Health Financial Systems	KOSCI USKO COMMUNI TY HOSPI TAL	In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g;		
payments made since the beginning of the cost		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COS	ST REPORT CERTIFICATION Provider CCN: 1	50133 Period: Worksheet S From 03/01/2015 Parts I-III
AND SETTLEMENT SUMMARY		To 02/29/2016 Date/Time Prepared:
		7/29/2016 9:00 am
PART I - COST REPORT STATUS		
Provider 1. [X] Electronically filed co		Date: 7/29/2016 Time: 9:00 am
use only 2. [] Manually submitted cos	report report enter the number of times the prov	ider resubmitted this cost report
4. [F] Medicare Utilization.	Enter "F" for full or "L" for low.	
	. Date Received:	10. NPR Date:
use only (1) As Submitted 7 (2) Settled without Audit 8	. Contractor No.	11. Contractor's Vendor Code: 4 CN 12. [ 0 ]If line 5, column 1 is 4: Enter
(2) Settled with Audit 9 (3) Settled with Audit 9	[ N ] Final Report for this Provider CCN	number of times reopened = 0-9.
(4) Reopened		
(5) Amended		
PART II - CERTIFICATION		
MISREPRESENTATION OF FALSIFICATION OF ANY INF	ORMATION CONTAINED IN THIS COST REPORT M	AY BE PUNISHABLE BY CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONME		
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRE		OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISON	MENT MAY RESULT.	
CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDER(S)	
I HERERY CERTLEY that I have read the	e above certification statement and that	L have examined the accompanying
	mitted cost report and the Balance Sheet	
	NITY HOSPITAL ( 150133 ) for the cost rep	
	t of my knowledge and belief, this report	
	and records of the provider in accordance	
	that I am familiar with the laws and regu	
laws and regulations.	ervices identified in this cost report we	re provided in compliance with such
raws and regulations.		
	(Si gned)	
		Administrator of Provider(s)
	Ti tl e	
	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	65, 513	77, 337	16, 083	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	65, 513	77, 337	16, 083	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.

11	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	A	Provi de	er CCN:	150133	Period: From 03/0	1/2015	Workshe Part I	et S-2	
								9/2015	Date/Ti		
	1.00	2.00	0	3.	00			4.00	7/27/20	16 2:0	pr 
	Hospital and Hospital Health Care Co										
	Street: 2101 EAST DUBOIS DRIVE City: WARSAW	PO Box: State: IN	7:	p Code:	14590	Cours		ΥO			1
,	City: WARSAW	Component Name			CBSA	Provi der	ty: KOSCIUS Date		ent Syst	em (P,	2
					lumber	Туре	Certifie	r k	r, 0, or		
		1.00			2 00	1.00	F 00	V	XVIII	XIX	-
_	Hospital and Hospital-Based Componen	<u>1.00</u> t Identification <sup>.</sup>	2	. 00	3.00	4.00	5.00	6.00	0 7.00	8.00	
	Hospi tal	KOSCIUSKO COMMUNIT	Y 15	0133	99915	1	07/01/196	6 0	Р	Р	3
)	Subprovider - IPF	HOSPI TAL									4.
	Subprovider - IRF										5.
	Subprovider - (Other)										6.
	Swing Beds - SNF										7.
	Swing Beds - NF Hospital-Based SNF										8.
00	Hospital-Based NF										10.
00	Hospi tal -Based OLTC Hospi tal -Based HHA										11.
	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14.
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.
	Hospital-Based (CMHC) I										17.
00	Renal Dialysis										18.
00	Other						Fro		То		19.
							1. (		2.0		1
	Cost Reporting Period (mm/dd/yyyy)						03/01/		02/29/	/2016	20.
00	Type of Control (see instructions) Inpatient PPS Information						4				21.
00	Does this facility qualify and is it	currently receivin	ng paymen	ts for d	i spropo	rtionate	Y		N		22.
	share hospital adjustment, in accorda	ance with 42 CFR §4	412.106?	In colu	mn 1, e	enter "Y"					
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, en <sup>.</sup>				106(c)(	2) (Pi ckl	e				
	Did this hospital receive interim un				cost re	porting	N		Y		22.
	period? Enter in column 1, "Y" for ye										
	reporting period occurring prior to ( for no for the portion of the cost re										
	(see instructions)										
	Is this a newly merged hospital that determined at cost report settlement?						N		N		22.
	or "N" for no, for the portion of the						.5				
	in column 2, "Y" for yes or "N" for i	no, for the portion	n of the o	cost rep	orting	period o	n				
	or after October 1. Did this hospital receive a geographi	c reclassification	n from ur	han to r	ural as	a resul	t N		N		22.
	of the OMB standards for delineating										22.
	in column 1, "Y" for yes or "N" for r						_				
	prior to October 1. Enter in column 2 cost reporting period occurring on o						e				
	hospital contain at least 100 but no	t more than 499 bed	ds (as cou		·		h				
	42 CFR 412.105)? Enter in column 3, ' Which method is used to determine Med			/or 25 h				3	N		23.
	1, enter 1 if date of admission, 2 if							5			25.
	method of identifying the days in thi										
	used in the prior cost reporting peri		n-State	In-Stat		ut-of	Out-of	Medi ca	aid 0	ther	
		N	Medi cai d	Medi cai	d S	tate	State	HMO da	ays   Med	li cai d	
		þ	aid days	eligibl unpaio			Medicaid   eligible		C	lays	
				days		adys	unpai d				
			1.00	2.00		3. 00	4.00	5.00		. 00	
	If this provider is an IPPS hospital, in-state Medicaid paid days in colum		292		368	0	5	1,	492	64	24.
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co	olumn 3,									
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
00	If this provider is an IRF, enter the	e in-state	0		0	О	0		0		25.
	Medicaid paid days in column 1, the i Medicaid eligible unpaid days in colu										
	out-of-state Medicaid days in column										
	out-of-state medical days in corullin										
	Medicaid eligible unpaid days in column HMO paid and eligible but unpaid days	umn 4, Medicaid									

	Financial Systems KOSCIUSKO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		NETY HOSPITAL Provider (		Period:		u of For Workshe		
					rom 03/01/ To 02/29/				
					Urban/Rur	al S	7/27/20 Date of		
6. 00	Enter your standard geographic classification (not wa	ne) sta	atus at the her	inning of the	1.00	2	2.0	00	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural ge) sta "2" fo	atus at the end or rural. If ap	of the cost		2			27.0
5.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. C
					Begi nni 1. 00		Endi 2. (		-
5.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line :	36 for number			2.0	10	36.0
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37.0
. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37. (
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/N 1.00		Y/ 2. (		-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	)? Ente uiremer	er in column 1 nts in accordan	"Y" for yes ce with 42			2. C N		39. (
). 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40. (
	······································	(555)			-1	V	XVIII	XIX	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for a	di sproporti onat	e share in ac	cordance	1. OC	0 2.00 N	3.00 N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. ( 48. (
. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"				57.
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer complet	nt for physicia te Wkst. D-5.		as	N			58.
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59. 60.
	provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	s or "N" for no IME	. (see instru Direct GME	ctions) IME		Direct	GME	
00		1.00	2.00	3.00	4.00		5. (		
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.0
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0. C	o				61.
. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0. C	o				61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0. C	o				61.
. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0. C	o				61.
	current cost reporting period.(see instructions). Enter the difference between the baseline primary		0.00	0. C	o				61.

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provider (		eriod: com 03/01/2015 o 02/29/2016	Worksheet S-2 Part I Date/Time Pre 7/27/2016 2:0	pared
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
I. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00				61. (
			Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
I. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61.
I. 20	5	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0. 00	61.
	· · ·			·			1.00	
	ACA Provisions Affecting the Hea							
2.00	Enter the number of FTE resident your hospital received HRSA PCRE			d in this cost	reporting peri	od for which	0.00	62.
2. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC proc	n Teachi gram. (s	see instruction		your hospital	0.00	62.
3. 00		nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				-	1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea period that begins on or after J				his base year	is your cost r	reporting	
1. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	y train apriman all non non-pn column	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pr	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	1.5
5. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.00	0.00	0. 000000	05.1

	Financial Systems		COMMUNITY H				n Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	.TA F	Provi der		Period: From 03/01/ To 02/29/		Workshe Part I Date/Ti 7/27/20	me Pre	
					Unweighted FTEs Nonprovider Site		n al	Ratio (c (col. 1 2))	+ col.)	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovider	Setting	1.00 sEffective	2.00 for cost re		<u>3.0</u> ng perio		
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	10 unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	ry care resid rovider setti ry care resid 3 the ratio o	ent ngs. ent	0. (		0.00	<u> </u>		66.00
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 3 4))	+ col.	
67.00	Entor in column 1 the program	1.00	2.00		3.00	4.00	0.00	5.0		67.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. (		0.00	0.		67.00
							1.00	) 2.00	3.00	
	Inpatient Psychiatric Facility P						1 1.00	, 2.00	5.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does	it cont	ain an IPF su	bprovi der?	N			70.00
71.00	If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	D04? Enter " lity train r (D)? Enter "	Y" for y esidents Y" for y	es or "N" for in a new tea es or "N" for	no. (see chi ng no.			0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	/(IRF), or d	oes it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 200 new teaching for no. Colu	4? Enter program mn 3: lf	"Y" for yes in accordance column 2 is	or "N" for e with 42 Y,			0	76.00
								1.0	0	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.					g period? E	nter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excl uded uni				no.	N		85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			1886(d)	(1)(B)(iv)(II	)? Enter "Y		N		87.00
	Tor yes or in ror no.					V		XIX		
	Title V and XIX Services					1.00		2.0	0	
90.00	Does this facility have title V		hospital ser	vi ces? E	nter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th				N		N		91.00
92, 00	full or in part? Enter "Y" for y Are title XIX NF patients occupy							N		92.00
	instructions) Enter "Y" for yes	or"N" for no in the	applicable c	olumn.	, , ,	N		N		93.00
	Does this facility operate an IC "Y" for yes or "N" for no in the	applicable column.								
94.00	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and "	N" for n	o in the	N		N		94.00

Health Financial Systems KOSCIUSKO COMMUNIT	Y HOSPI TAL		I	n Lieu	u of Form	n CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150133	Period: From 03/01/ To 02/29/		Workshe Part I Date/Ti	me Pre	epared:
			V		7/27/20 XI X		)6 pm
			1.00		2.0		
<ul> <li>95.00 If line 94 is "Y", enter the reduction percentage in the appli</li> <li>96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes o applicable column.</li> </ul>			0. 00 N		0. 0 N	0	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appli Rural Providers		٦.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH) 106.00 If this facility qualifies as a CAH, has it elected the all-in for outpatient services? (see instructions)		nod of paymen	t N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II.	. (see instr 5 and the pr	ructions) lf rogram is cos					107.00
108.00 Is this a rural hospital qualifying for an exception to the CR CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respira 4.0		-
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
					1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for		on project (4	10A Demo)fo	r	N		110.00
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers)	f column 2 i for long ter	s "E", enter rm care (incl	in column udes	N		0	115. 00
Pub.15-1, chapter 22, §2208.1. 116.00   s this facility classified as a referral center? Enter "Y" fo 117.00   s this facility legally-required to carry malpractice insuran			"N" for	Y N			116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	sy? Enter 1 i	f the policy	is	1			118.00
		Premiums	Losse	s	Insura	ance	
		1.00	2.00		3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:		30, 8		3, 263	3.0		0 118. 01
			1.00		2.0	0	-
118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.			N		2.0	0	118.02
119.00 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y' ifies for th	' for yes or ne Outpatient			Ν		119.00 120.00
121.00 Did this facility incur and report costs for high cost implant	able devices	s charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00Does the cost report contain state health or similar taxes? En			Ν				122.00
for no in column 1. If column 1 is "Y", enter in column 2 the	WUI KSHEEL A	TTHE Humber					
for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information							125 00
for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.	yes and "N"	for no. If	N				125. 00 126. 00
for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	yes and "N" er the certin	for no. If fication date					
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter</li> </ul>	yes and "N" or the certin the certifi	for no. If fication date cation date					126.00
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	yes and "N" or the certif the certifi the certifi	for no. If fication date cation date cation date					126. 00 127. 00
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> </ul>	yes and "N" or the certifi the certifi the certifi the certific oter the certific	for no. If Fication date cation date cation date cation date i tification					126. 00 127. 00 128. 00 129. 00 130. 00
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter</li> </ul>	yes and "N" er the certifi the certifi the certifi the certific the certific the certific enter the certific enter the certific an 2.	for no. If fication date cation date cation date cation date i tification ertification					126. 00 127. 00 128. 00 129. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		HOSPITAL	CN. 1E0100	Peri od:		u of Form CMS- Worksheet S-:	
	DATA	Provider C	UN: 150133	From 03	3/01/2015	Part I	
				To 02	2/29/2016	Date/Time Pr 7/27/2016 2:	
					1.00	2.00	-
33.00  f this is a Medicare certified other transplant c	enter, enter	the certific	ation date		1.00	2.00	133.00
in column 1 and termination date, if applicable, i 34.00 If this is an organ procurement organization (OPO)		100 number in	column 1				134.00
and termination date, if applicable, in column 2. All Providers							-
40.00 Are there any related organization or home office chapter 10? Enter "Y" for yes or "N" for no in col				e .	Y	449008	140. 00
are claimed, enter in column 2 the home office cha	<u>ain number. (s</u>			5			
<u> </u>	2.00	s 141 through	h 142 tho	namo and	3.00	of the	
home office and enter the home office contractor n				name anu	auuress	or the	
1.00 Name: CHS/COMMUNITY HEALTH SYSTEMS, Contractor'	s Name: WPS		Contrac	tor's Nur	mber: 5228	0	141.00
12.00 Street: 4000 MERIDIAN BLVD PO Box:							142.00
I3.00 City: FRANKLIN State:	TN		Zip Cod	e:	3706	7	143.00
						1.00	-
44.00 Are provider based physicians' costs included in W	lorksheet A?					Y	144.00
					1.00	2.00	-
45.00  f costs for renal services are claimed on Wkst. A					N	2.00	145.00
inpatient services only? Enter "Y" for yes or "N" no, does the dialysis facility include Medicare ut							
period? Enter "Y" for yes or "N" for no in column	ı 2.		. 0				
16.00 Has the cost allocation methodology changed from t Enter "Y" for yes or "N" for no in column 1. (See "				f	N		146.00
yes, enter the approval date (mm/dd/yyyy) in colum		· ·					
						1.00	-
17.00Was there a change in the statistical basis? Enter						N	147.00
48.00 Was there a change in the order of allocation? Ent 49.00 Was there a change to the simplified cost finding (						N	148.00
49. OU was there a change to the simplified cost finding	method? Enter	Part A	Part B		tle V	Title XIX	149.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provider that qualifi or charges? Enter "Y" for yes or "N" for no for ea							
55.00Hospi tal		N	N		N	N	155. 00
56.00 Subprovi der – I PF		N	N		N	N	156.00
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER		N	Ν		N	N	157.00
59. 00 SNF		N	Ν		Ν	Ν	159.00
50.00HOME HEALTH AGENCY		N	Ν		Ν	Ν	160.00
61.00 CMHC			Ν		N	N	161.00
						1.00	-
Multicompus	at has one or	more campus	es in diff	erent CB	SAs?	N	165. 00
			00 III 4. II				
65.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no.		County		ip Code	CBSA	FTE/Campus	
65.00 Is this hospital part of a Multicampus hospital th	C	county 1.00		ip Code 3.00	CBSA 4.00	FTE/Campus 5.00	-
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 56.00 If line 165 is yes, for each	C		State Z			5.00	0 166. 00
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 56.00 If line 165 is yes, for each campus enter the name in column	C		State Z			5.00	0166.00
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 56.00 If line 165 is yes, for each	C		State Z			5.00	0 166. 00
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	C		State Z			5.00	0 166. 00
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	C		State Z			5.00	0 166. 00
55.00       Is this hospital part of a Multicampus hospital th         Enter "Y" for yes or "N" for no.       Name         0       0         56.00       If line 165 is yes, for each         campus enter the name in column       0         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)	C	1.00	State Z 2.00	3.00		5.00	0 166. 00
55.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in t	the American R	1.00 Recovery and	State Z 2.00 Rei nvestme	3.00		5.00 0.0	_
65.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in t 67.00 Is this provider a meaningful user under §1886(n)?	the American R Enter "Y" f	1.00 Recovery and for yes or "N	State     Z       2.00     2.00       Rei nvestme       " for no.	3.00 ent Act	4.00	5.00 0.0 1.00 Y	0 166. 00 166. 00 167. 00 0 168. 00
65.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in t 67.00 Is this provider a meaningful user under §1886(n)? 68.00 If this provider is a CAH (line 105 is "Y") and is reasonable cost incurred for the HIT assets (see i	the American R 2 Enter "Y" f 5 a meaningful nstructions)	1.00 Recovery and For yes or "N user (line	State     Z       2.00	3.00 ent Act ), enter	4.00	5.00 0.0 1.00 Y	167. 00 0168. 00
65.00 Is this hospital part of a Multicampus hospital th Enter "Y" for yes or "N" for no. Name 0 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in t 67.00 Is this provider a meaningful user under §1886(n)? 68.00 If this provider is a CAH (line 105 is "Y") and is	the American R Enter "Y" f a meaningful nstructions) user, does th	1.00 Recovery and for yes or "N user (line his provider	State     Z       2.00     2.00       Reinvestme       "for no.       167 is "Y"       qualify fc	3.00 ent Act ), enter r a hard	4.00	5.00 0.0 1.00 Y	167.00
55.00       Is this hospital part of a Multicampus hospital th         Enter "Y" for yes or "N" for no.       Name         0       0         66.00       If line 165 is yes, for each         campus enter the name in column       0         0, county in column 1, state in       0         column 2, zip code in column 3,       CBSA in column 4, FTE/Campus in         column 5 (see instructions)       Incentive in t         4       Heal th Information Technology (HIT) incentive in t         57.00       If this provider a meaningful user under §1886(n)?         88.00       If this provider is a CAH (line 105 is "Y") and is         reasonable cost incurred for the HIT assets (see is         58.01       If this provider is a CAH and is not a meaningful	the American R Enter "Y" for s a meaningful nstructions) user, does th yes or "N" for	1.00 Recovery and for yes or "N user (line his provider no. (see in	State     Z       2.00     2.00       Reinvestme       "for no.       167 is "Y"       qualify for       structions	3.00 ent Act ), enter r a hard )	4.00 the shi p	5.00 0.0 1.00 Y	167. 00 0168. 00

