 139 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 245415 636 0 0 156 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 237272 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0. 096197 770, 724 0 0 74, 141 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 855, 295 0 0 49, 577 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 244691 631, 290 0 0 154, 471 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 18, 404, 076 0 54, 027 1, 403, 200 73. 00 76. 01 03610 SLEEP LAB 0. 000000 0 0 0 0 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 0 76. 03 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 76. 03 001FBR ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 76. 03 001FBR ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 76. 07 00900 CLI NI C 0. 265238 580, 678 0 0 154, 018 79. 00 09000 CLI NI C 0. 120369 3, 670, 708 0 0 441, 839 91. 00 79. 00 09000 CLI NI C 0. 120369 3, 670, 708 0 0 0 79. 00 09500 ABSERVATI ON BEDS (NON-DI STI NCT PART 0. 297305 1, 039, 349 0 0 0 0 79. 00 09500 ABSERVATI ON BEDS (NON-DI STI NCT PART 0. 297305 1, 039, 349 0 0 0 0 79. 00 09500 ABSERVATI ON BEDS (NON-DI STI NCT PART 0. 297305 1, 039, 349 0 0 0 0 79. 00 09500 ABSERVATI ON BEDS (NON-DI STI NCT PART 0. 297305 1, 039, 349 0 0 0 0 79. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0 0 0 0 70 001 0						· ·	1
67. 00					0		
68.00 06800 SPEECH PATHOLOGY 0. 237272 0 0 0 0 0 0 68.00 69.00 69.00 ELECTROCARDI OLOGY 0. 096197 770, 724 0 0 0 74, 141 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 855, 295 0 0 49, 577 71.00 7200 IMPL. DEV. CHARGED TO PATI ENTS 0. 244691 631, 290 0 0 154, 471 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 18, 404, 076 0 54, 027 1, 403, 200 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 18, 404, 076 0 54, 027 1, 403, 200 73.00 76.00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 76.00 76.01 03610 SLEEP LAB 0. 0000000 0 0 0 0 0 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 0 0 0 0 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 0 0 76.02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-		1
69. 00 06900 ELECTROCARDIOLOGY 0. 096197 770, 724 0 0 74, 141 69. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 057965 855, 295 0 0 49, 577 71. 00 72. 00 70. 00 IMPL. DEV. CHARGED TO PATI ENTS 0. 244691 631, 290 0 0 154, 471 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 076244 18, 404, 076 0 54, 027 1, 403, 200 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 0 0 0 0 0 0 76. 00 76. 00 03950 0THER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 76. 00 76. 01 03610 SLEEP LAB 0. 000000 0 0 0 0 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 0 0 0 76. 02 76. 03 03951 0THER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 76. 02 76. 03 03951 0THER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 76. 03 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ł .	•	-		1
71. 00							
72. 00					0		
73. 00 07300 DRUGS CHARGED TO PATIENTS					0		
76. 00							
76. 01					54, 027	1, 403, 200	73. 00
76. 02					0	0	76. 00
76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 76. 03 000000 00000 00000 00000 00000 00000 0000					0	0	
90. 00					0	0	
90. 00		0. 000000	0	(0	0	76. 03
91. 00							
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0. 297305 1, 039, 349 0 0 309, 004 92. 00							
OTHER REIMBURSABLE COST CENTERS O. 000000 O. 0000000 O. 000000 O. 0000000 O. 000000 O. 0000000 O. 000000 O. 000000 O. 000000 O. 000000 O. 000000 O. 0000000 O. 00000000							
95. 00		0. 297305	1, 039, 349	(0	309, 004	92. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0 0 0 96. 00 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0		_					1
200.00 Subtotal (see instructions) 55,130,614 0 58,021 6,191,407 200.00 201.00 0 0 0 0 0 0 0 0 0							
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		0. 000000			-	_	
Only Charges			55, 130, 614		58, 021		
					0		201. 00
202.00 Net Charges (line 200 +/- line 201) 55, 130, 614 0 58, 021 6, 191, 407 202.00							
	202.00 Net Charges (line 200 +/- line 201)		55, 130, 614		58, 021	6, 191, 407	202. 00

				From 03/01/2014 To 02/28/2015	Part V Date/Time Pre 7/30/2015 3:1	
		Ti tl	e XVIII	Hospi tal	PPS	
	Co:	sts				
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0)			50. 00
51.00 05100 RECOVERY ROOM	0	0)			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)			52.00
53. 00 05300 ANESTHESI OLOGY	0	0	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)			54.00
54. 01 05401 ULTRASOUND	0	0				54. 01
54. 02 05402 ONCOLOGY	0	0				54. 02
56. 00 05600 RADI 0I SOTOPE	0	0)			56. 00
57.00 05700 CT SCAN	0	0)			57. 00
58. 00 05800 MRI	0	o o				58. 00
60. 00 06000 LABORATORY	0	415				60.00
65. 00 06500 RESPIRATORY THERAPY	0	ol o	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		ı			67. 00
68. 00 06800 SPEECH PATHOLOGY	0		j			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		j			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		,			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		,			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	4, 119	,			73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS) .,,	,			76. 00
76. 01 03610 SLEEP LAB						76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES						76. 02
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS						76. 03
OUTPATIENT SERVICE COST CENTERS		,	1			1 70:00
90. 00 09000 CLI NI C	0	0	ı			90.00
91. 00 09100 EMERGENCY		•				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS		,	1			72.00
95. 00 09500 AMBULANCE SERVI CES	1 0	S				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED						96.00
200.00 Subtotal (see instructions)		4, 534				200.00
201.00 Less PBP Clinic Lab. Services-Program		4, 554				200.00
Only Charges		1				201.00
202.00 Net Charges (line 200 +/- line 201)	0	4, 534				202. 00
202. 00 Not onal ges (Tric 200 1/ Tric 201)	1	1 7,004	I			1202.00