Health Financial Systems	KOSCI USKO COMMUNI TY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	IFICATION DATA	Provider CCN: 150133	Period: From 03/01/2015	Worksheet S-2 Part I	
			To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginnin period respectively (mm/dd/yyyy)	g date and ending date	for the reporting	10/01/2014	12/29/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provider ha Medicare cost plans reported on Wkst. S-3 (see instructions)				N	171.00

OSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150133		Date/Time Pro 7/27/2016 2:0	epared:
				Y/N	Date	
_	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	1.00 er all dates in t	2.00	
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	begi ppi pg_of	the cost	N		1.00
. 00	reporting period? If yes, enter the date of the change in co					1.0
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	N			4.00
	those on the filed financial statements? If yes, submit rec					0.0
	Approved Educational Activities			Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	5 N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved a		during the	N N		7.0 8.0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		cal education	Ν		9.0
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		he current	N		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (N	11.0
					Y/N 1.00	-
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pr period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? If	fyes, see ins	structions.	Ν	14.0
5.00	Did total beds available change from the prior cost reportin	<u> </u>	yes, see inst t A		N t B	15.0
		Y/N	Date	Y/N	Date	
	DS*D Data	1.00	2.00	3.00	4.00	
6. 00	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	Y	06/27/2016	Y	06/27/2016	16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19. 0

ISPITAL AND HOSPIT	STEMS KOSCI USKO COMML AL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE	JNI TY HOSPI TAL Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	u of Form CMS Worksheet S- Part II Date/Time Pr 7/27/2016 2:	2 epare
		Descri	iption	Y/N	Y/N	
		(	0	1.00	3.00	
	r 17 is yes, were adjustments made to PS&R			N	N	20
Report data	for Other? Describe the other adjustments:	N/ (9)		N/ (1)		_
		Y/N	Date	Y/N	Date	
00 Wee the east	report prepared only using the provider's	1.00	2.00	3.00	4.00	01
	yes, see instructions.	N		N		21
			4			
					1.00	
COMPLETED BY	COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
Capital Rela	ted Cost					
.00 Have assets	been relifed for Medicare purposes? If yes, see	e instructions			N	22
	occurred in the Medicare depreciation expense	due to apprais	als made dur	ring the cost	N	23
	riod? If yes, see instructions.					
	ses and/or amendments to existing leases entere	ed into during	this cost re	eporting period?	N	24
	instructions een new capitalized leases entered into during	the cost roper	ting poriod	2 If yes soo	Ν	25
instructions		the cost repor	ting periods	i i yes, see	IN	25
	subject to Sec.2314 of DEFRA acquired during th	he cost reporti	ng period?	f ves, see	Ν	26
i nstructi ons			3 F 100. 1	J==, 200		-`
.00 Has the prov	ider's capitalization policy changed during the	e cost reportin	g period? If	fyes, submit	Ν	27
copy.						
Interest Exp						
	ns, mortgage agreements or letters of credit er	ntered into dur	ing the cost	t reporting	N	28
	es, see instructions.					
	ider have a funded depreciation account and/or		DT Service H	Reserve Fund)	N	29
	funded depreciation account? If yes, see instr debt been replaced prior to its scheduled matu		dobt2 If you	5 500	Ν	30
i nstructi ons		unity with new	debt: II yes	5, 500	IN	1.50
	n recalled before scheduled maturity without is	ssuance of new	debt? If ves	s, see	Ν	3
instructions	· · · · · · · · · · · · · · · · · · ·		J.	,		
Purchased Se	rvi ces					
	or new agreements occurred in patient care ser		d through co	ontractual	N	32
	with suppliers of services? If yes, see instru					
	s yes, were the requirements of Sec. 2135.2 app	plied pertainin	g to competi	tive bidding? If	Ν	33
no, see inst	ed Physi ci ans					
	furnished at the provider facility under an ar	rrangement with	nrovi der-h	ased physicians?	Y	34
	instructions.	i angement with	provider-be	used physicians:	I	5.
	s yes, were there new agreements or amended exi	isting agreemen	ts with the	provi der-based	Ν	35
	uring the cost reporting period? If yes, see in					
				Y/N	Date	
				1.00	2.00	
Home Office						
	fice costs claimed on the cost report?		h	Y		36
	s yes, has a home office cost statement been pr	repared by the	nume office's	? Y		3
00 If line 36 i	instructions. s yes , was the fiscal year end of the home of	fice different	from that of	F Y	12/31/2015	38
	? If yes, enter in column 2 the fiscal year end			I	12/ 51/ 2013	
	s yes, did the provider render services to othe			s, N		39
see instruct			,			
	${\bf s}$ yes, did the provider render services to the	home office?	lf yes, see	Ν		40
instructions						
			00	-	00	-
Cost Doport	Proparor Contact Information	1.	00	2.	00	-
	Preparer Contact Information rst name, last name and the title/position	MICHAEL		TEA		41
	cost report preparer in columns 1, 2, and 3,					4
respecti vel y						
	ployer/company name of the cost report	COMMUNITY HEAL	TH SYSTEM			42
preparer.		144452 400 4555			2 NET	43
00 Enter the te	lephone number and email address of the cost rer in columns 1 and 2, respectively.	(615) 628-6555		MI CHAEL_TEA@CH	5. NET	43

Heal th	Financial Systems	KOSCIUSKO COMMUN	NITY HOSF	TAL			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	QUESTI ONNAI RE	Pro	vider C	CN: 150133	Peri		Worksheet S-2	2
						To	03/01/2015 02/29/2016	Part II Date/Time Pre 7/27/2016 2:0	
		_		2.00	<u></u>				
				3.00	)				_
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the ti	tle/position D	DI RECTOR,	REVENU	JE MANAGEME	NT			41.00
	held by the cost report preparer in column								
	respectively.								
	Enter the employer/company name of the cos	t roport							42.00
	1 3 1 3	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addre	ess of the cost							43.00
	report preparer in columns 1 and 2, respec	cti vel y.							

	Financial Systems K TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	OSCIUSKO COMMU			CCN: 150133	Pe	eriod:	Worksheet S		2552-10
105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			11001 del	CCN. 150155		rom 03/01/2015	Part I	rep	
								I/P Days / O, Visits / Trip	/P	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		58	21, 2	28	0.00		0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider									2.00 3.00
4.00	HMO I RF Subprovi der									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			FO	21.2	20	0.00		0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			58	21, 2	28	0.00		0	7.00
8.00	INTENSIVE CARE UNIT	31.00		14	5, 1	24	0.00		0	8.00
9.00	CORONARY CARE UNI T									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, 3	52	0.00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE									23.00 24.00
		30.00								24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00								24.10
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			12					0	28.00
29.00	Ambulance 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									33.00

HOSPI 1	Financial Systems k TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der		Period: From 03/01/20 To 02/29/20		epared:
		I/P Days	/ O/P Visits	/ Trips	Full Tir	ne Equivalents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Inter & Resident		
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	3, 726	1, 290				1.00
2.00	HMO and other (see instructions)	2, 530	201				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3, 726	1, 290				7.00
8.00	INTENSIVE CARE UNIT	681	247	1, 55	8		8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		483	1, 01	1		13.00
14.00	Total (see instructions)	4, 407	2, 020	12, 43	6 0	458.97	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER – I PF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						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	458.97	27.00
28.00	Observation Bed Days		0	2, 61	1		28.00
29.00	Ambul ance Trips	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		0		32.00
32.01	Total ancillary labor & delivery room	-			0		32.01
	outpatient days (see instructions)						
22 00	LTCH non-covered days	0		1	1	1	33.00

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 2.	23 527	3, 703	1.0
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			7	15 0 0 0		2. 0 3. 0 4. 0 5. 0 6. 0 7. 0
8.00 9.00 10.00 11.00 12.00 13.00	I NTEŃSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						8. 0 9. 0 10. 0 11. 0 12. 0 13. 0
<ol> <li>4.00</li> <li>5.00</li> <li>6.00</li> <li>7.00</li> <li>8.00</li> <li>9.00</li> <li>20.00</li> <li>21.00</li> <li>22.00</li> </ol>	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	1, 2	23 527	3, 703	14. ( 15. ( 16. ( 17. ( 18. ( 19. ( 20. ( 21. ( 22. (
22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0. 00					23. 0 24. 0 24. 1 25. 0 26. 2 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0

SPI I	AL WAGE INDEX INFORMATION			Provi der	F	Period: From 03/01/2015 Fo 02/29/2016		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	22, 916, 090	0 0	22, 916, 090	954, 660. 00	24.00	1.0
~~	instructions)		,				0.00	
00	Non-physician anesthetist Part A		(	0	(	0.00	0.00	2.0
00	Non-physician anesthetist Part		(	o o		0. 00	0.00	3.0
00	B Dhuaiaian Dant A		,			0.00	0.00	1 1 0
00	Physician-Part A - Administrative		(			0.00	0.00	4.0
01	Physicians - Part A - Teaching		(	0 0	0			
00	Physician-Part B		(	0	(	0.00		
00 00	Non-physician-Part B Interns & residents (in an	21.00	(			0.00		
00	approved program)	21.00				0.00	0.00	/.0
01	Contracted interns and		(	0 0	(	0.00	0.00	7.0
	residents (in an approved programs)							
00	Home office personnel		(	o o	0	0.00	0.00	8.0
00	SNF	44.00	(	0 0	(	0.00		
. 00	Excluded area salaries (see instructions)		29, 735	5 141, 557	171, 292	2 7, 619. 00	22. 48	10.0
	OTHER WAGES & RELATED COSTS							
. 00	Contract Labor: Direct Patient		1, 348, 775	5 0	1, 348, 775	5 35, 949. 75	37. 52	11.0
. 00	Care Contract Labor: Top Level		(	0	0	0.00	0.00	12.0
. 00	management and other		(			0.00	0.00	12.0
	management and administrative							
. 00	services Contract Labor: Physician-Part		339, 616	5 0	339, 616	2, 502. 45	135. 71	12 0
. 00	A - Administrative		557,010		337,010	2, 302. 43	155.71	15.0
. 00	Home office salaries &		1, 519, 274	1 O	1, 519, 274	4 28, 151. 00	53.97	14.0
. 00	wage-related costs Home office: Physician Part A		(	0		0.00	0.00	15.0
. 00	- Administrative		· · · · · · · · · · · · · · · · · · ·			0.00	0.00	15.0
. 00	Home office and Contract		(	0 0	0	0.00	0.00	16.0
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
. 00	Wage-related costs (core) (see		4, 757, 149	9 0	4, 757, 149	9		17. C
00	instructions)		,					10.0
. 00	Wage-related costs (other) (see instructions)		(	0	(			18.0
. 00	Excluded areas		38, 36	0	38, 361	1		19.0
. 00	Non-physician anesthetist Part		(	0 0	(	ס		20.0
. 00	A Non-physician anesthetist Part		(	0	(	0		21.0
	В			-				
. 00	Physician Part A - Administrative		(	0	(	D		22.0
. 01	Physician Part A - Teaching		(	0 0	0	0		22.0
. 00	Physician Part B		(	0 0	0	D		23.0
. 00	Wage-related costs (RHC/FQHC)		(	0	(			24.0
. 00	Interns & residents (in an approved program)		(	0	(			25.0
	OVERHEAD COSTS - DIRECT SALARIE	S		1	1			
. 00	Employee Benefits Department	4.00	161, 75					
. 00 . 00	Administrative & General Administrative & General under	5.00	3, 423, 77 11, 38		3, 115, 535 11, 387			
	contract (see inst.)		11,00		,	102110		20.0
. 00	Maintenance & Repairs	6.00	(	0	(			
. 00 . 00	Operation of Plant Laundry & Linen Service	7.00 8.00	507, 10 <sup>-</sup>		507, 101	1 25, 188. 00 0. 00		
. 00	Housekeepi ng	9.00	581, 62	í o	581, 621			
. 00	Housekeeping under contract			0 0	(	0.00		
00	(see instructions)	10 00	E74 07	410.000	1/0 05	1 11 / / / / 7	10.01	24
. 00 . 00	Dietary Dietary under contract (see	10.00	574, 074	412,020	162, 054	4 11, 646. 67 0. 00		
	instructions)		,			0.00	0.00	35.0
. 00	Cafeteri a	11.00	(	412, 020	412, 020			
. 00 . 00	Maintenance of Personnel Nursing Administration	12.00 13.00	( 1, 042, 018	0 0 3 166, 679	( 1, 208, 697	0.00 7 37,413.00		37.0
. 00	Central Services and Supply	14.00	241, 523		241, 523			
. 00	Pharmacy	15.00	827, 292					

Health Financial Systems	K	OSCIUSKO COMMU	JNI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 03/01/2015		
					o 02/29/2016	Date/Time Pre 7/27/2016 2:0	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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	535, 756	0	535, 756	28, 651. 00	18. 70	41.00
Records Library	17.00					0.00	10.00
42.00 Social Service	17.00	-	0		0.00		42.00
43.00 Other General Service	18.00	C	0	(	0.00	0.00	43.00

Heal th	Financial Systems	к	OSCIUSKO COMMU	INI TY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
						From 03/01/2015 To 02/29/2016		bared:
							7/27/2016 2:00	5 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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		22, 927, 477	0	22, 927, 47	7 954, 762. 48	24.01	1.00
	instructions)							
2.00	Excluded area salaries (see		29, 735	141, 557	171, 293	2 7, 619. 00	22.48	2.00
	instructions)							
3.00	Subtotal salaries (line 1		22, 897, 742	-141, 557	22, 756, 18	5 947, 143. 48	24.03	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 207, 665	0	3, 207, 66	66, 603. 20	48. 16	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 757, 149	0	4, 757, 14	9 0.00	20. 90	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		30, 862, 556	-141, 557	30, 720, 99	9 1, 013, 746. 68	30. 30	6.00
7.00	Total overhead cost (see		7, 906, 300	-141, 557	7, 764, 74	3 363, 320. 48	21.37	7.00
	instructions)							
				-				

	Financial Systems KOSCIUSKO COMMUNI AL WAGE RELATED COSTS		CCN: 15013		u of Form CMS-2 Worksheet S-3	
позрі і	AL WAGE RELATED COSTS	Provider	CCN. 13013.	From 03/01/2015	Part IV	
				To 02/29/2016	Date/Time Pre	pared
					7/27/2016 2:0 Amount	6 pm
					Reported	
					1.00	<u> </u>
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					1
	RETI REMENT COST					1
. 00	401K Employer Contributions				390, 442	1.0
. 00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2.0
8.00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	3.0
ł. 00	Qualified Defined Benefit Plan Cost (see instructions)				0	4.0
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				·	1
5.00	401K/TSA Plan Administration fees				0	5.0
. 00	Legal /Accounting/Management Fees-Pension Plan				0	1 0.
. 00	Employee Managed Care Program Administration Fees				0	7.
	HEALTH AND INSURANCE COST					
. 00	Health Insurance (Purchased or Self Funded)				2, 335, 547	
. 00	Prescription Drug Plan				0	1
0.00	Dental, Hearing and Vision Plan				36, 739	
1. 00	Life Insurance (If employee is owner or beneficiary)				29, 801	
2.00	Accident Insurance (If employee is owner or beneficiary)				1, 885	
3.00	Disability Insurance (If employee is owner or beneficiary)				18, 319	
4.00	Long-Term Care Insurance (If employee is owner or beneficiary	)			0	
5.00	'Workers' Compensation Insurance				168, 097	
6.00	Retirement Health Care Cost (Only current year, not the extra	ordinary acc	ruai requi	red by FASB 106.	0	16.
	Non cumulative portion) TAXES					1
7.00	FICA-Employers Portion Only				1, 294, 962	1 17
8.00	Medicare Taxes - Employers Portion Only				302, 854	
9.00	Unemployment Insurance				0	
	State or Federal Unemployment Taxes				86, 898	
0.00	OTHER				00,070	20.
1.00	Executive Deferred Compensation (Other Than Retirement Cost R	eported on I	ines 1 thr	ough 4 above. (see	0	21.
	(instructions))					
2.00	Day Care Cost and Allowances				0	22.
3.00	Tuition Reimbursement				0	23.
4.00	Total Wage Related cost (Sum of lines 1 -23)				4, 665, 544	24.
	Part B - Other than Core Related Cost					
5.00	OTHER BENEFITS				129, 965	25.