					To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
			Ti t	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
	NOLLLADY CEDYLOG COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS	0.005040		T			
	5000 OPERATING ROOM	0. 095919	l		870, 224	0	
	5100 RECOVERY ROOM	0. 279361	0		95, 593	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 356732	0		20, 753	0	52.00
	5300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
1	5400 RADI OLOGY-DI AGNOSTI C	0. 256181	0		1, 070, 343	0	54. 00
	5401 ULTRASOUND	0. 000000	0		0	0	54. 01
	5402 ONCOLOGY	0. 216374	0		629, 662	0	54. 02
	5600 RADI OI SOTOPE	0. 084112	0		166, 954	0	56. 00
	5700 CT SCAN	0. 020260	0		1, 946, 846	0	57. 00
	5800 MRI	0. 075738			506, 701	0	58. 00
	6000 LABORATORY	0. 104005			1, 738, 294	0	60.00
	6500 RESPI RATORY THERAPY	0. 132185	0		254, 502	0	65. 00
	6600 PHYSI CAL THERAPY	0. 466216	0		119, 990	0	66. 00
	6700 OCCUPATI ONAL THERAPY	0. 245415	0		34, 039	0	67. 00
	6800 SPEECH PATHOLOGY	0. 237272	0		8, 802	0	68. 00
	6900 ELECTROCARDI OLOGY	0. 096197	0		109, 088	0	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 057965	0		225, 124	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 244691	0		179, 414	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 076244	0		2, 934, 656	0	73. 00
	3950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0	0	76. 00
	3610 SLEEP LAB	0. 000000			0	0	76. 01
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			0	0	76. 02
	3951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 (C	0	76. 03
	UTPATIENT SERVICE COST CENTERS	_					
	9000 CLI NI C	0. 265238			164, 732	0	90.00
	9100 EMERGENCY	0. 120369			1, 804, 078	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 297305	0		280, 854	0	92. 00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	0. 000000			O		95. 00
	9600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
200.00	Subtotal (see instructions)		0		13, 160, 649	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0		13, 160, 649	0	202. 00

					To 02/28/2015	Date/Time Pre 7/30/2015 3:1	pared: 4 pm
			Ti t	le XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	1	6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0	83, 471				50.00
51. 00	05100 RECOVERY ROOM	0	26, 705				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 403	1			52. 00
53. 00	05300 ANESTHESI OLOGY	0	C				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	274, 202	1			54. 00
54. 01	05401 ULTRASOUND	0	C	1			54. 01
54. 02	05402 ONCOLOGY	0	136, 242	1			54. 02
56. 00	05600 RADI OI SOTOPE	0	14, 043	1			56. 00
57.00	05700 CT SCAN	0	39, 443	1			57. 00
58. 00	05800 MRI	0	38, 377	1			58. 00
60.00	06000 LABORATORY	0	180, 791				60.00
65.00	06500 RESPI RATORY THERAPY	0	33, 641	1			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	55, 941				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	8, 354				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	2, 088				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	10, 494				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 049	'			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	43, 901				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	223, 750)			73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C				76. 00
76. 01	03610 SLEEP LAB	0	(C)			76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C				76. 02
76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	C				76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	10,0,0	1			90. 00
91. 00	09100 EMERGENCY	0	217,100				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	83, 499				92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	1			96. 00
200.00	Subtotal (see instructions)	0	1, 536, 242				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0	1, 536, 242				202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150133	Peri od: From 03/01/2014	Worksheet D-1	
			Date/Time Pre 7/30/2015 3:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1 00	

Inpatient days (including private room days, excluding saing-bed and newborn days) 12,435 2,00			Title XVIII	Hospi tal	PPS	. p
NAME 1 - ALL PROVIDER COMPONENTS NAME		Cost Center Description			1 00	
INPATIENT DAYS 1.00 Inpatient days (Including private room days and seing-bed days, excluding newborn) 12,435 2.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 2.30 2.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days) 12, 435 2,00		I NPATI ENT DAYS				
7.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line. 7.00 Semi-private room days (excluding swing-bed and observation bed days). 8.01 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calledary sever, enter 0 on this line). 8.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (if calledary sever, enter 0 on this line). 8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary sever, enter 0 on this line). 9.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in line to the Program (excluding swing-bed and newborn days). 9.01 Total lineatient days including private room days applicable to title xVIII only (including private room days). 10.02 Swing-bed SMF type inpatient days applicable to title xVIII only (including private room days) after December 31 of the cost reporting period (including private room days). 11.03 Swing-bed SMF type inpatient days applicable to title xVIII only (including private room days) after December 31 of the cost reporting period (including private room days). 12.00 Swing-bed SMF type inpatient days applicable to title xVIII only (including private room days). 13.00 Swing-bed SMF type inpatient days applicable to itless V or XIX only (including private room days). 13.00 Swing-bed SMF type inpatient days applicable to itless V or XIX only (including private room days). 13.00 Swing-bed SMF type inpatient days applicable to itless V or XIX only (including private room days). 13.00 Swing-bed SMF type inpatient days applicable to itless V or XIX only (including private room days). 13.00 Swing-bed SMF type inpatient days applicable to itless V or XIX only (including private room days). 13.00 Swing-bed SMF type i	1.00				12, 435	1.00
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Fype inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Fype inpatient days (including private room days) after December 31 of the cost reporting period 8. 00 Total swing-bed Fype inpatient days (including private room days) after December 31 of the cost reporting period 7. 00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and nextern days) 8. 00 Swing-bed SM type inpatient days applicable to this line) 9. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) after 10. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) after 11. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) after 12. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) after 13. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) after 14. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) 15. 00 Swing-bed SM type inpatient days applicable to the Program (excluding private room days) 16. 00 Swing-bed SM type inpatient days applicable to the William of the Exclusion days 17. 00 Total swing-bed SM type inpatient days applicable to the William of the Exclusion days 18. 00 Swing-bed Net type inpatient days applicable to the William of the Exclusion days 18. 00 Total swing-bed SM type inpatient days applicable to the Swing-bed SW type inpatient days applicable to swing-bed SW type inpatient days applicable to swing-bed SW type inpatient days appl						2. 00
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reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SMstype inpatient days applicable to 11tle XVIII only (including private room days) 11. 00 Swing-bed SMstype inpatient days applicable to 11tle XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SMstype inpatient days applicable to 11tles VVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to 11tles V or XIX only (including private room days) of 12. 00 Honology of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to 11tles V or XIX only (including private room days) of 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medically necessary private room days applicable to 11tles V or XIX only (including swing-bed days) 18. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only) 19. 00 Nursery da	7 00		days) through December 3	R1 of the cost	0	7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)	7.00		days) in ough becomber to	or the cost	· ·	7.00
10.00 Swing-bed SNF type inpatitent days applicable to the Program (excluding swing-bed and newborn days) 0.00 10.00	8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
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through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical in precessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 No Nestery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 No Nestery days (title V or XIX only) 19.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost one period (including private room days) 19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost one period (including private room days) 19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost one period (including private room days) 19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost one period (including private room days applicable (including pri	10. 00		y (including private roo	om days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 12.00				,		
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 759.81 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 30.00 30.00 30.00 0.00	28 00		and observation bed char	raes)	0	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Average per diem private room cost differential (line 9, 448, 176) 37.00 Average per diem private room cost differential (line 9, 448, 176) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average private room cost differential (line 9, 448, 176) 37.00 Average per diem private room cost differential (line 9, 448, 176) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average private room cost differential (line 32 minus line 33)(see instructions) 37.00 General inpatient routine service cost and private room cost differential (line 9, 448, 176) 37.00 Average per diem private room cost differential (line 33)(see instructions) 38.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 38.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) 37.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 38.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 39.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 39.00 Average per diem priv		,	and observation bed one.	900)		29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.	30.00				0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 43.00 33.00 34.00 34.00 35.00 36.00 36.00 37.		,	line 28)			31.00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 35.00 9, 448, 176 9, 448, 176		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 448, 176 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			s line 33)(see instructi	ons)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 46.00				Olis)		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,729,997 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			,			36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,729,997 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		d private room cost diff	ferential (line	9, 448, 176	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 759.81 2, 729, 997 39.00 dedically necessary private room cost applicable to the Program (line 14 x line 35) 759.81 38.00 2, 729, 997 39.00 dedically necessary private room cost applicable to the Program (line 14 x line 35)						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 759.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 759.81 38.00 2,729,997 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 759.81 38.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,729,997 39.00 40.00	38. 00				759, 81	38. 00
						39. 00
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 2,729,997 41.00		1 3 1	,			40. 00
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		2, 729, 997	41.00

COMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		NI TY HOSPI TAI Provi de	r CCN: 150133	Peri od:	worksheet D-1	
					From 03/01/2014 To 02/28/2015		
				tle XVIII	Hospi tal	PPS	. p
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per ysDiem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
12. 00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42. 0
13. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 811, 705	1, 29	97 2, 167.	85 520	1, 127, 282	43. 0
14. 00		2,811,703	1, 2	2, 107.	520	1, 127, 202	44. 0
45. 00							45. 0
	SURGICAL INTENSIVE CARE UNIT						46. 0
17. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1. 00	
18. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 200)			4, 953, 885	48. 0
19. 00	3 1 .	41 through 48)((see instructi	ions)		8, 811, 164	49.0
	PASS THROUGH COST ADJUSTMENTS						ļ
50. 00	Pass through costs applicable to Program inp	atient routine	services (fr	om Wkst. D, su	m of Parts I and	552, 804	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	rv services (from Wkst. D.	sum of Parts II	350, 393	51.0
	and IV)		,	,			
52. 00	Total Program excludable cost (sum of lines					903, 197	1
53. 00	Total Program inpatient operating cost exclu	9 1	elated, non-pl	nysician anest	hetist, and	7, 907, 967	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00						0	54.0
55. 00						0.00	55. 0
6.00	,			(1) = = ()	1. 50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount	(IINe 56 MINUS	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996.	updated and c	ompounded by the		59.0
	market basket	5 1	3	.,			
50.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
51. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.0
	amount (line 56), otherwise enter zero (see		.5 (111165 54 .	x 00), 01 1/8 0	i the target		
52. 00	1	,				0	62.0
53. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.0
54. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	amber 31 of th	he cost report	ing period (See	1 0	64. 0
J4. 00	instructions)(title XVIII only)	ts through beec	sinder 31 of th	ne cost report	riig perrou (see	Ĭ	04.0
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 0
	instructions) (title XVIII only)	no costo (lino	(4 plus lips	/F)/+:+	II anlu) Fan		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (iine	64 prus rine	os)(title xvi	ii oniy). For	0	66. 0
57. 00	, ,	e costs through	December 31	of the cost r	eporting period	0	67. 0
	(line 12 x line 19)					_	
58. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after L	December 31 o	f the cost rep	orting period	0	68. 0
59. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + li	ne 68)		0	69. 0
	PART III - SKILLED NURSING FACILITY, OTHER N						
70.00	Skilled nursing facility/other nursing facil	,					70.0
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ iine	e 2)			71. 0
73. 00	Medically necessary private room cost applic		n (line 14 x	line 35)			73. 0
74. 00	Total Program general inpatient routine serv	9	•	,			74. 0
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.0
77. 00	'	,					77. 0
78. 00	,						78. 0
79.00	95 5						79.0
30.00			cost limitatio	on (line 78 mi	nus line 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 0 82. 0
33. 00	1 '		•				83. 0
34. 00	Program inpatient ancillary services (see in		•				84. 0
	Utilization review - physician compensation						85. 0
36. 00	Total Program inpatient operating costs (sum		nrough 85)				86. 0
37. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					2, 990	87. 0
	Adjusted general inpatient routine cost per	•	- Line 2)			759. 81	
38. 00	riaj do tod gonor di Tripati ont Toditi no doct por	a. o (1 00.0

Health Financial Systems	KOSCIUSKO COMMU	INI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 03/01/2014 To 02/28/2015	Date/Time Prep 7/30/2015 3:14	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 449, 322	9, 448, 176	0. 15339	7 2, 271, 832	348, 492	90.00
91.00 Nursing School cost	0	9, 448, 176	0.00000	2, 271, 832	0	91.00
92.00 Allied health cost	0	9, 448, 176	0.00000	2, 271, 832	0	92.00
93.00 All other Medical Education	0	9, 448, 176	0.00000	2, 271, 832	0	93.00