Heal th	Financial Systems	KOSCI USKO COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150133	Period:	Worksheet S-3	
					From 03/01/2015 To 02/29/2016		narod
					10 02/29/2010	7/27/2016 2:0	
	Cost Center Description		· · ·		Contract Labor		
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident						
1.00	Total facility's contract labor and benefit	t cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF						4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF					 	8.00
9.00	Hospital-Based NF					 	9.00
10.00	Hospital-Based OLTC					 	10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC					 	12.00
13.00	Hospital-Based Hospice					 	13.00
14.00	Hospital-Based Health Clinic RHC					 	14.00
15.00	Hospital-Based Health Clinic FQHC					 	15.00
16.00	Hospital-Based-CMHC					 	16.00
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA       Provider CON: 150133       Period: Prom 32/07/2015 To 02/29/2016       Morksheet S-10         1.00       Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)       0.112875       1.00         2.00       Net revenue from Midi Cald       0.012875       1.00         2.00       Net revenue from Midi Cald       7,576,399       2.00         2.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       7,576,399       2.00         3.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if (.427,744       8.00         3.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if (.427,744       8.00         3.00       Net revenue from stand-alone SCHP       0       9,000         4.00       Difference between net revenue and costs for stand-alone SCHP (line 11 minus line 9; if < zero then enter zero)       0         3.00       Net revenue from stand - lone SCHP       0       1.00         4.00       Diff	Heal th	Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Incompensated and indigent care cost computation         1.00           1.00         Creat to charge ratio (Marksheet C, Part I line 202 column 3 divided by line 202 column 8)         0.112875           2.00         Net revenue from Medicaid         7.576.398         2.00           0.00         Did you receive USH or supplemental payments from Medicaid?         7.576.398         2.00           0.00         If you receive USH or supplemental payments from Medicaid?         7.576.398         2.00           0.00         If you receive USH or supplemental payments from Medicaid?         7.576.398         2.00           0.00         If the 4 is "no", then enter DSH or supplemental payments from Medicaid?         7.576.398         2.00           0.00         Medicaid cost (line 1 times 1ine 6)         8.00         79.770.915         6.00           0.00         Medicaid cost (line 1 times 1ine 10)         1.427.744         8.00         79.770.915         6.00           1.00         State Children's Health Linearance Program (SCHP) (see instructions for each line)         0				Provi der	CCN: 150133			0
Incompensated and indigent care cost computation         1722/2016.2.06 pm           1.00         Cost to change ratio (Worksheet C, Pert L Line 20 column 3 divided by Line 202 column 8)         0.112875           0.00         Did you receive DBH or supplemental payments from Medicaid?         7.576.398           0.00         If ine 3 is 'yes', does line 2 include all DBH or supplemental payments from Medicaid?         7.576.398           0.00         If ine 3 is 'yes', does line 2 include all DBH or supplemental payments from Medicaid?         7.576.398           0.00         If ine 3 is 'yes', does line 2 include all DBH or supplemental payments from Medicaid?         9.770.70.916           0.00         DBH or supplemental payments from Medicaid?         9.770.716.916           0.00         DBH or supplemental payments from Medicaid?         9.770.716.916           0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Incompensated and indigent care cost computation         1.00           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.112875           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.112875           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.112875           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.112875           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.112875           1.00         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.012875           0.01         Cost to charge ratio (Worksheet C, Part I line 30 column)         0.012875         0.00           0.01         Cost to charge ratio (Worksheet C, Part I line 30 column)         0.00         0.00         0.00           0.01         Cost to cost in cost opportance program (SCHP) (See instructions for each line)         0         0.00           0.00         State Children's Health Insurance Program (Sei Instructions for each line)         0         0.00           0.00         State or local indigent care program (Sei Instructions for each line)         0         0.00           1.00						0 02/29/2016		
Uncompensated and indigent care cost computation         I.00           1.00         Cost to charge ratio (Norksheet C, Part I line 202 column 3) divided by line 202 column 8)         0.112875           1.00         Cost to charge ratio (Norksheet C, Part I line 202 column 3)         0.112875           1.00         Did you receive DSH or supplemental payments from Medicaid 7         7.576,398           0.00         If line 3 is 'yes', does line 2 linclude all DSH or supplemental payments from Medicaid 7         7.576,398           0.00         DM dicial d charges         7.576,398           0.00         DIT revence from tenter cost payments from Medicaid 7         7.770,976           0.00         Difference between and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 7         9.00           0.01         Difference between from stand-al one SCHP         0         9.00           0.01         State Children's Health Insurance Program (SCHP) (see instructions for each line)         0         9.00           0.01         State or local government indigent care program (see instructions for each line)         0         9.00           0.02         Difference between net revenue and costs for state or local indigent care program (Not included on lines 2, 5 or 9)         12.00           1.00         Data or local indigent care program (see instructions for each line)         11.00           1.00							///2//2010 2.0	
1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.112875       1.00         2.00       Net revenue from Medicald       7,576.398       2.00         3.00       Did you receive DSH or supplemental payments from Medicaid?       3.00       3.00         4.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       7,576.398       3.00         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       9.00.4.122       7.00         6.00       Medicaid cost (line 1 times line 6)       9.00.4.122       7.00       9.00         8.00       State Children's Health Insurance Program (SCHP) (see instructions for each line)       9.00.4.122       7.00       10.00         9.00       Net revenue from stand-alone SCHP cost (line 1 times line 10)       0       10.00       10.00       11.00       10.00       11.00       12.00       11.00       12.00       11.00       12.00       13.00       14.02       14.02       14.02       14.02       14.02       14.02       14.02       15.00       14.02       15.00       14.02       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00							1.00	
Medicaid (see instructions for each line)         2.00           2.00 Net revenue from Medicaid         7,576,398         2.00           3.00 Did you receive DSH or supplemental payments from Medicaid         7,576,398         2.00           0.00 If fline 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid         0         7,576,398         3.00           0.00 Medicaid cost (line 1 times line 6)         9,004,142         7.00         5.00         9,004,142         7.00           0.00 Net revenue from stand-alone SCHIP         (line 7 minus sum of lines 2 and 5: if         1,427,744         8.00           0.00 State Children's the Rel th Insurance Program (SCHIP) (see instructions for each line)         9,004,142         9,00           0.10 Stand-alone SCHIP cost (line 1 times line 10)         10.00         10.00         10.00         10.00           0.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9: If < zero then of 10.00		Uncompensated and indigent care cost compu	tation					
2.00       Net revenue from Medicaid       7.576.398       2.00         3.00       Did you receive DSH or supplemental payments from Medicaid?       7.576.398       3.00         0.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid?       7.576.398       3.00         0.00       Medicaid charges       7.576.398       4.00         0.00       Medicaid charges       7.576.398       4.00         0.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       1.427.744       8.00         0.00       State Children's Health Insurance Program (SCHP) (see instructions for each line)       9.004.142       7.00         0.00       State Children's Health Insurance Program (SCHP) (see instructions for each line)       0       9.004.142         0.00       State or local government Indigent care program (Not included in lines 2. for 9)       0       10.00         12.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       13.00       431.676       14.00         13.00       State or local indigent care program cost (line 1 times line 14)       15.00       26.6070       13.00         14.00       Charges for patients covered under state or local indigent care program (Not include in lines 6 or 10.00       20.00       20.00       14	1.00		line 202 column 3 div	ided by lir	ne 202 column	8)	0. 112875	1.00
3.00       Did you receive DSH or supplemental payments from Medicaid?       3.00         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       4.00         5.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       9.00         6.00       Medicaid cost (line 1 times line 6)       79.770.915       6.00         70.00       Net cost (line 1 times line 6)       9.004.142       7.00         State Children's Health Insurance Program (SCHP) (see instructions for each line)       9.00       9.00         9.00       Net revenue from stand-alone SCHP       0       0.00       0       0       0.00         0.00       State Children's Health Insurance Program (SCHP) (see instructions for each line)       0       0       0.00         0.00       State Stand-alone SCHP cost (line 1 times line 10)       0       0       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.01       0.00       0.01       0.00       0.01       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00<								
4.00       If line 3 is "yes", does line 2 include all DSM or supplemental payments from Medicaid?       4.00         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       0         6.00       Medicaid charges       7.70,915         6.00       DIfference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1, 427,744         8.00       DIfference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       0, 9.00         9.00       Net revenue from stand-alone SCHP       0       9.00         9.00       State Children's Health Insurance Program (SCHP) (see instructions for each line)       0       10.00         9.00       Difference between net revenue and costs for stand-alone SCHP cost (line 1 times line 10)       0       10.00         10.00       Difference between net revenue from state or local indigent care program (see instructions for each line)       0       10.00         11.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 12, cost 10)       13.00       Net revenue from state or local indigent care program (line 16 minus line 12, cost 10)       14.00         13.00       Net revenue from state or local indigent care program (line 15 minus line 12, if < zero then enter zero)							7, 576, 398	
5:00       If line 4 is 'no'', then enter DSH or supplemental payments from Medicaid       0<								
6.00       Medicaid cost (line 1 times line 6)       79, 770, 915       6.00         7.00       Medicaid cost (line 1 times line 6)       9,004, 142       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,427,744       8.00         9.00       Net revenue from stand-alone SOHP       0       0,00					from Medicaid	)		
7.00       Medicaid cost <sup>2</sup> (line 1 times line 6)       9.004, 142       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1, 427, 744       8.00         9.00       Net revenue from stand-alone SCHIP (line 1 times line 10)       0       9.00       1, 427, 744       8.00         9.00       State Children's Healt 1. Insurance Program (SCHIP) (see instructions for each line)       0       9.00       10.00         10.00       Stand-alone SCHIP cost (line 1 times line 10)       0       10.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       12.00       Net revenue from state or local indigent care program (Net included on lines 2, 5 or 9)       26,070       13.00         11.00       Charges for patients covered under state or local indigent care program (Net included on lines 2, 5 or 9)       26,070       13.00         12.00       Net revenue from state or local indigent care program (Not included in lines 6 or 10.00       13.01       48,725       16.00         13.00       State or local indigent care program cost (line 1 times line 14)       48,725       16.00       16.00         10.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 22, 655       16.00       17.00       10.00       18.00       17.		1	emental payments from	Medi cai d			, s	
8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,427,744       8.00         9.00       Net revenue from stand-alone SCHIP       0       9.00       0		5						
< zero then enter zero)								
State Children's Health Insurance Program (SCHIP) (see instructions for each line)       0       9.00         9.00       Net revenue from stand-alone SCHIP       0       0.00         10.00       Stand-alone SCHIP cost (line 1 times line 10)       0       0.00         12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	8.00		or Medicaid program (	line 7 minu	us sum of line	es 2 and 5; if	1, 427, 744	8.00
9.00       Net revenue from stand-alone SCHIP       0       9.00         10.00       Stand-alone SCHIP cost (line 1 times line 10)       0       0       0         12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)				· · · · · · · · · ·				-
10.00       Stand-al one SCHIP charges       0       10.00         11.00       Stand-al one SCHIP cost (line 1 times line 10)       0       11.00       0         12.00       Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9: if < zero then enter zero).	0.00		(SCHIP) (see Instruct	ions for ea	ach line)			
11.00       Stand-alone SCHIP cost (line 1 times line 10)       0       11.00       0       0       11.00       0       0       11.00       0       11.00       0       11.00       12.00       0       0       12.00       0       0       12.00       0       0       12.00       0       0       12.00       0       0       12.00       0       0       12.00       0       0       13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       26,070       13.00       14.00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       26,070       14.00       14.00         10.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.01       48,725       15.00       16.00       11.00       20.05       16.00       17.00       18.00       0       18.00       0       18.00       0       18.00       0       18.00       18.00       19.00       19.00       18.00       18.00       18.00       18.00       19.00       19.00       19.00       19.00       19.00       18.00       18.00       19.00       19.00       19.00       19.00       19.00       10.00       2.00       10.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			10)				-	
enter zero)       enter zero)         00 Ther state or local government indigent care program (see instructions for each line)         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       26,070         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       431,676         15.00       State or local indigent care program cost (line 1 times line 14)       48,725         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 12, 656       22,665         17.00       Private grants, donations, or endowment income restricted to funding charity care 10, 11, 100       0       11, 00         19.00       Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 1, eccl. 2)       11, 100       1, 450, 399         19.00       Total unreimbursed cost centers) for the entire facility care (at full charges excluding non-reimbursable cost centers) for the entire facility 21, 00       20, 00       3, 00       1, 107, 322       20, 00         20.00       Total initial obligation of patients approved for charity care (line 1 grants, donation of patients approved for charity care (line 1 grants, donation of patients approved for charity care (line 1 grants, donation of patients approved for charity care (line 1 grants, donation of patients approved for charity care (line 1 grants, donation of patients approved for charity care (line 2 grants, donatin dog at a grants				(1) - 11 -		6 +h	-	
Other state or local government indigent care program (see instructions for each line)         13.00         Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)         26,070         13.00           14.00         Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)         26,070         13.00           15.00         State or local indigent care program cost (line 1 times line 14)         48,725         15.00           15.00         Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13)         48,725         15.00           13.00         Private grants, donations, or endowment income restricted to funding charity care         0         17.00           19.00         Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines         1,450,399         19.00           20.00         Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility         1.00         2.00         3.00           21.00         Cost of charity care (line 21 minus line 22)         9,758         32,628         131,761         21.00           22.00         Cost of charity care (line 21 minus line 22)         9,758         32,628         130,136         23.00           22.00         Des the amount in line 20 column 2 include char	12.00		or stand-arone schip	(The Thm	nus i ne 9; i	i < zero then		12.00
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       26,070       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       48,725       15.00         15.00       State or local indigent care program cost (line 1 times line 14)       48,725       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero)			are program (see inst	ructions fo	or each line)			
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       431,676       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       48,725       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13); if < zero then enter zero)	13 00						26.070	13 00
10)       10       10       10       10         15.00       State or local indigent care program cost (line 1 times line 14)       48,725       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line       22,655       16.00         13: if < zero then enter zero)								
16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13. if < zero then enter zero)	11.00		r roedr rhargent eare	program (i			101,070	
13: if < zero then enter zero)	15.00	State or local indigent care program cost	(line 1 times line 14	)			48, 725	15.00
Uncompensated care (see instructions for each line)       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       0         18.00       Government grants, appropriations or transfers for support of hospital operations       0         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       1,450,399         19.00       Insured patients       Insured patients       Total (col. 1         patients       patients       + col. 2)       1.00         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       878,256       289,066       1,167,322       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1       99,133       32,628       131,761       21.00         22.00       Partial payment by patients approved for charity care       1,625       0       1,625       22.00         23.00       Cost of charity care (line 21 minus line 22)       97,508       32,628       130,136       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       22,404,791       26.00       229,494,791       26.00 <td>16.00</td> <td>Difference between net revenue and costs f</td> <td>or state or local ind</td> <td>igent care</td> <td>program (line</td> <td>e 15 minus line</td> <td>22, 655</td> <td>16.00</td>	16.00	Difference between net revenue and costs f	or state or local ind	igent care	program (line	e 15 minus line	22, 655	16.00
17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       1.450,399       19.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       Total (col. 1       1         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       1.00       2.00       3.00         21.00       Cost of initial obligation of patients approved for charity care       1, 625       0       1, 625       28, 066       1, 625       22, 00         22.00       Partial payment by patients approved for charity care       1, 625       0       1, 625       23, 00       1, 625       0       1, 625       23, 00       1.00       22, 00       23, 00       22, 00 matients covered by Medicaid or other indigent care program?       1.00       22, 400, 0       22, 404, 791       26, 00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit       0       22, 265, 271       27, 00       22, 494, 791       26, 0								
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines       0       1.450, 399       19.00         8, 12 and 16       Uninsured patients       Insured patients       recol. 2)       1.00       2.00       3.00         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       878, 256       289, 066       1, 167, 322       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1 ines line 20)       99, 133       32, 628       131, 761       21.00         22.00       Partial payment by patients approved for charity care       1, 625       0       1, 625       22.00         23.00       Cost of charity care (line 21 minus line 22)       97, 508       32, 628       130, 136       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       20.00       20.00       20.00       20.00								
19.00       Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 1, 450, 399       19.00         8, 12 and 16)       Uninsured patients       Insured patients       1, 450, 399       19.00         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       878, 256       289, 066       1, 167, 322       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1 times line 20)       99, 133       32, 628       131, 761       21.00         22.00       Partial payment by patients approved for charity care       1, 625       0       1, 625       22.00         23.00       Cost of charity care (line 21 minus line 22)       97, 508       32, 628       130, 136       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       22, 494, 791       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       22, 2494, 791       26.00         27.00       Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       22, 265, 27							-	
8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 + col. 2)         20.00       Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility       878, 256       289, 066       1, 167, 322       20.00         21.00       Cost of initial obligation of patients approved for charity care (line 1 times line 20)       99, 133       32, 628       131, 761       21.00         22.00       Partial payment by patients approved for charity care       1, 625       0       1, 625       22.00         22.00       Cost of charity care (line 21 minus line 22)       97, 508       32, 628       130, 136       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       22, 494, 791       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       22, 249, 517       27.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)       2, 513, 193       29, 00         29.00       Cost of uncompensated care (line 23 column 3 plus line 29)       2, 643, 329       30.00 </td <td></td> <td>5 11 1</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>		5 11 1					-	
Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility times line 20)878, 256289, 0661, 167, 32220.0021.00Cost of initial obligation of patients approved for charity care (line 1 times line 20)99, 13332, 628131, 76121.0022.00Partial payment by patients approved for charity care times line 20)1, 62501, 62522.0023.00Cost of charity care (line 21 minus line 22)97, 50832, 628130, 13623.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0024.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program?22, 494, 79126.0027.00Medi care and non-reimbursable Medi care bad debt expense (line 26 minus line 27)22, 205, 27428.0029.00Cost of non-Medi care and non-reimbursable Medi care bad debt expense (line 1 times line 28)2, 643, 32930.00	19.00		IP and state and loca	I indigent	care programs	s (sum of lines	1, 450, 399	19.00
1.002.003.0020.00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00878,256289,0661,167,32220.0021.00Cost of initial obligation of patients approved for charity care (line 1 times line 20)99,13332,628131,76121.0022.00Partial payment by patients approved for charity care (line 21 minus line 22)1,62501,62522.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0024.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?025.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program?22,494,79126.0026.00Total bad debt expense for the entire hospital complex (see instructions) 28.0022,50722,65,27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.0022,65,27428.0022,643,32930.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,32930.0022,643,32930.00					Uni nsured	Insured	Total (col. 1	
20.00Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility (Cost of initial obligation of patients approved for charity care (line 1 times line 20)878, 256 (289, 066)289, 066 (1, 167, 322)1, 167, 322 (20.00)22.00Partial payment by patients approved for charity care times line 20)1, 625 (0, 1, 625)0 (1, 625)1, 625 (0, 1, 625)0 (1, 625)1, 625 (22.00)0 (1, 625)1, 625 (22.00)0 (1, 625)23.001, 625 (23.00)0 (1, 625)1, 625 (23.00)0 (1, 625)1, 625 (23.00)0 (1, 625)1, 625 (23.00)0 (1, 625)1, 625 (23.00)0 (23.00)1, 625 (23.00)0 (23.00)1, 625 (23.00)1, 625 (23.00)0 (23.00)0 (24.00)1, 625 (23.00)0 (24.00)1, 625 (23.00)0 (23.00)0 (24.00)1, 625 (23.00)0 (24.00)0 (24.00)24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?24.00 (22.00)24.00 (22.404, 791)24.00 (25.00)25.00If line 24 is "yes," charges for patient days beyond an indigent care program?0 (22.404, 791)26.00 (22.404, 791)26.00 (22.404, 791)22.00 (22.205, 517)22.00 (22.205, 517)22.00 (22.205, 517)22.00 (22.205, 517)22.00 (22.205, 517)22.20, 226, 216, 216, 216, 216, 216, 216, 216					patients	pati ents	+ col. 2)	
charges excluding non-reimbursable cost centers) for the entire facility99,13332,628131,76121.0021.00Cost of initial obligation of patients approved for charity care (line 199,13332,628131,76121.0022.00Partial payment by patients approved for charity care1,62501,62522.0023.00Cost of charity care (line 21 minus line 22)97,50832,628130,13623.0024.00Dees the amount in line 20 column 2 include charges for patient days beyond a length of stay limit24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program?25.0025.00Total bad debt expense for the entire hospital complex (see instructions)22,494,79126.00Non-Medicare bad debts for the entire hospital complex (see instructions)22,295,17728.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22,265,27429.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19329.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,329		1						
21.00Cost of initial obligation of patients approved for charity care (line 1 times line 20)99,133 32,62832,628 131,761131,761 21.0022.00Partial payment by patients approved for charity care (line 21 minus line 22)1,625 97,5080 32,6281,625 100,13622.00 23.0024.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 22, 494, 791 26.000 25.0025.00Non-Medicare bad debts for the entire hospital complex (see instructions) 28.0022,494,791 26,0022,000 22,265,27428.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.0022,265,274 2,265,27422,000 2,000 2,643,32929.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,329 30.002,643,329 30.00	20.00				878, 25	289, 066	1, 167, 322	20.00
times line 20)Partial payment by patients approved for charity care1, 62501, 62522. 0023. 00Cost of charity care (line 21 minus line 22)97, 50832, 628130, 13623. 001. 0024. 00Dees the amount in line 20 column 2 include charges for patient days beyond a length of stay limitimposed on patients covered by Medicaid or other indigent care program?25. 00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit26. 00Total bad debt expense for the entire hospital complex (see instructions)22, 494, 79126. 0027. 00Medicare bad debts for the entire hospital complex (see instructions)22, 494, 79126. 0027. 00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22, 265, 27428. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2, 513, 19329. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)2, 643, 32930. 00								
22.00Partial payment by patients approved for charity care1,62501,62522.0023.00Cost of charity care (line 21 minus line 22)97,50832,628130,13623.001.0024.00Dees the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0025.0026.00Total bad debt expense for the entire hospital complex (see instructions)22,494,79126.0027.00Medicare bad debts for the entire hospital complex (see instructions)22,95,17227.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 27)22,265,27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,32930.00	21.00		roved for charity car	e (line 1	99, 13	32, 628	131, 761	21.00
23.00       Cost of charity care (line 21 minus line 22)       97,508       32,628       130,136       23.00         24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       24.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       22,494,791       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       22,9,517       27.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       22,265,274       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)       2,513,193       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       2,643,329       30.00	~~ ~~				1 (0)		4 (05	00.00
24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program?       24.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       22,494,791       26.00         27.00       Medicare bad debts for the entire hospital complex (see instructions)       22,494,791       26.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)       22,265,274       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)       2,513,193       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       20       2,643,329       30.00								
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.000025.00Total bad debt expense for the entire hospital complex (see instructions)025.0027.00Medicare bad debts for the entire hospital complex (see instructions)22, 494, 79126.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22, 265, 27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2, 513, 19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 643, 32930.00	23.00	Cost of charity care (The 21 minus The 2	2)		97, 50	3 32, 628	130, 136	23.00
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?24.0025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.000025.00Total bad debt expense for the entire hospital complex (see instructions)025.0027.00Medicare bad debts for the entire hospital complex (see instructions)22, 494, 79126.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22, 265, 27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2, 513, 19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 643, 32930.00							1.00	
imposed on patients covered by Medicaid or other indigent care program?025.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit026.00Total bad debt expense for the entire hospital complex (see instructions)22,494,79127.00Medicare bad debts for the entire hospital complex (see instructions)22,494,79128.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22,265,27429.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19330.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,329	24.00	Doos the amount in Line 20 column 2 includ	o charges for nationt	dave bovor	ad a Longth of	<sup>2</sup> stav limit	1.00	24.00
25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)22,494,79126.0027.00Medicare bad debts for the entire hospital complex (see instructions)22,51727.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22,265,27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,32930.00	24.00					Stay Thint		24.00
26.00Total bad debt expense for the entire hospital complex (see instructions)22,494,79126.0027.00Medicare bad debts for the entire hospital complex (see instructions)22,51727.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22,265,27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,32930.00	25 00	If line 24 is "ves" charges for natient	days beyond an indige	nt care pro	oaram's Lenath	n of stav limit	0	25 00
27.00Medicare bad debts for the entire hospital complex (see instructions)229, 51727.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22, 265, 27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2, 513, 19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 643, 32930.00		Total bad debt expense for the entire bosh	ital complex (see ins	tructions)	sg. um S i crigti	. Si Stay i i mi t	-	
28.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)22, 265, 27428.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2, 513, 19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 643, 32930.00								
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)2,513,19329.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,643,32930.00					sline 27)			
30.00         Cost of uncompensated care (line 23 column 3 plus line 29)         2,643,329         30.00						28)		
			•	0.130 (1116				1
				ne 30)				