Health Financial Systems INPATIENT ANCILLARY SERVICE		COMMUNITY HOSPITAL Provider	CCN: 150133	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEART SERVICE	COST ALTORITONWENT	Trovider		From 03/01/2014 To 02/28/2015	Date/Time Pre 7/30/2015 3:1	pared:
		Ti tl	e XVIII	Hospi tal	PPS	т рііі
Cost Center Des	cription		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SER	VICE COST CENTERS					
30. 00 03000 ADULTS & PEDI AT	RICS			7, 478, 562		30.00
31.00 03100 INTENSIVE CARE	UNI T			1, 639, 969		31.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE COS	T CENTERS					
50. 00 05000 OPERATING ROOM			0. 09591	3, 633, 681	348, 539	50.00
51.00 05100 RECOVERY ROOM			0. 27936	390, 909	109, 205	51.00
52.00 05200 DELIVERY ROOM &	LABOR ROOM		0. 35673	7, 090	2, 529	52. 00
53. 00 05300 ANESTHESI OLOGY			0.00000		0	
54. 00 05400 RADI OLOGY-DI AGN	OSTI C		0. 25618	2, 728, 433	698, 973	54. 00
54. 01 05401 ULTRASOUND			0.00000	00	0	54. 01
54. 02 05402 ONCOLOGY			0. 21637	74 38, 613	8, 355	54. 02
56. 00 05600 RADI 0I SOTOPE			0. 08411		21, 445	
57.00 05700 CT SCAN			0. 02026		74, 005	
58. 00 05800 MRI			0.07573		28, 204	
60. 00 06000 LABORATORY			0. 10400	05 6, 358, 597	661, 326	
65. 00 06500 RESPIRATORY THE			0. 13218		263, 755	
66. 00 06600 PHYSI CAL THERAP			0. 46621		161, 909	
67. 00 06700 OCCUPATI ONAL TH			0. 24541		8, 263	
68.00 06800 SPEECH PATHOLOG			0. 23727		11, 507	68. 00
69. 00 06900 ELECTROCARDI OLO			0. 09619		2, 694	
71.00 07100 MEDICAL SUPPLIE			0.05796		88, 725	
72.00 07200 I MPL. DEV. CHAR			0. 24469	2, 667, 112	652, 618	72. 00
73.00 07300 DRUGS CHARGED T			0. 07624		1, 210, 786	
76. 00 03950 OTHER ANCILLARY	SERVICE COST CENTERS		0.00000		0	76.00
76. 01 03610 SLEEP LAB			0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSY			0.00000		0	76. 02
76. 03 03951 OTHER ANCILLARY			0.00000	00 0	0	76. 03
OUTPATIENT SERVICE CO	ST CENTERS					1
90. 00 09000 CLI NI C			0. 26523		35, 857	90.00
91. 00 09100 EMERGENCY			0. 12036		290, 584	91.00
92. 00 09200 OBSERVATI ON BED			0. 29730	923, 650	274, 606	92. 00

0.000000

43, 441, 383

43, 441, 383

95.00

96.00 0 4, 953, 885 200. 00

201. 00 202. 00

201.00

202.00

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems KOSCIUSKO	COMMUNITY HOSPITAL		In lie	eu of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150133	Peri od:	Worksheet D-3	
			From 03/01/2014		
			To 02/28/2015	Date/Time Pre 7/30/2015 3:1	
	Ti tl	e XIX	Hospi tal	Cost	4 рііі
Cost Center Description		Ratio of Cos		Inpati ent	
· ·		To Charges	Program	Program Costs	
		· ·	Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			873, 787		30. 00
31. 00 03100 I NTENSI VE CARE UNI T			244, 088		31. 00
43. 00 04300 NURSERY			140, 841		43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 09591		71, 245	
51.00 05100 RECOVERY ROOM		0. 27936		22, 710	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 35673		42, 096	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25618		51, 531	54.00
54. 01 05401 ULTRASOUND		0.00000		0	54. 01
54. 02 05402 0NCOLOGY		0. 21637		3, 480	1
56. 00 05600 RADI 0I SOTOPE		0. 08411			56. 00
57. 00 05700 CT SCAN		0. 02026			
58. 00 05800 MRI		0. 07573		3, 762	
60. 00 06000 LABORATORY		0. 10400			
65. 00 06500 RESPI RATORY THERAPY		0. 13218			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 46621			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24541		199	
68. 00 06800 SPEECH PATHOLOGY		0. 23727		587	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 09619		568	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05796			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24469		70, 369	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 07624		178, 800	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000		0	76. 00
76. 01 03610 SLEEP LAB		0. 00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000		0	76. 02
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000	0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS		0.04	al a	,	
90. 00 09000 CLI NI C		0. 26523			90.00

285, 715 93, 378

5, 807, 802

5, 807, 802

0. 120369

0. 297305

0.000000

34, 391 27, 762

0 96.00 649,481 200.00

91.00

92. 00

95.00

201. 00 202. 00

91. 00 09100 EMERGENCY

201.00

202.00

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Period: From 03/01/2014 To 02/28/2015	Worksheet E Part A Date/Time Pre 7/30/2015 3:1	epared:
	Title		Hospi tal	PPS	ı 4 piii
_	0	1.00	on/after 1/1 1.01	2. 00	-
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	<u> </u>	1.00	1.01	2.00	
1.00 DRG Amounts Other than Outlier Payments			0		1.00
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3, 874, 24	5	I	1. 01
1.02 DRG amounts other than outlier payments for discharges		2, 511, 96	8	I	1. 02
occurring on or after October 1 (see instructions)				I	
1.03 DRG for federal specific operating payment for Model 4			0	I	1. 03
BPCI for discharges occurring prior to October 1 (see instructions)				I	
1.04 DRG for federal specific operating payment for Model 4			О	I	1. 04
BPCI for discharges occurring on or after October 1 (see				I	
instructions) 2.00 Outlier payments for discharges. (see instructions)		33, 09	7	I	2.00
2.01 Outlier reconciliation amount			О	I	2. 01
2.02 Outlier payment for discharges for Model 4 BPCI (see			0	I	2. 02
instructions) 3.00 Managed Care Simulated Payments			0	I	3.00
4.00 Bed days available divided by number of days in the cost		63.8	1	I	4. 00
reporting period (see instructions)					
Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the		0.0			5.00
most recent cost reporting period ending on or before		0.0	O O	I	3.00
12/31/1996. (see instructions)				I	
6.00 FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new		0. 0	0	I	6. 00
programs in accordance with 42 CFR 413.79(e)				I	
7.00 MMA Section 422 reduction amount to the IME cap as		0. 0	О	I	7. 00
speci fi ed under 42 CFR §412. 105(f) (1) (i v) (B) (1)		0.0		l	7 01
7.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the		0.0	U	I	7. 01
cost report straddles July 1, 2011 then see instructions.				I	
8.00 Adjustment (increase or decrease) to the FTE count for		0. 0	0	I	8. 00
allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b),				I	
413. 79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67 FR				I	
50069 (August 1, 2002).		0.0		l	0.01
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0.0	0	I	8. 01
straddl es July 1, 2011, see instructions.				I	
8.02 The amount of increase if the hospital was awarded FTE cap		0. 0	0	I	8. 02
slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				I	
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	О	I	9.00
lines (8, 8,01 and 8,02) (see instructions)		0.0		I	10.00
10.00 FTE count for allopathic and osteopathic programs in the current year from your records		0.0	O	I	10.00
11.00 FTE count for residents in dental and podiatric programs.		0. 0	o	I	11.00
12.00 Current year allowable FTE (see instructions)		0. 0		I	12.00
13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the penultimate year if that		0. 0 0. 0		I	13. 00 14. 00
year ended on or after September 30, 1997, otherwise enter		0.0		I	14.00
zero.				I	
15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program		0. 0 0. 0		I	15. 00 16. 00
17.00 Adjustment for residents displaced by program or hospital		0. 0		I	17. 00
closure				I	
18.00 Adjusted rolling average FTE count		0.0		1	18.00
19.00 Current year resident to bed ratio (line 18 divided by line 4).		0. 00000	U .	I	19. 00
20.00 Prior year resident to bed ratio (see instructions)		0. 00000	О	I	20.00
21.00 Enter the lesser of lines 19 or 20 (see instructions)		0. 00000		1	21.00
22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions)			0	I	22. 00 22. 01
Indirect Medical Education Adjustment for the Add-on for Secti	ion 422 of the		<u> </u>		22.01
23.00 Number of additional allopathic and osteopathic IME FTE		0. 0	0		23. 00
resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions)		0. 0	0	I	24. 00
25.00 If the amount on line 24 is greater than -0-, then enter		0. 0		I	25. 00
the lower of line 23 or line 24 (see instructions)				I	
26.00 Resident to bed ratio (divide line 25 by line 4)		0. 00000 0. 00000		1	26. 00
27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions)		O. OOOOO	U	ı	27. 00
` ` ` ` '			0	1	28 00
28.01 IME add-on adjustment amount - Managed Care (see			0		28. 00 28. 01
28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28)			<u> </u>		

			T: ±1	- 20/11	11: 4-1	7/30/2015 3: 14	4 pm
				e XVIII	Hospi tal	PPS	
			0	before 1/1 1.00	on/after 1/1 1.01	2. 00	
29. 01	Total IME payment - Managed Care (sum of line	as 22 01 and	0	1.00	1.01	2.00	29. 01
27.01	28. 01)	23 22. 01 and					27.01
	Disproportionate Share Adjustment		'				
30.00	Percentage of SSI recipient patient days to M	Medicare Part		1. 36			30. 00
	A patient days (see instructions)						
31. 00	Percentage of Medicaid patient days (see inst	tructi ons)		16. 81			31. 00
32. 00	Sum of lines 30 and 31	_		18. 17			32. 00
33. 00	Allowable disproportionate share percentage ((see		4. 56			33. 00
24 00	instructions)	ictions)		72 904			24 00
34. 00	Disproportionate share adjustment (see instru	actions)		72, 804 Pri or to		On/After	34. 00
				October 1		October 1	
			0	1.00	1. 01	2. 00	
	Uncompensated Care Adjustment						
35.00	Total uncompensated care amount (see			9, 046, 380, 143		7, 647, 644, 885	35. 00
	instructions)						
35. 01	Factor 3 (see instructions)			0. 000072798		0. 000071950	
35. 02	Hospital uncompensated care payment (If			658, 558		550, 234	35. 02
	line 34 is zero, enter zero on this line)						
25 02	(see instructions)			204 112		227, 631	25 02
35. 03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			386, 113		227, 031	35. 03
36. 00	Total uncompensated care (sum of columns 1			613, 744			36. 00
30. 00	and 2 on line 35.03)			013, 744			30. 00
	Additional payment for high percentage of ESR	D beneficiary	discharges (li	nes 40 through	46)		
40.00	Total Medicare discharges on Worksheet S-3,		<i>y</i> ,	0	,		40. 00
	Part I excluding discharges for MS-DRGs 652,						
	682, 683, 684 and 685 (see instructions)						
41. 00	Total ESRD Medicare discharges excluding			0	0		41. 00
	MS-DRGs 652, 682, 683, 684 an 685. (see						
41 01	instructions)				0		41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683,			0	0		41. 01
	684 an 685. (see instructions)						
42. 00	Divide line 41 by line 40 (if less than 10%,			0.00			42. 00
12.00	you do not qualify for adjustment)			0.00			12.00
43. 00	Total Medicare ESRD inpatient days excluding			0			43. 00
	MS-DRGs 652, 682, 683, 684 an 685. (see						
	instructions)						
44. 00	Ratio of average length of stay to one week			0. 000000			44. 00
	(line 43 divided by line 41 divided by 7						
45.00	days)			0.00	0.00		45 00
45. 00	Average weekly cost for dialysis treatments (see instructions)			0.00	0.00		45. 00
46. 00	Total additional payment (line 45 times line						46. 00
40.00	44 times line 41.01)						40.00
47.00	Subtotal (see instructions)			7, 105, 858			47. 00
48. 00	Hospital specific payments (to be completed			0			48. 00
	by SCH and MDH, small rural hospitals						
	only. (see instructions)						
49. 00	Total payment for inpatient operating costs			7, 105, 858			49. 00
	(see instructions)			540.05/			
50. 00	Payment for inpatient program capital (from			513, 356			50. 00
51. 00	Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program			0			51. 00
51.00	capital (Wkst. L, Pt. III, see instructions)						51.00
52. 00	Direct graduate medical education payment			0			52. 00
02.00	(from Wkst. E-4, line 49 see instructions).						02.00
53.00	Nursing and Allied Health Managed Care			0			53.00
	payment						
54.00	Special add-on payments for new technologies			0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt.			0			55. 00
-,	III, col. 1, line 69)						E / 00
56. 00	Cost of physicians' services in a teaching			0			56. 00
57. 00	hospital (see intructions) Routine service other pass through costs						57. 00
57.00	(from Wkst. D, Pt. III, column 9, lines 30						57.00
	through 35).						
58. 00	Ancillary service other pass through costs			0			58. 00
	from Wkst. D, Pt. IV, col. 11 line 200)						
59. 00	Total (sum of amounts on lines 49 through			7, 619, 214			59. 00
	58)						
60.00	Primary payer payments			3, 784			60.00
61. 00	Total amount payable for program			7, 615, 430			61. 00
42.00	beneficiaries (line 59 minus line 60)			1 000 000			42.00
0∠. 00	Deductibles billed to program beneficiaries			1, 003, 088			62. 00

nearth Financial Systems	KUSCI USKU CUIVIIVIUIVI I I I	HUSPI IAL	III LI EL	u 01 F01111 CW3-2332-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Peri od:	Worksheet E
				Part A
			To 02/28/2015	Date/Time Prepared:
				7/30/2015 3:14 pm