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	KOSCIUSKO COMMUNI DF EXPENSES		CCN: 150133	Peri od:	eu of Form CMS-2 Worksheet A	2002 10
					From 03/01/2015 To 02/29/2016		
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1 1		1		I	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 757, 132				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	4/4 757	3, 365, 520				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	161, 757	116, 689				
5.01	00540 OTHER ADMINISTRATIVE AND GENERAL	3, 423, 771	14, 903, 617				
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	0 507 101	0		0 4, 535, 878		
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	507, 101	1, 619, 135 319, 417				7.00
8.00 9.00	00900 HOUSEKEEPING	581, 621	228, 725				
9.00 10.00	01000 DI ETARY	574,074	630, 687				
11.00	01100 CAFETERIA	574,074	030, 087		0 864, 298		
13.00	01300 NURSI NG ADMI NI STRATI ON	1,042,018	137, 877				
14.00	01400 CENTRAL SERVICES & SUPPLY	241, 523	3, 011, 098				
15.00	01500 PHARMACY	827, 292	5, 584, 109				
16.00	01600 MEDI CAL RECORDS & LI BRARY	535, 756	283, 130				1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000,700	200, 100	010,00	1,211	017,072	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 157, 161	1, 978, 799	6, 135, 90	-696, 857	5, 439, 103	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 151, 963	194, 099				
43.00	04300 NURSERY	0	0		0 204, 215		
	ANCI LLARY SERVI CE COST CENTERS	· · · · ·		1			
50.00	05000 OPERATI NG ROOM	1, 257, 561	1, 337, 878	2, 595, 43	39 -12, 826	2, 582, 613	50.00
51.00	05100 RECOVERY ROOM	655, 755	130, 866	786, 62	21 -1, 105	785, 516	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	12		12 486, 705	486, 717	52.00
53.00	05300 ANESTHESI OLOGY	0	787, 132	787, 13	32 -15, 777	771, 355	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 106, 890	2, 130, 206	4, 237, 09	96 -1, 794, 724	2, 442, 372	54.00
54.01	05401 ULTRASOUND	461, 134	72, 979	534, 1 <sup>-</sup>	13 -534, 113	0	54.01
54.02	05402 ONCOLOGY	0	0	)	0 1, 786, 507	1, 786, 507	54.02
56.00	05600 RADI OI SOTOPE	148, 520	214, 538	363, 0	58 0	363, 058	56.00
57.00	05700 CT SCAN	265, 802	312, 038	577, 84	40 - 37, 087	540, 753	
58.00	05800 MRI	207, 467	134, 213				
60.00	06000 LABORATORY	1, 345, 564	2, 010, 942				
65.00	06500 RESPI RATORY THERAPY	391, 836	69, 696				
66.00	06600 PHYSI CAL THERAPY	595, 980	1, 180, 651				
67.00	06700 OCCUPATIONAL THERAPY	22, 407	192, 415				
68.00	06800 SPEECH PATHOLOGY	0	30, 975				
69.00	06900 ELECTROCARDI OLOGY	74, 701	10, 333				
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 456, 209		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 2, 260, 272		
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 5,013,304	5, 013, 304 0	73.00
	03950 OTHER ANGILLARY SERVICE COST CENTER	74, 559	42, 909		-	-	
	03951 OTHER ANCI LLARY SERVICE COST CENTER	65, 777	42, 909				
70.03	OUTPATIENT SERVICE COST CENTERS	05,777	51, 705	77,74	+2 -71,142	0	70.03
90.00	09000 CLINIC	467, 376	41, 341	508, 7	17 94, 718	603, 435	90.00
90.00	09100 EMERGENCY	1, 540, 989	527, 217				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 340, 707	527,217	2,000,20	50 52,071	2,010,100	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		22, 886, 355	43, 388, 340	66, 274, 69	-404, 877	65, 869, 818	118 00
	NONREI MBURSABLE COST CENTERS	22/000/000	10/000/010	00/2/1/0		00,00,000	1.101.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 735	25, 334	55, 00	-913	54, 156	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	60, 173				
	19201 WELLNESS CENTER	0	00,170		0 0		192.01
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 MARKETI NG	0	0		0 522, 136	-	
	07952 SENI OR CI RCLE	0	-3, 464	-3, 40			194.02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.03
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.05
200.00	TOTAL (SUM OF LINES 118-199)	22, 916, 090	43, 470, 383	66, 386, 4	73 0	66, 386, 473	200. 00
							•

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	KOSCIUSKO COMML OF EXPENSES		CCN: 150133		u of Form CMS-2 Worksheet A	2552-1
					To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
	Cost Center Description	Adjustments	Net Expenses		· .		
		(See A-8) 6.00	For Allocation 7.00	4			
	GENERAL SERVICE COST CENTERS	0.00	7.00	I			
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 987, 438	5, 654, 160				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-534, 422					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 582	3, 369, 787				4.00
5.01	00540 OTHER ADMINISTRATIVE AND GENERAL	-498, 931	8, 815, 601				5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	-1, 382, 289	3, 153, 589				5.02
7.00	00700 OPERATION OF PLANT	0	2, 177, 425				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-10, 735		1			8.00
9.00	00900 HOUSEKEEPI NG	0					9.00
10.00	01000 DI ETARY	0	339, 944	1			10.00
11.00		-347, 125		1			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0		1			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	508, 632	1			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	12 102	1, 272, 934				15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	-13, 193	804, 479	1			16.00
30. 00	03000 ADULTS & PEDIATRICS	-1, 292, 706	4, 146, 397				30.00
31.00	03100 I NTENSI VE CARE UNI T	-1, 272, 700					31.00
43.00	04300 NURSERY						43.00
10.00	ANCI LLARY SERVICE COST CENTERS		201,210	1			10.00
50.00	05000 OPERATI NG ROOM	-108, 650	2, 473, 963				50.00
51.00	05100 RECOVERY ROOM	0	785, 516				51.00
52.00		0	486, 717				52.00
53.00	05300 ANESTHESI OLOGY	-771, 355		)			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 745					54.00
54.01	05401 ULTRASOUND	0	C				54.01
54.02	05402 ONCOLOGY	-257, 637	1, 528, 870				54.02
56.00	05600 RADI OI SOTOPE	-315	362, 743				56.00
57.00	05700 CT SCAN	-8, 381	532, 372				57.00
58.00	05800 MRI	-19, 695					58.00
60.00	06000 LABORATORY	0	3, 163, 839				60.00
65.00	06500 RESPI RATORY THERAPY	0	578, 514				65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 774, 239	1			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	214, 023				67.00
68.00	06800 SPEECH PATHOLOGY	0	30, 975				68.00
69.00	06900 ELECTROCARDI OLOGY	0	85,034				69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		456, 209	1			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS		2, 260, 272	1			72.00
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTER		5,013,304				76.00
76.00	03610 SLEEP LAB						76.01
76.03							76.03
70.05	OUTPATIENT SERVICE COST CENTERS		η C	1			1 /0.05
90 00	09000 CLINIC	0	603, 435				90.00
	09100 EMERGENCY	0		1			91.00
92.00							92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2, 261, 323	63, 608, 495				118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54, 156				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	198, 223	138, 586	,			192.00
192. Oʻ	1 19201 WELLNESS CENTER	0	C				192.01
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	) C				194.00
	1 07951 MARKETI NG	0	522, 136				194.01
	2 07952 SENI OR CI RCLE	0	C				194. 02
	3 07953 OTHER NONREI MBURSABLE COST CENTERS	0	C				194.03
194.05	07955 OTHER NONREI MBURSABLE COST CENTERS	0	C				194.05
200.00	TOTAL (SUM OF LINES 118-199)	-2,063,100	64, 323, 373	1			200.00

ch Financial Systems ASSIFICATIONS	K	KOSCI USKO COMMU		CCN: 150133 Period:	In Lieu of Form CMS-255 Worksheet A-6
				From O3/	
	Increases				//2//2016_2:06_p
Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
A - EMPLOYEE BENEFITS					
EMPLOYEE BENEFITS DEPARTME	<u>ENT 4.00</u>	0	<u>3, 095, 694</u> 3, 095, 694		1
B – OXYGEN					
MEDICAL SUPPLIES CHARGED T PATIENT	ΓΟ 71.00	0	24, 253		1
	0.00	о	0		2
TOTALS			24, 253		
C - LEASE AND RENTAL CAP REL COSTS-BLDG & FIXT	1.00	0	214, 681		1
CAP REL COSTS-MVBLE EQUIP	2.00	0	863, 350		
	0.00	0	0		
	0. 00 0. 00	0	0		2
	0.00	0	0		
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	0.00	0	0		14
	0.00	0	0		10
0	0. 00 0. 00	0	0		1
	0.00	0	0		10
0	0.00	0	0		20
	0. 00 0. 00	0	0		22
TOTALS		— — — <del>o</del>	1,078,031		
D - OTHER CAPITAL CAP REL COSTS-BLDG & FIXT	1.00	0	110 422		
CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	1.00	0	119, 422 575, 487		
CAP REL COSTS-MVBLE EQUIP	2.00	0	1 <u>5, 5</u> 37		
TOTALS		0	710, 446		
E – MARKETI NG MARKETI NG	194.01	141, 557	384, 043		
TOTALS		141, 557	384, 043		
NURSI NG ADMI NI STRATI ON	13.00	166, 679	0		
TOTALS		166, 679	ō		
G - CHARGABLE SUPPLIES MEDICAL SUPPLIES CHARGED T	ΓΟ 71.00	0	431, 956		
PATI ENT	71.00	0	431, 930		
IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2, 260, 272		:
PATTENTS	0.00	o	0		
TOTALS		0	2, 692, 228		
H - DRUGS DRUGS CHARGED TO PATIENTS	73.00	0	5,013,304		
TOTALS		— — — <del>0</del>	5, 013, 304		
I - LABOR AND DELIVERY					
NURSERY DELIVERY ROOM & LABOR ROOM	43.00 1 52.00	173, 247 412, 908	30, 968 73, 797		
TOTALS		586, 155	104, 765		
J - MISC DEPARTMENTS			04.04-		
CLI NI C RESPI RATORY THERAPY	90.00 65.00	65, 777 74, 559	31, 965 42, 423		
OTHER ADMINISTRATIVE AND	5. 02	1, 432, 251	3, 103, 627		
GENERAL	104.00		2 444		
SENI OR_CI RCLE	194.02	1, 572, 587	<u>3, 464</u> 3, 181, 479		2
K – RADI OLOGY			E		
ONCOLOGY	54.02	736, 081	1, 050, 426		
TOTALS	0.00	0 736, 081	00000000_0_0_0		1
L – DIETARY					
		412,020	452, 278		
TOTALS M - MOB UTILITIES		412, 020	452, 278		
OPERATION OF PLANT	7.00	0	52,005		
TOTALS		0	52,005		
00 Grand Total: Increases		3, 615, 079	17, 838, 952		500

LASS	SEFECATIONS			Provi der		Period: From 03/01/2015	Worksheet A-6
						To 02/29/2016	Date/Time Prepared 7/27/2016 2:06 pm
		Decreases		· · · · · · · · · · · · · · · · · · ·			
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - EMPLOYEE BENEFITS	7.00	8.00	9.00	10.00		
0	OTHER ADMI NI STRATI VE AND	5.01	0	3, 095, 694	(	0	1.
	GENERAL					_	
			0	3, 095, 694			
	B - OXYGEN CENTRAL SERVICES & SUPPLY	14.00	0	8, 476		0	1.
	ANESTHESI OLOGY	53.00	0	15, 777		0	2.
-	TOTALS			24, 253		-	
	C – LEASE AND RENTAL						
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 771			1.
0	OTHER ADMI NI STRATI VE AND GENERAL	5.01	0	46, 364	10	0	2.
0	OPERATION OF PLANT	7.00	o	816		0	3.
	DI ETARY	10.00	0	519		0	4.
	NURSING ADMINISTRATION	13.00	0	2, 372		0	5.
0	CENTRAL SERVICES & SUPPLY	14.00	0	45, 959		0	6.
-	PHARMACY MEDI CAL RECORDS & LI BRARY	15.00 16.00	0	125, 163 1, 214		0	7.
	ADULTS & PEDIATRICS	30.00	0	5, 937		0	9.
-	INTENSIVE CARE UNIT	31.00	0	3, 890		0	10.
	OPERATING ROOM	50.00	0	10, 292		0	11.
	RECOVERY ROOM	51.00	0	1, 105		0	12.
	RADI OLOGY-DI AGNOSTI C CT SCAN	54.00 57.00	0	542, 330 37, 087		0	13.
	LABORATORY	60.00	0	192, 667		0	14.
	PHYSICAL THERAPY	66.00	Ő	2, 392		0	17.
00	OCCUPATIONAL THERAPY	67.00	О	799		0	18.
	SLEEP LAB	76. 01	0	486		0	19.
		90.00	0	2, 884		0	20.
	EMERGENCY GIFT, FLOWER, COFFEE SHOP &	91.00 190.00	0	52, 071 913		0	21.
00	CANTEEN	170.00	Ŭ	715			22.
	TOTALS		0	1,078,031		7	
	D - OTHER CAPITAL	F 01		( 40 ( 41	1		1
0	OTHER ADMI NI STRATI VE AND GENERAL	5.01	0	642, 641	1:	2	1.
0	PHYSICIANS' PRIVATE OFFICES	192.00	o	67, 805	1:	3	2.
0		0.00	0	0			3.
	TOTALS		0	710, 446			
	E - MARKETING OTHER ADMINISTRATIVE AND	5.01	141 557	204 042		0	1.
0	GENERAL	5.01	141, 557	384, 043		0	1.
	TOTALS		141, 557	384, 043		-	
	F - CNO COST				1	-	
0	OTHER ADMINISTRATIVE AND	5.01	166, 679	0		0	1.
	GENERAL	+	166, 679	— — — ō		-	
	G - CHARGABLE SUPPLIES		100,077	0			
	CENTRAL SERVICES & SUPPLY	14.00	0	2, 689, 554		0	1.
	OPERATING ROOM	50.00	0	2, 534		0	2.
0	CLINIC	90.00	0	140		0	3.
	H - DRUGS		0	2, 692, 228			
0	PHARMACY	15.00	0	5, 013, 304		0	1.
	TOTALS		<u>_</u>	5, 013, 304		1	
	I - LABOR AND DELIVERY						
0	ADULTS & PEDIATRICS	30.00	586, 155	104, 765		0	1.
0	TOTALS	0.00	0 586, 155	000000		0	2.
	J - MISC DEPARTMENTS		500, 155	104, 705	I		
0	OTHER ANCI LLARY SERVICE COST	76.03	65, 777	31, 965		0	1.
	CENTER						
	SLEEP LAB	76.01	74, 559	42, 423		0	2.
0	OTHER ADMI NI STRATI VE AND GENERAL	5.01	1, 432, 251	3, 103, 627	(	0	3.
0	MARKETING	194.01	0	3, 464		0	4.
	TOTALS		1, 572, 587	3, 181, 479		1	
	K - RADI OLOGY					1	
	RADI OLOGY-DI AGNOSTI C	54.00	274, 947	977, 447		0	1.
0	ULTRASOUND	54.01	461, 134	72, 979	1 (	0	2.

Heal th	Financial Systems		KOSCIUSKO COMMI	JNI TY HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 150133	Peri od:	Worksheet A-	6
						From 03/01/2015 To 02/29/2016	Date/Time Pr 7/27/2016 2:	epared: 06_pm
		Decreases						
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	L – DIETARY							
1.00	DI ETARY	10.00	412, 020	452, 278		0		1.00
	TOTALS		412, 020	452, 278		7		
	M - MOB UTILITIES							1
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	52,005		0		1.00
	TOTALS		0	52,005		7		1
500.00	Grand Total: Decreases		3, 615, 079	17, 838, 952				500.00

Heal th	Financial Systems	KOSCI USKO COMMUI	NI TY HOSPI TAL		_	In Lie	u of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150133		riod: om 03/01/2015 02/29/2016	Worksheet A-7 Part I Date/Time Pre	
					10	02/2//2010	Date/Time Pre 7/27/2016 2:0	6 pm
		-		Acquisition:	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	158, 709	0		0	0	0	
2.00	Land Improvements	1, 501, 575	38, 362		0	38, 362	664	2.00
3.00	Buildings and Fixtures	54, 569, 700	507, 058		0	507, 058	0	
4.00	Building Improvements	134, 232	27, 700		0	27, 700	0	4.00
5.00	Fixed Equipment	4, 033, 687	114, 111		0	114, 111	0	5.00
6.00	Movable Equipment	35, 104, 905	1, 102, 252		0	1, 102, 252	190, 109	6.00
7.00	HIT designated Assets	2, 375, 096	0		0	0	100, 775	7.00
8.00	Subtotal (sum of lines 1-7)	97, 877, 904	1, 789, 483		0	1, 789, 483	291, 548	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	97, 877, 904	1, 789, 483		0	1, 789, 483	291, 548	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	158, 709	0					1.00
2.00	Land Improvements	1, 539, 273	0					2.00
3.00	Buildings and Fixtures	55, 076, 758	0					3.00
4.00	Building Improvements	161, 932	0					4.00
5.00	Fixed Equipment	4, 147, 798	0					5.00
6.00	Movable Equipment	36, 017, 048	0					6.00
7.00	HIT designated Assets	2, 274, 321	0					7.00
8.00	Subtotal (sum of lines 1-7)	99, 375, 839	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	99, 375, 839	0					10.00

Heal th	Financial Systems	KOSCIUSKO COMML	JNI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150133	Period: From 03/01/2015	Worksheet A-7 Part II	
					To 02/29/2016	Date/Time Pre	
						7/27/2016 2:0	6 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 AMOUNTS FROM WO			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 757, 132	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 365, 520	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	5, 122, 652	0		0 0	0	3.00
		SUMMARY C	OF CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	IN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	C	1, 757, 132				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	C	3, 365, 520				2.00
3.00	Total (sum of lines 1-2)	C	5, 122, 652				3.00

Heal th	n Financial Systems	KOSCIUSKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 03/01/2015 To 02/29/2016	Worksheet A-7 Part III Date/Time Prep 7/27/2016 2:06	
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	56, 936, 673 42, 439, 167 99, 375, 840	0	56, 936, 67 42, 439, 16 99, 375, 84	7         0. 427057           0         1. 000000		1.00 2.00 3.00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1	1			
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			2, 487, 707           2, 712, 406           5, 200, 113	128, 242 863, 350 991, 592	1.00 2.00 3.00
0100			SI	JMMARY OF CAPI		7711072	0100
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		I				
1.00	CAP REL COSTS-BLDG & FIXT	2, 298, 916					1.00
2.00 3.00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1–2)	0 2, 298, 916			0 118, 692 7 163, 078		2.00 3.00

vstems	KOSCI USKO	COMMUNITY HOSPITAL	

Health Financial Systems ADJUSTMENTS TO EXPENSES	K	OSCIUSKO COMMU		In Lie Period:	eu of Form CMS-2 Worksheet A-8	2552-1
ADJUSTINENTS TO EXI ENSES				From 03/01/2015 Fo 02/29/2016		
			Expense Classification on To/From Which the Amount is			
		A	Cost Costor			
Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
3.00 Investment income - other		0		0.00	0	3.0
(chapter 2) 4.00 Trade, quantity, and time		0		0.00	0	4.0
discounts (chapter 8) 5.00 Refunds and rebates of		0		0.00	0	5.0
expenses (chapter 8)		0				
5.00 Rental of provider space by suppliers (chapter 8)		0		0.00		6.0
7.00 Telephone services (pay stations excluded) (chapter 21)	В		OTHER ADMINISTRATIVE AND GENERAL	5. 01	0	7.0
3.00 Television and radio service (chapter 21)	A	-27, 925	CAP REL COSTS-MVBLE EQUIP	2.00	9	8. 0
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment	A-8-2	0 -2, 470, 533		0.00	0 0	9. 00 10. 00
11.00 Sale of scrap, waste, etc.	В	-76	RADI OLOGY-DI AGNOSTI C	54.00	0	11.0
(chapter 23) 12.00 Related organization transactions (chapter 10)	A-8-1	1, 619, 543			0	12. 0
<ul><li>3.00 Laundry and Linen service</li><li>4.00 Cafeteria-employees and guest</li></ul>	s B	0 -347 125	CAFETERI A	0.00 11.00		13. C 14. C
5.00 Rental of quarters to employe		-347, 123		0.00		
and others Sale of medical and surgical supplies to other than		0		0.00	0	16. C
patients 17.00 Sale of drugs to other than		0		0.00	0	17.0
patients 18.00 Sale of medical records and	В	-13, 193	MEDICAL RECORDS & LIBRARY	16.00	0	18.0
abstracts 19.00 Nursing school (tuition, fees		0		0.00		
books, etc.)	· ·	0				
20.00 Vending machines 21.00 Income from imposition of		0		0.00		20. C 21. C
interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare		0		0.00	0	22. 0
overpayments and borrowings t	0					
23.00 repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.0
Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.0
limitation (chapter 14) 25.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.0
(chapter 21) 6.00 Depreciation - CAP REL	А	730, 575	CAP REL COSTS-BLDG & FIXT	1.00	9	26. C
COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL	А	-651, 402	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.0
COSTS-MVBLE EQUIP 8.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 0
9.00 Physicians' assistant	4 9 2	0		0.00		
0.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATI ONAL THERAPY	67.00		30. C
0.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 9
Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31. C
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		
33.00 34.00 RENTAL INCOME	В	0 -86, 439	CAP REL COSTS-BLDG & FIXT	0.00		33. 0 34. 0

	Financial Systems	КО	SCIUSKO COMMUNI			eu of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provi der CCN: 150133	Period: From 03/01/2015 To 02/29/2016		pared:
			T	Expense Classification c o/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MISC INCOME	В		THER ADMINISTRATIVE AND ENERAL	5.01	0	35.00
36.00			0		0.00	0	36.00
37.00	PATIENT PHONE WAGE COST	A		THER ADMINISTRATIVE AND ENERAL	5.02	0	37.00
38.00	PATIENT PHONE BENEFIT COSTS	A	-1, 582 EM	MPLOYEE BENEFITS DEPARTME	NT 4.00	0	38.00
39. 00	PATIENT PHONE EXPENSE	A		THER ADMINISTRATIVE AND ENERAL	5.02	0	39.00
40.00	PATIENT PHONE DEPRECIATION	A	-948 C/	AP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00	PATIENT TV - DEPRECIATION	A	-9, 506 C/	AP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	MARKETING	A		THER ADMINISTRATIVE AND ENERAL	5.01	0	42.00
43.00	PHYSICIAN RECRUITING	A		THER ADMINISTRATIVE AND ENERAL	5.01	0	43.00
44.00	CHARI TABLE CONTRI BUTI ONS	A		THER ADMINISTRATIVE AND ENERAL	5.01	0	44.00
45.00	UNCOLLECTED PHYSICAN RENT	A	GI	THER ADMINISTRATIVE AND ENERAL	5.01	0	45.00
45. 01	MINORITY INTEREST	A		THER ADMINISTRATIVE AND ENERAL	5.01	0	45. 01
45. 02	LOBBYING EXPENSE IN ASSOCIATION DUES	A	GI	THER ADMINISTRATIVE AND ENERAL	5.01	0	45.02
45.03	TRANSPORTATION COSTS	A	GI	THER ADMINISTRATIVE AND ENERAL	5. 01	0	
45.04	LEGAL FEES	A	GI	THER ADMINISTRATIVE AND ENERAL	5. 01	0	45.04
45.05	POB DEPRECIATION	A		HYSICIANS' PRIVATE OFFICE			
45.06	POB RENT	A	395, 672 Pł	HYSICIANS' PRIVATE OFFICE			
45.07			0		0.00		
45.08			0		0.00		
45. 09	MEALS AND ENTERTAINMENT	A		THER ADMINISTRATIVE AND ENERAL	5. 01	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2, 063, 100				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

A. costs - fri cost, frierdaring appreciate 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.

	Financial Systems		IUNI TY_HOSPI TAL	In Lie	eu of Form CMS-2	2552-
	IENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provi der CCN: 150133	Period: From 03/01/2015 To 02/29/2016		oared
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	<u> </u>
	1 00	2 00	3 00	4 00	5.00	
1. 00 2. 00 3. 00 4. 00 4. 02 4. 03 4. 04 4. 05 4. 04 4. 05 4. 06 4. 07 4. 08 4. 09 4. 10 4. 11 4. 12 4. 13 4. 14 4. 15 4. 16 4. 17	1.00 2.00 5.01 1.00 2.00 5.01 1.00 2.00 5.01 5.01 5.01 5.01 5.02 5.02 5.02 5.01 5.01 5.01 5.01 5.01 5.01 0.00 0.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT OTHER ADMINISTRATIVE AND GEN CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OTHER ADMINISTRATIVE AND GEN CAP REL COSTS-MVBLE EQUIP OTHER ADMINISTRATIVE AND GEN OTHER ADMINISTRATIVE AND GEN	DIRECT ALLOCATION - CAPITAL- PASI CAPITAL COSTS - BLDG & PASI CAPITAL COSTS - MOVEABI PASI OPERATING COSTS PRE-ACQ LEGACY CAPITAL COSTS PRE-ACQ LEGACY CAPITAL COSTS PRE- ACQ PERIOD NON-CAPITAL NEW CAPITAL - BUILDING & FI) NEW CAPITAL - MOVABLE EQUIP NON-CAPITAL HOME OFFICE COST MALPRACTICE COSTS (SEE EXHIE CIG LEASED EQUIPMENT (SEE E) MANAGEMENT FEES 401K FEES AUDIT FEES CORPORATE OVERHEAD ALLOCATIO	- 2, 298, 916 26, 712 3, 902 418, 065 5 3, 464 5 20, 452 212, 499 ( 14, 210 4 94, 338 7 1, 361, 023 8 233, 263 ( 145, 827 0 0 0	CLAI MED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1 & 0 \\ 2 & 0 \\ 3 & 0 \\ 4 & 0 \\$
4. 18 4. 19 4. 20 4. 21 4. 22 4. 23 4. 24 4. 25 4. 26 4. 27 5. 00	0.00 0.00 5.02 5.02 5.02 5.02 5.01 5.01 5.02 2.00	OTHER ADMINISTRATIVE AND GEN OTHER ADMINISTRATIVE AND GEN OTHER ADMINISTRATIVE AND GEN OTHER ADMINISTRATIVE AND GEN OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES EBOS FEES PASI LIEN UNIT COLLECTION FE MALPRACTICE ALLOCATIONS (PEF	R 0	25, 550 0 371, 646 11, 685 70, 874 184, 572 258, 235 0 319, 321 3, 558, 381	4. 1 4. 2 4. 2 4. 2 4. 2 4. 2 4. 2 5. 0

\* 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 noi	been posted to worksheet A,	corumns ranu/or z, the amour	it allowable sh		or this part.			
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	3yiiib01 (1)	Name		Name				
			Ownership		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	0.00 COMMUNITY HEALTH SYSTEMS 100.00	6.00
7.00	С	0.00H0SPITAL LAUNDR 20.00	7.00
8.00	С	0.00 PASI 100.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 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
STATEME	INT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider	CCN: 150133	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 03/01/2015		
					To 02/29/2016	Date/Time Pre	
						7/27/2016 2:0	)6 pm
				Related Orga	nization(s) and/o	or Home Office	
				-			
	Symbol (1)	Name	Percentage of	1	lame	Percentage of	
			Ownershi p			Ownership	
	1.00	2.00	3.00	4	l. 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.