						7/30/2015 3:1	4 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
		0		October 1	1 01	October 1	
63. 00	Coinsurance billed to program beneficiaries	0		1. 00 9, 120	1. 01	2. 00	63. 00
64. 00	Allowable bad debts (see instructions)			-63, 174			64. 00
65. 00	Adjusted reimbursable bad debts (see			-41, 063			65. 00
03.00	instructions)			-41,003			05.00
66. 00	Allowable bad debts for dual eligible			-84, 844		•	66. 00
00.00	beneficiaries (see instructions)			01,011			00.00
67.00	Subtotal (line 61 plus line 65 minus lines			6, 562, 159			67.00
	62 and 63)			., ,			
68.00	Credits received from manufacturers for			0			68. 00
	replaced devices for applicable to MS-DRGs						
	(see instructions)						
69. 00	Outlier payments reconciliation (sum of			0			69. 00
	lines 93, 95 and 96). (For SCH see						
70.00	instructions)						70.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70. 50	(SPECIFY)			_			70. 50
70. 30	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment			0			70. 30
70.09	amount (see instructions)			U			70.09
70. 90	HSP bonus payment HVBP adjustment amount			0			70. 90
70. 70	(see instructions)						70.70
70. 91	HSP bonus payment HRR adjustment amount (see			0			70. 91
	instructions)						
70. 92	Bundled Model 1 discount amount (see			0			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			9, 168			70. 93
	instructions)						
70. 94	HRR adjustment amount (see instructions)			-48, 958			70. 94
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
70. 97	prior to 10/1) Low volume adjustment for federal fiscal		0	_			70. 97
10. 71	year (yyyy) (Enter in column 0 the		O				10. 77
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
70. 99	HAC adjustment amount (see instructions)			0			70. 99
71.00	Amount due provider (line 67 minus lines 68			6, 522, 369			71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			130, 447			71. 01
72.00	Interim payments			6, 450, 528			72. 00
73. 00	Tentative settlement (for contractor use			0			73. 00
7	only)			-a .a.			
74. 00	Balance due provider (Program) (line 71			-58, 606			74. 00
75 00	minus lines 71.01, 72, and 73)			1 244 012			75. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			1, 366, 012			/5.00
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 through	igh 96)					1
90.00	Operating outlier amount from Wkst. E, Pt.	.g /		0			90.00
	A, line 2 (see instructions)						
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0			91.00
92.00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
93. 00	Capital outlier reconciliation adjustment			0			93. 00
04.00	amount (see instructions)						04.00
94. 00	The rate used to calculate the time value of			0.00			94. 00
95. 00	money (see instructions) Time value of money for operating expenses			0			95. 00
70. UU	(see instructions)						95.00
96. 00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						
	1 1 2 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		'	•	•	•	

Health Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL		In Li	eu of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150133	Peri od: From 03/01/201	Worksheet E 1 Part A	
				To 02/28/201	Date/Time Pre 7/30/2015 3:1	
		Ti tl	e XVIII	Hospi tal	PPS	
			Prior to 10/	1	On/After 10/1	
			1.00	1. 01	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100. 00
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions)				0	0	101. 00
102.00 HVBP adjustment amount for HSP bonus paymen	t (see instructions)			0	0	102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)			0.00	00	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment	(see instructions)			0	0	104.00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15013	From 03/01/2014	Worksheet E Part B Date/Time Prepared: 7/30/2015 3:14 pm
	T. 11 . 2011 1	11 * 1	DDC

			10 02/28/2015	7/30/2015 3:1	
		Title XVIII	Hospi tal	PPS	т рііі
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4, 534	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		6, 191, 407	2.00
3.00	PPS payments			5, 962, 870	3.00
4.00	Outlier payment (see instructions)			10, 933	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruct	irons)		0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		0	9.00
10. 00	Organ acquisitions	7, 601. 13, 11116 200		Ö	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 534	1
	COMPUTATION OF LESSER OF COST OR CHARGES			1,001	
	Reasonable charges				İ
12. 00	Ancillary service charges			58, 021	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	ol. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	•		58, 021	14.00
	Customary charges				1
15. 00	Aggregate amount actually collected from patients liable for pa	nyment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	•
18. 00	Total customary charges (see instructions)		44) (58, 021	•
19. 00	Excess of customary charges over reasonable cost (complete only	/ If line 18 exceeds li	ne 11) (see	53, 487	19. 00
20.00	instructions)	, if line 11 evenede li	no 10) (coo		20.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	/ IT TIME IT exceeds IT	ne 18) (See	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		4, 534	21. 00
22. 00	Interns and residents (see instructions)	Thistractions)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1011 0113)		5, 973, 803	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			271127222	
25.00	Deductibles and coinsurance (for CAH, see instructions)			360	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		1, 305, 311	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23) (for	4, 672, 666	27. 00
	CAH, see instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			4, 672, 666	•
31. 00	Primary payer payments			503	ı
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	·c)		4, 672, 163	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	.3)		0	33.00
34. 00	Allowable bad debts (see instructions)			30, 917	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			20, 096	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)		17, 656	
37. 00				4, 692, 259	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		ŕ	0	39. 99
40.00	Subtotal (see instructions)			4, 692, 259	40.00
40. 01	Sequestration adjustment (see instructions)			93, 845	40. 01
41.00	Interim payments			4, 714, 880	41.00
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			-116, 466	43. 00
44.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93. 00 94. 00
74. UU	Total (sum of lines 91 and 93)			, 0	74.00

Health Financial Systems KOSCIU
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150133 | Period: | Worksheet E-1 | Part I | Date/Time Prepared: | 7/30/2015 | 3:14 pm