Health Financial Systems			KOSCI U	KOSCI USKO COMMUNI TY HOSPI TAL			In Lieu of Form CMS-2552-10			
STATEME OFFICE	INT OF COSTS OF COSTS	SERVI CES	FROM RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN: 150133	From 03/01/2015	Worksheet A Date/Time Pr 7/27/2016 2:	repared:
	Net	Wkst. A-7	Ref.						//2//2010 2.	

		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	2, 298, 916			1.00
2.00	26, 712			2.00
3.00	3, 902			3.00
4.00	418, 065			4.00
4.01	3, 464			4.01
4.02	20, 452	14		4.02
4.03	212, 499	0		4.03
4.04	14, 210	14		4.04
4.05	94, 338	14		4.05
4.06	1, 361, 023	0		4.06
4.07	233, 263	0		4.07
4.08	145, 827	0		4.08
4.09	-798, 387	0		4.09
4.10	-5, 271	0		4.10
4.11	-63, 468	0		4.11
4.12	-1, 449, 372	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	-25, 550	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	-371, 646	0		4.21
4.22	-11, 685	0		4. 22
4.23	-70, 874	0		4.23
4.24	-184, 572	0		4.24
4.25	-258, 235			4.25
4.26	36, 667			4.26
4.27	-10, 735	0		4.27
5.00	1, 619, 543			5.00
* The			, pscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines a	s

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 no	been posted to worksheet A,	cordinins r and/or 2, the amount arrowable should be rindicated in cordinin 4 or this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	51		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei iibui									
6.00	HOSPITAL MANAGEMENT	6.00							
7.00	LAUNDRY SERVICES	7.00							
8.00	DEBT COLLECTION	8.00							
9.00		9.00							
10.00		10.00							
100.00		100.00							

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

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

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

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

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

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

Heal th	Financial Syste	ems	KOSCIUSKO COMN	IUNI TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC				CCN: 150133	Peri od:	Worksheet A-8	
						From 03/01/2015 To 02/29/2016		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remunerati on	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5. 01	OTHER ADMINISTRATIVE AND GENERAL	10, 125	10, 125	(	0	0	1.00
2.00		ADULTS & PEDIATRICS	1, 292, 706	1, 292, 706	(	0 0	0	2.00
3.00	50.00	OPERATING ROOM	108, 650	108, 650	(	0 0	0	3.00
4.00	53.00	ANESTHESI OLOGY	771, 355	771, 355	(	0 0	0	4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 669	1, 669	(	0 0	0	5.00
6.00	54.02	ONCOLOGY	257, 637	257, 637	(	0 0	0	6.00
7.00	56.00	RADI OI SOTOPE	315	315	(	0 0	0	7.00
8.00	57.00	CT SCAN	8, 381	8, 381	(	0 0	0	8.00
9.00	58.00	MRI	19, 695	19, 695	(	0 0	0	9.00
10.00	0, 00		0	0	(	0	0	10.00
200.00			2, 470, 533	2, 470, 533	(		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		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	0	1.00
		GENERAL						
2.00	30.00	ADULTS & PEDIATRICS	0	0	(	0 0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	(	0 0	0	3.00
4.00	53.00	ANESTHESI OLOGY	0	0	(	0 0	0	4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(	0 0	0	5.00
6.00	54.02	ONCOLOGY	0	0	(	0 0	0	6.00
7.00	56.00	RADI OI SOTOPE	0	0	(	0 0	0	7.00
8.00	57.00	CT SCAN	0	0	(	0 0	0	8.00
9.00	58.00	MRI	l o	0	(	0	0	9.00
10.00	0.00		l o	0	(	0	0	10.00
200.00			0	0	(	0	0	
	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	5. 01	OTHER ADMINISTRATIVE AND	0	0	(	10, 125		1.00
		GENERAL				4 000 70/		
2.00		ADULTS & PEDIATRICS	0	0	(			2.00
3.00		OPERATING ROOM	0	0	(			3.00
4.00		ANESTHESI OLOGY	0	, v	(			4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	(	1,007		5.00
6.00		ONCOLOGY	0	0	(	2011001		6.00
7.00		RADI OI SOTOPE	0	0	(	010		7.00
8.00		CT SCAN	0	0	(	0,001		8.00
9.00	58.00		0	0	(	19, 695		9.00
10.00	0.00		0	0	(			10.00
200.00			0	0	(	2, 470, 533		200.00

		KOSCIUSKO COMMU		001 450400		u of Form CMS-2	2552-10
CUST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 03/01/2015 To 02/29/2016	Worksheet B Part I Date/Time Pre 7/27/2016 2:0	
			CAPI TAL REL	ATED COSTS		172772010 210	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 654, 160	5, 654, 160				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 709, 985	14 010	3, 709, 98			2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL	3, 369, 787 8, 815, 601	14, 212 265, 612	9, 32 174, 28		9, 506, 521	4.00 5.01
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL	3, 153, 589	427, 960	280, 80		4, 075, 945	•
7.00	00700 OPERATION OF PLANT	2, 177, 425	427, 900	200, 00		2, 958, 333	•
8.00	00800 LAUNDRY & LINEN SERVICE	308, 682	8, 818	5, 78		323, 286	•
9.00	00900 HOUSEKEEPI NG	810, 346	18, 607	12, 20		927, 899	9.00
10.00	01000 DI ETARY	339, 944	51, 118	33, 54	1 24, 167	448, 770	10.00
11.00	01100 CAFETERI A	517, 173	42, 946	28, 17	9 61, 444	649, 742	11.00
13.00	01300 NURSING ADMINISTRATION	1, 344, 202	11, 126	7,30		1, 542, 880	
14.00	01400 CENTRAL SERVICES & SUPPLY	508, 632	29, 542	19, 38			•
15.00	01500 PHARMACY	1, 272, 934	34, 289	22, 49			•
16.00	01600 MEDICAL RECORDS & LIBRARY	804, 479	40, 712	26, 71	3 79, 897	951, 801	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 146, 397	618, 145	405, 59	6 532, 533	5, 702, 671	30.00
30.00	03100 I NTENSI VE CARE UNI T	1, 342, 172	138, 171	403, 39 90, 66		1, 742, 795	•
43.00	04300 NURSERY	204, 215	13, 228	8, 67			•
101.00	ANCI LLARY SERVI CE COST CENTERS	2017210	10/ 220	0,0,	20,000	2017700	
50.00	05000 OPERATI NG ROOM	2, 473, 963	257, 279	168, 81	4 187, 539	3, 087, 595	50.00
51.00	05100 RECOVERY ROOM	785, 516	12, 125	7, 95	6 97, 792	903, 389	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	486, 717	50, 589	33, 19		632, 077	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 440, 627	191, 625	125, 73		3, 031, 183	•
54.01 54.02	05401 ULTRASOUND 05402 ONCOLOGY	1, 528, 870	0 173, 459	113, 81	0 0 5 109, 771	0 1, 925, 915	54.01 54.02
54.02 56.00	05600 RADI OI SOTOPE	362, 743	7, 510	4, 92		397, 330	
57.00	05700 CT SCAN	532, 372	37, 140	24, 37		633, 521	57.00
58.00	05800 MRI	321, 985	49, 266	32, 32		434, 516	
60.00	06000 LABORATORY	3, 163, 839	89, 581	58, 77			•
65.00	06500 RESPI RATORY THERAPY	578, 514	44, 430	29, 15	3 69, 553	721, 650	65.00
66.00	06600 PHYSI CAL THERAPY	1, 774, 239	133, 423	87, 54	6 88, 878	2, 084, 086	66.00
67.00	06700 OCCUPATI ONAL THERAPY	214, 023	0		0 3, 342	217, 365	•
68.00	06800 SPEECH PATHOLOGY	30, 975	1, 470	96		33, 409	•
69.00	06900 ELECTROCARDI OLOGY	85,034	735	48		97, 391	•
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	456, 209	0		0 0	456, 209	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 260, 272 5, 013, 304	0		0 0	2, 260, 272 5, 013, 304	
	03950 OTHER ANCI LLARY SERVICE COST CENTER	0,013,304	0		0 0	0,013,304	76.00
76.01	03610 SLEEP LAB	0	0		0 0	0	76.01
	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.03
	OUTPATIENT SERVICE COST CENTERS	·					1
90.00	09000 CLI NI C	603, 435	55, 968	36, 72	3 79, 509	775, 635	90.00
91.00	09100 EMERGENCY	2, 016, 135	196, 946	129, 22	.6 229, 806	2, 572, 113	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS		0.444.000	0.050.00		50.010.001	1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	63, 608, 495	3, 441, 890	2, 258, 39	3, 367, 780	59, 919, 094	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54, 156	9, 039	5, 93	4, 434	73 560	190.00
	19000 PHYSI CLANS' PRI VATE OFFICES	138, 586	9, 039 1, 889, 235	1, 239, 62		3, 267, 448	•
	19201 WELLNESS CENTER	0	173, 327	113, 72		287, 056	
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 MARKETI NG	522, 136	30, 732	20, 16	5 21, 110	594, 143	•
	07952 SENI OR CI RCLE	0	0		0 0		194.02
		1	100 007	72, 13	5 0	182, 072	
194. 02 194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	109, 937	72, 13	0		
194.02 194.03 194.05	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0	109, 937 0	72, 13	0 0	0	194.05
194. 02 194. 03 194. 05 200. 00	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	109, 937 0	72, 13	0 0	0 0	194. 05 200. 00
194.02 194.03 194.05	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0 0 64, 323, 373	0 0		0 0 0 0	0 0 0	194. 05 200. 00 201. 00

Heal th	Financial Systems	KOSCI USKO COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 03/01/2015 To 02/29/2016	Worksheet B Part I	pared:
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	Subtotal	OTHER ADMI NI STRATI V AND GENERAL	'E PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5A. 01	5.02	7.00	8.00	
4 00	GENERAL SERVICE COST CENTERS			1			1 0 0
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00							2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT	0 504 501					4.00
5.01 5.02	00540 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL	9, 506, 521 706, 863	4, 782, 808	4, 782, 80	0		5. 01 5. 02
5.02 7.00	00700 OPERATION OF PLANT	513,043	4, 782, 808				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	56, 065	379, 351			419, 274	8.00
9.00	00900 HOUSEKEEPING	160, 919	1, 088, 818			0	9.00
10.00	01000 DI ETARY	77, 827	526, 597			0	10.00
11.00	01100 CAFETERI A	112, 680	762, 422			0	11.00
13.00	01300 NURSING ADMINISTRATION	267, 571	1, 810, 451			0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	102, 940	696, 516			14, 511	14.00
15.00	01500 PHARMACY	252,000	1, 705, 095	146, 39	4 28, 592	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	165, 064	1, 116, 865	95, 89	33, 947	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	988, 993	6, 691, 664	574, 54	2 515, 438	94, 316	30.00
31.00	03100 I NTENSI VE CARE UNI T	302, 241	2, 045, 036			25, 393	31.00
43.00	04300 NURSERY	43, 695	295, 653	25, 38	4 11, 030	0	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	535, 460	3, 623, 055			92, 503	50.00
51.00	05100 RECOVERY ROOM	156, 668	1, 060, 057			0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	109, 617	741, 694	63, 68	42, 183	43, 531	52.00 53.00
53.00 54.00	05400 RADI OLOGY OLOGY	525, 677	3, 556, 860	305, 38	1 159, 786	41, 196	53.00
54.00	05400 RADIOLOGI DI AGNOSTI C	525, 077	3, 550, 800		0 0	41, 190	54.00
54.02	05402 ONCOLOGY	333, 998	2, 259, 913		0 0	4, 575	54.02
56.00	05600 RADI OI SOTOPE	68, 906	466, 236			0	56.00
57.00	05700 CT SCAN	109, 867	743, 388			0	57.00
58.00	05800 MRI	75, 355	509, 871			0	58.00
60.00	06000 LABORATORY	609, 211	4, 122, 073			0	60.00
65.00	06500 RESPI RATORY THERAPY	125, 151	846, 801	72, 70	4 37, 048	0	65.00
66.00	06600 PHYSI CAL THERAPY	361, 428	2, 445, 514	209, 96	4 111, 255	24, 744	66.00
67.00	06700 OCCUPATI ONAL THERAPY	37, 696	255, 061	21, 89	9 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	5, 794	39, 203	3, 36	6 1, 226	0	68.00
69.00	06900 ELECTROCARDI OLOGY	16, 890	114, 281	9, 81	2 613	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 117	535, 326			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	391, 983	2, 652, 255			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	869, 422	5, 882, 726			0	73.00
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTER	0	0		0 0	0	76.00
76.01	03610 SLEEP LAB	0	0		0 0 0 0	0	76.01 76.03
76.03	03951 OTHER ANCI LLARY SERVICE COST CENTER OUTPATI ENT SERVICE COST CENTERS	U	U	/	0 0	0	76.03
90, 00	09000 CLINIC	134, 513	910, 148	78, 14	3 46, 669	7, 255	90.00
91.00	09100 EMERGENCY	446, 064	3, 018, 177			50, 786	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	110,001	0,010,177		101,222	00,700	92.00
72.00	SPECIAL PURPOSE COST CENTERS			1			12.00
118.00		8, 742, 718	59, 155, 291	4, 668, 27	6 1, 924, 723	398, 810	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 757	86, 317	7, 41	1 7, 537	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	566, 651	3, 834, 099		0 1, 575, 334	0	192.00
	19201 WELLNESS CENTER	49, 782	336, 838	28, 92	0 144, 528	9, 903	192. 01
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	C		0 0		194.00
	07951 MARKETI NG	103, 038	697, 181	59, 85	8 25, 626		194.01
	07952 SENIOR CIRCLE	0	C		0 0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	31, 575	213, 647	18, 34	3 91, 670		194.03
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	10, 561	194.05
200.00			0			_	200.00
201.00	0		) בדכ ככב 64	4 702 00	0 2 740 410		201.00
202.00	)   TOTAL (sum lines 118-201)	9, 506, 521	64, 323, 373	4, 782, 80	3, 769, 418	417,274	202.00