					7/30/2015 3: 12	1 pm
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		6, 368, 191		4, 577, 206	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	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	02/28/2015	35, 437	02/28/2015	88, 374	3. 01
3.02		02/28/2015	46, 900	02/28/2015	49, 300	3. 02
3.03			C)	0	3. 03
3.04			C)	0	3. 04
3.05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3.53			O		0	3. 53
3. 54	Cultural (Linna 2 01 2 40 Linna		00 227		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		82, 337		137, 674	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		6, 450, 528		4, 714, 880	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 430, 320		4, 714, 000	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			•		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5. 03	Dravi dan ta Dragnam		C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			(1 0	5. 50
5. 50	TENTATI VE TO PROGRAM					5. 50
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ď			5. 99
2	5. 50-5. 98)]			J. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6.02	SETTLEMENT TO PROGRAM		58, 606		116, 466	6. 02
7. 00	Total Medicare program liability (see instructions)		6, 391, 922		4, 598, 414	7. 00
				Contractor	NPR Date	
		,	`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
6.00	Name of Contractor	I		I	1	0.00

111-4-	Fire and all Contains	/ HOCDLTAI	1-1:-	6 F CMC /	NEE 2 4 0
	Financial Systems KOSCIUSKO COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150133	Peri od:	u of Form CMS-2 Worksheet E-1	2552-10
CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT FOR HIT	Trovider con. 130133	From 03/01/2014		
			To 02/28/2015		
		T' 11 \0/4.11		7/30/2015 3: 14	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	3, 486	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		4, 113	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 237	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		10, 742	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			462, 338, 280	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		1, 192, 602	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Wkst. S-2, Pt. I	ol	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			731, 214	8. 00
9.00	Sequestration adjustment amount (see instructions)			14, 624	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		716, 590	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			701, 685	30.00
31.00	Other Adjustment (specify)			0	31. 00
22 00	Polones due provider (line 0 (en line 10) minus line 20 and li	no 21) (coo i notruoti on	->	14 005	22 00

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

701, 685 30. 00 0 31. 00 14, 905 32. 00

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

Provider CCN: 150133 | Period: | From 03/01/201

Period: Worksheet G From 03/01/2014 To 02/28/2015 Date/Time Prepared: 7/30/2015 3:14 pm

				02, 20, 2010	7/30/2015 3: 1	4 pm
		General Fund		Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT AGGETS	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	F04 700	1 0	٥		1 00
1.00	Cash on hand in banks	-504, 782		0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	24 510 010	0	0	0	3.00
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	34, 518, 918	0	0	0	4. 00 5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-14, 788, 036	0	0	0	6. 00
7. 00	Inventory	1, 769, 358		0	0	7. 00
8.00	Prepai d expenses	897, 701		0	0	8. 00
9.00	Other current assets	227, 400		0	0	9. 00
10.00	Due from other funds	227, 400		0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	22, 120, 559		-	0	11. 00
11.00	FIXED ASSETS	22, 120, 337	0	<u> </u>	0	11.00
12. 00	Land	2, 769, 169	0	0	0	12. 00
13. 00	Land improvements	1, 122, 286		0	0	13. 00
14. 00	Accumulated depreciation	-587, 580		0	0	14. 00
15. 00	Bui I di ngs	35, 723, 757		0	0	15. 00
16. 00	Accumulated depreciation	-7, 675, 200		0	0	16. 00
17. 00	Leasehold improvements	13, 778, 748		0	0	17. 00
18. 00	Accumul ated depreciation	-3, 365, 389		0	0	18. 00
19. 00	Fi xed equipment	2, 297, 670		0	0	19. 00
20. 00	Accumulated depreciation	-1, 153, 899		0	0	20. 00
21. 00	Automobiles and trucks	110, 970		0	0	21. 00
22.00	Accumulated depreciation	-84, 124		0	0	22. 00
23.00	Major movable equipment	17, 874, 847	0	0	0	23. 00
24.00	Accumul ated depreciation	-12, 874, 677	0	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	5, 198, 691	0	0	0	25. 00
26.00	Accumul ated depreciation	-3, 271, 963	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28.00	Accumul ated depreciation	0	0	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	49, 863, 306	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	2, 054, 387		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	2, 054, 387		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	74, 038, 252	0	0	0	36. 00
	CURRENT LI ABI LI TI ES		-			
37. 00	Accounts payable	2, 103, 737			0	37. 00
38. 00	Salaries, wages, and fees payable	3, 084, 526		0	0	38. 00
39. 00	Payroll taxes payable	197, 375	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0			0	42.00
43.00	Due to other funds	-254, 095, 511		0	0	43. 00
44. 00	Other current liabilities	1, 524, 624		-	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	-247, 185, 249	0	0	U	45. 00
44 00	LONG TERM LIABILITIES	0		0	0	46. 00
46. 00 47. 00	Mortgage payable Notes payable		1	0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	47.00
49. 00	Other long term liabilities	2, 146, 497		0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	2, 146, 497		0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	-245, 038, 752			0	51. 00
31.00	CAPITAL ACCOUNTS	-243, 030, 732	0	٥	0	31.00
52. 00	General fund balance	319, 077, 004				52. 00
53. 00	Specific purpose fund	317,077,004	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			n		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			n		56. 00
57. 00	Plant fund balance - invested in plant			Ĭ	0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion				Ü	.
59. 00	Total fund balances (sum of lines 52 thru 58)	319, 077, 004	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	74, 038, 252		o	0	60. 00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 150133

					10 02/28/201	7/30/2015 3:1	
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		271, 306, 253			0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		47, 770, 751				2. 00
3.00	Total (sum of line 1 and line 2)		319, 077, 004			0	3. 00
4.00	Additions (credit adjustments) (specify)	0			O	0	
5. 00		0		1	O	0	
6.00		0			0	0	
7.00		0				0	
8.00		0				0	
9.00	Total additions (our of line 4.0)	U	0	'	J	0	
10.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		210 077 004				10.00
11. 00 12. 00	Deductions (debit adjustments) (specify)	0	319, 077, 004		o	0	
12.00	beductions (debit adjustments) (specify)				0	0	
14. 00		0)	0	
15. 00)	0	
16. 00					5	0	
17. 00						0	
18. 00	Total deductions (sum of lines 12-17)		0	,		n o	18.00
19. 00	Fund balance at end of period per balance		319, 077, 004				19. 00
17.00	sheet (line 11 minus line 18)		0.7,077,001				.,,
		Endowment Fund	PI ant	Fund			
		6, 00	7. 00	8. 00	_		
1.00	Fund balances at beginning of period	0.00	7.00		2		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)			,			2. 00
3.00	Total (sum of line 1 and line 2)				n		3. 00
4. 00	Additions (credit adjustments) (specify)		0	,			4. 00
5. 00	(Specify)		0				5. 00
6. 00			0				6.00
7. 00			o				7. 00
8.00			o				8.00
9.00			o				9. 00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			O		11. 00
12.00	Deductions (debit adjustments) (specify)		o				12.00
13.00			0				13.00
14.00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			O		18. 00
19. 00	Fund balance at end of period per balance	0		(0		19. 00
	sheet (line 11 minus line 18)	1					
	Isheet (Title II milius IIIIe 10)						

Health Financial Systems KO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			10 02/28/2015	7/30/2015 3:1	
	Cost Center Description	I npati ent	Outpati ent	Total	T PIII
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	19, 809, 88	4	19, 809, 884	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		o	0	5. 00
6.00	Swing bed - NF		o	0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY		o	0	8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	19, 809, 88	4	19, 809, 884	
	Intensive Care Type Inpatient Hospital Services	, , , , , , , , , , , , , , , , , , , ,		,	
11. 00	INTENSIVE CARE UNIT	2, 759, 99	1	2, 759, 991	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 759, 99	1	2, 759, 991	
	11-15)	_,,		_, ,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	22, 569, 87	5	22, 569, 875	17. 00
18. 00	Ancillary services	112, 048, 33		112, 048, 332	
19. 00	Outpati ent servi ces		0 327, 720, 073	327, 720, 073	
20. 00	RURAL HEALTH CLINIC		0 0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	1
22. 00	HOME HEALTH AGENCY			Ŭ	22. 00
23. 00	AMBULANCE SERVICES		0	0	1
24. 00	CMHC			Ŭ	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0	0	1
27. 00	OTHER (SPECIFY)		0	Ö	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	134, 618, 20	7 327, 720, 073	-	ł
	G-3, line 1)	,,		,,	
	PART II - OPERATING EXPENSES		<u>'</u>		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89, 875, 124		29. 00
30.00	ADD (SPECIFY)		o		30. 00
31.00			o		31.00
32.00			o		32. 00
33.00			o		33.00
34.00			o		34.00
35.00			o		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		o		37. 00
38.00			o		38. 00
39.00			o		39. 00
40.00			o		40.00
41.00			o		41.00
42. 00	Total deductions (sum of lines 37-41)	1	0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	89, 875, 124		43.00
	to Wkst. G-3, line 4)				
		•	•		-

	e Prepare 5 3:14 pr 8,280 1	om
To 02/28/2015 Date/Tir	5 3: 14 pr 8, 280 1	om
	8, 280 1	
	8, 280 1	
1.00		
		1. 00
2.00 Less contractual allowances and discounts on patients' accounts 326, 21		2. 00
3.00 Net patient revenues (line 1 minus line 2) 136,12		3. 00
		4. 00
	8, 067 5	5. 00
OTHER I NCOME		
6.00 Contributions, donations, bequests, etc	•	6. 00
7.00 Income from investments		7. 00
8.00 Revenues from telephone and other miscellaneous communication services	•	8. 00
9.00 Revenue from television and radio service	•	9. 00
10. 00 Purchase di scounts		0. 00
11.00 Rebates and refunds of expenses		1. 00
12.00 Parking lot receipts	- 1	2. 00
13.00 Revenue from Laundry and Linen service	0 13	
14.00 Revenue from meals sold to employees and guests	0 14	
15.00 Revenue from rental of living quarters	0 15	
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16	
17.00 Revenue from sale of drugs to other than patients	0 17	
18.00 Revenue from sale of medical records and abstracts	0 18	
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19	
20.00 Revenue from gifts, flowers, coffee shops, and canteen		0. 00
21.00 Rental of vending machines	- 1	1. 00
22.00 Rental of hospital space		2. 00
23.00 Governmental appropriations	0 23	3. 00
	2, 684 24	4. 00
	2, 684 25	5. 00
		6. 00
27. 00 OTHER EXPENSES (SPECIFY)	-	7. 00
28.00 Total other expenses (sum of line 27 and subscripts)		8. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	0, 751 29	€. 00

	Financial Systems KOSCIUSKO COMMUNI ATION OF CAPITAL PAYMENT	Provi der CCN: 150133	Peri od:	Worksheet L	2552-1
CALCUI	ATTON OF CAPITAL PAINLINE	Frovider CCN. 130133	From 03/01/2014 To 02/28/2015	Parts I-III Date/Time Prep 7/30/2015 3:14	
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			506, 268	1. 0
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 0
2. 00	Capital DRG outlier payments			7, 088	2. 0
2. 01	Model 4 BPCI Capital DRG outlier payments				2. 0
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructi ons)	29. 43	3. 0
4. 00	Number of interns & residents (see instructions)			0. 00	4.00
5. 00	Indirect medical education percentage (see instructions)			0. 00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by the			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	atient days (Worksheet E	, part A line	0. 00	7. 0
8. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		0.00	8. 00
9. 00	Sum of lines 7 and 8	cti ons)		0.00	9. 00
10. 00	Allowable disproportionate share percentage (see instructions)			10. 00
11. 00	Disproportionate share adjustment (line 10 times the sum of I			0	11. 00
12. 00	1 ' '			513, 356	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
	Capital cost payment factor (see instructions)			0	
	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	4. 00 5. 00
1.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			1.00	1. 00
1.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	es (see instructions)		1.00	1. 00 2. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		1.00	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 1.00 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	structions)	Line (1)	0 1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions)	line 6)	0 1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x	line 6)	0 1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	structions) circumstances (line 2 x	,	0 1.00 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x cable) apital payments (line 8	less line 9)	0 1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri	less line 9) or year	0 1.00 0 0 0.00 0.00 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin	less line 9) or year e 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level to capital payments on of capital minimum payment level to capital payment l	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 1.00 0 0 0.00 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment le	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital pacurrent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparis	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 1.00 0 0 0.00 0.00 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital pacurrent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparis	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 1.00 0 0 0.00 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00