031 A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 03/01/2015 To 02/29/2016	Worksheet B  Part I  Date/Time Pre	narod
						7/27/2016 2:0	)6 pm
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS				· · · · ·		
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 01	00540 OTHER ADMINISTRATIVE AND GENERAL						5.0
. 02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.0
. 00	00700 OPERATION OF PLANT						7.0
. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG	1, 197, 816					9.0
0. 00	01000 DI ETARY	24, 552	638, 985				10.0
1.00	01100 CAFETERI A	20, 627	0	884, 318	3		11. C
3.00	01300 NURSI NG ADMI NI STRATI ON	5, 344	0	47, 71			13.0
	01400 CENTRAL SERVICES & SUPPLY	14, 189	0	19, 679		829, 329	
5.00	01500 PHARMACY	16, 469	0	26, 309		21, 248	
5.00	01600 MEDI CAL RECORDS & LI BRARY	19, 554	0	36, 519		2, 330	
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	17, 334	0	50, 51	<u>/</u>	2, 330	1 10. (
0. 00	03000 ADULTS & PEDIATRICS	296, 890	346, 063	177, 638	684, 975	49, 351	30.
1.00	03100 I NTENSI VE CARE UNI T	66, 363	59, 890	49, 992		13, 723	
3. 00		6, 353	0	6, 551	1 33, 232	0	) 43.
	ANCI LLARY SERVI CE COST CENTERS	100 570	40.050	50.00	044,000	1.17.000	1 50
0.00	05000 OPERATI NG ROOM	123, 570	12, 352	52, 883		147, 308	
1.00	05100 RECOVERY ROOM	5, 824	0	27, 476		9, 682	
2.00	05200 DELIVERY ROOM & LABOR ROOM	24, 297	61, 043	15, 621	1 79, 203	0	
3.00	05300 ANESTHESI OLOGY	0	0	(	-	0	
1.00	05400 RADI OLOGY-DI AGNOSTI C	92, 037	0	96, 510	0 0	16, 742	2 54.0
4. 01	05401 ULTRASOUND	0	0	(	) 0	0	54.0
1. 02	05402 ONCOLOGY	83, 311	0	29, 147	7 141, 193	6, 246	54.0
5.00	05600 RADI OI SOTOPE	3, 607	0	5, 463	3 0	245	56.0
7.00	05700 CT SCAN	17, 838	0	12, 75	7 0	10, 005	57.0
3. 00	05800 MRI	23, 662	0	9, 521	0	519	58.0
D. 00	06000 LABORATORY	43, 025	0	87, 254		70, 099	60.0
5.00	06500 RESPI RATORY THERAPY	21, 340	0	25, 328		4, 661	
5.00	06600 PHYSI CAL THERAPY	64, 082	0	43, 707		5, 352	
7.00	06700 OCCUPATI ONAL THERAPY	01,002	0	2, 360		782	
. 00 3. 00	06800 SPEECH PATHOLOGY	706	0	2, 300		0	
9.00	06900 ELECTROCARDI OLOGY	353	0	5,066	5 14, 329	587	
. 00		0	0	5,000	14, 329		
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0			65, 094	
. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	l		340, 611	
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	
. 00	03950 OTHER ANCI LLARY SERVICE COST CENTER	0	0	(	0	0	
. 01	03610 SLEEP LAB	0	0	(	) 0	0	
. 03	03951 OTHER ANCI LLARY SERVICE COST CENTER	0	0	(	) 0	0	) 76.
	OUTPATIENT SERVICE COST CENTERS						4
. 00	09000 CLI NI C	26, 881	0	29, 173		16, 203	
. 00	09100 EMERGENCY	94, 592	0	67, 947	7 295, 588	39, 932	2 91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	SPECIAL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 095, 466	479, 348	874, 612	2 2, 028, 223	820, 720	118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 341	0	2, 466	0 د	3, 360	190.
2.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	o o	0	192.
	19201 WELLNESS CENTER	83, 248	0	(	0 0		192.
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	) ดี		194.
	07951 MARKETI NG	14, 761	0	7, 240	0	5, 249	
	07952 SENI OR CI RCLE	, , , , , , , , , , , , , , , , , , , ,	62, 680	7,240			194.
	07952 SENTOR CIRCLE 07953 OTHER NONREIMBURSABLE COST CENTERS						
		0	96, 957				194.
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0	0	) 194.
0.00							200.
1.00		0 1, 197, 816	0	(	0 (		201.
2.00	TOTAL (sum lines 118-201)		638, 985	884, 318	3 2, 028, 223	829, 329	1202

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider (	1	Period: From 03/01/2015 To 02/29/2016	Worksheet B Part I Date/Time Pre 7/27/2016 2:0	pared: 6 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	GENERAL SERVICE COST CENTERS	15.00	16.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.01 5.02 7.00 8.00 9.00	00200 CAP REL COSTS-MUBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00
10. 00 11. 00 13. 00 14. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						10.00 11.00 13.00 14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 944, 107 0	1, 305, 106				15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		1, 303, 100				10.00
30.00	03000 ADULTS & PEDIATRICS	0	109, 978	9, 540, 85		9, 540, 855	1
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	8, 204 3, 083	2, 780, 36 381, 28		2, 780, 361 381, 286	1
43.00	ANCI LLARY SERVICE COST CENTERS	U	3,003	301, 20	<u>0</u>	301, 200	43.00
50.00	05000 OPERATI NG ROOM	0	144, 212	4, 962, 70	1 0	4, 962, 701	50.00
	05100 RECOVERY ROOM	0	12, 971	1, 342, 91		1, 342, 919	
	05200 DELIVERY ROOM & LABOR ROOM	0	7, 347	1, 078, 59		1, 078, 599	•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	57, 505	4, 326, 01	0 0	0 4, 326, 017	53.00 54.00
	05401 ULTRASOUND	0	0,,005	4, 320, 01	0 0	4, 320, 017	54.00
	05402 ONCOLOGY	0	28, 766	2, 891, 81	8 0	2, 891, 818	54.02
56.00	05600 RADI OI SOTOPE	0	20, 644	542, 48		542, 488	•
	05700 CT SCAN	0	143, 953	1,022,73		1,022,735	•
58.00 60.00	05800 MRI 06000 LABORATORY	0	32, 549 147, 398	660, 97 4, 898, 45		660, 978 4, 898, 455	•
65.00	06500 RESPIRATORY THERAPY	0	43, 663	1, 141, 00		1, 141, 007	65.00
66.00	06600 PHYSI CAL THERAPY	0	18, 521	2, 923, 13		2, 923, 139	
67.00	06700 OCCUPATI ONAL THERAPY	0	3, 343	283, 44		283, 445	
68.00	06800 SPEECH PATHOLOGY	0	440	44, 94		44, 941	•
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 409 38, 784	152, 45 685, 16		152, 450 685, 165	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	40, 028	3, 260, 60		3, 260, 609	
	07300 DRUGS CHARGED TO PATIENTS	1, 944, 107	329, 291	8, 661, 19		8, 661, 197	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	
	03610 SLEEP LAB	0	0		0 0	0	
76.03	03951 OTHER ANCI LLARY SERVICE COST CENTER OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0	76.03
90 00	09000 CLINIC	0	13, 126	1, 229, 86	6 0	1, 229, 866	90.00
91.00	09100 EMERGENCY	0	93, 891	4, 084, 26		4, 084, 267	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 944, 107	1, 305, 106	56, 895, 29	8 0	56, 895, 298	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	111, 43	2 0	111, 432	190 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	5, 409, 43		5, 409, 433	
192.01	19201 WELLNESS CENTER	0	0	603, 43		603, 437	192.01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 MARKETI NG	0	0	809, 91		809, 915	
	07952 SENIOR CIRCLE 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	62, 68 420, 61		62, 680 420, 617	•
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	420, 81 10, 56			194.03
200.00			0		0 0		200.00
201.00		0	0		0 0	0	201.00
202.00		1, 944, 107			3 0	64, 323, 373	

	Financial Systems FION OF CAPITAL RELATED COSTS	KOSCI USKO COMMU		CCN: 150133	Period:	u of Form CMS-2 Worksheet B	2552-10
					From 03/01/2015 To 02/29/2016	Part II	pared: 6 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	0.00			
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL	0	14, 212 265, 612	9, 32 174, 28		23, 537	4.00 5.01
	00540 OTHER ADMINISTRATIVE AND GENERAL	0	427, 960	280, 80		1, 741 1, 481	5.01
	00700 OPERATION OF PLANT	0	425, 858	279, 42		524	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	8, 818	5, 78	36 14, 604	0	8.00
	00900 HOUSEKEEPI NG	0	18, 607	12, 20		601	9.00
	01000 DI ETARY 01100 CAFETERI A	0	51, 118	33, 54		168	
	01300 NURSING ADMINISTRATION	0	42, 946 11, 126	28, 17 7, 30		426 1, 250	
	01400 CENTRAL SERVICES & SUPPLY	0	29, 542	19, 38		250	
	01500 PHARMACY	0	34, 289	22, 49		855	1
	01600 MEDICAL RECORDS & LIBRARY	0	40, 712	26, 71		554	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-			-		
	03000 ADULTS & PEDIATRICS	0	618, 145			3, 703	30.00
	03100 INTENSIVE CARE UNIT	0	138, 171	90, 66		1, 191	31.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	13, 228	8, 67	21,907	179	43.00
	05000 OPERATI NG ROOM	0	257, 279	168, 81	4 426, 093	1, 300	50.00
	05100 RECOVERY ROOM	0	12, 125	7, 95		678	
	05200 DELIVERY ROOM & LABOR ROOM	0	50, 589	33, 19	83, 783	427	52.00
	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	191, 625	125, 73	35 317, 360	1, 894	54.00
	05401 ULTRASOUND 05402 ONCOLOGY	0	0 173, 459	113, 81	0 0 15 287, 274	0 761	54.01 54.02
	05600 RADI OI SOTOPE	0	7, 510	4, 92		154	
	05700 CT SCAN	0	37, 140	24, 37		275	
58.00	05800 MRI	0	49, 266	32, 32	26 81, 592	215	58.00
	06000 LABORATORY	0	89, 581	58, 77		1, 391	60.00
	06500 RESPI RATORY THERAPY	0	44, 430	29, 15		482	1
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	133, 423 0	87, 54	16 220, 969 0 0	616	
	06800 SPEECH PATHOLOGY	0	1, 470	96	-	23 0	68.00
	06900 ELECTROCARDI OLOGY	0	735	48		77	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	
	03610 SLEEP LAB 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/0.03
+	09000 CLINIC	0	55, 968	36, 72	92, 691	551	90.00
	09100 EMERGENCY	0	196, 946			1, 593	
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
ł	SPECIAL PURPOSE COST CENTERS		0 444 000	0.050.00		00.0(0	1110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	3, 441, 890	2, 258, 39	98 5, 700, 288	23, 360	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 039	5, 93	14, 970	31	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 889, 235				192.00
192.01	19201 WELLNESS CENTER	0	173, 327	113, 72		0	192.01
101 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 MARKETI NG	0	30, 732	20, 16	55 50, 897		194.01
194.01				1	0 0	, 0'	194.02
194. 01 194. 02	07952 SENI OR CI RCLE	0	100.007	70 44	100 070		104 00
194. 01 194. 02 194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0 109, 937 0	72, 13	35 182, 072	0	194.03
194. 01 194. 02 194. 03 194. 05	07953 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0 109, 937 0	72, 13	35 182, 072 0 0 0	0	194.05
194. 01 194. 02 194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0 109, 937 0 0	72, 13	35 182, 072 0 0 0 0 0 0	0 0	

	Cost Center Description			1	0 02/29/2016	Date/Time Pre 7/27/2016 2:0	
		OTHER ADMI NI STRATI VE AND GENERAL	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.01	5.02	7.00	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS						1 4 00
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
	00540 OTHER ADMINISTRATIVE AND GENERAL	441, 635					5. 01
	00560 OTHER ADMINISTRATIVE AND GENERAL	32, 840					5.01
	00700 OPERATI ON OF PLANT	23, 835					7.00
	00800 LAUNDRY & LINEN SERVICE	2,605					8.00
	00900 HOUSEKEEPI NG	7, 476				56, 611	1
	01000 DI ETARY	3, 616			0	1, 160	1
11.00	01100 CAFETERI A	5, 235	10, 170	7, 372	0	975	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	12, 431	24, 150	1, 910	0	253	13.00
	01400 CENTRAL SERVICES & SUPPLY	4, 782	9, 291	5, 071	823	671	14.00
	01500 PHARMACY	11, 708				778	
	01600 MEDICAL RECORDS & LIBRARY	7,669	14, 898	6, 988	0	924	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	45.004	00.000	40/ 405	5 0 4 0	11.001	
	03000 ADULTS & PEDIATRICS	45, 921	89, 280			14, 034	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	14, 042 2, 030			1, 440 0	3, 136 300	
	ANCI LLARY SERVI CE COST CENTERS	2,030	3, 944	2,271	U	300	43.00
	05000 OPERATI NG ROOM	24, 877	48, 328	44, 162	5, 247	5, 840	50.00
	05100 RECOVERY ROOM	7, 279				275	1
	05200 DELIVERY ROOM & LABOR ROOM	5,093			2, 469	1, 148	
	05300 ANESTHESI OLOGY	0,0,0			2, 107	0	1
	05400 RADI OLOGY-DI AGNOSTI C	24, 422	47, 445	32, 893	2, 337	4, 350	1
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
54.02	05402 ONCOLOGY	15, 517	30, 145	29, 774	260	3, 937	54.02
	05600 RADI OI SOTOPE	3, 201	6, 219	1, 289	0	170	56.00
	05700 CT SCAN	5, 104	9, 916	6, 375	0	843	57.00
	05800 MRI	3, 501				1, 118	
	06000 LABORATORY	28, 303			0	2, 033	
	06500 RESPI RATORY THERAPY	5,814				1,009	
	06600 PHYSI CAL THERAPY	16, 791	32, 621	22, 902		3, 029	
	06700 OCCUPATIONAL THERAPY	1, 751			-	0	1
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	269 785			0	33	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 676		0		0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 211			0	0	
	07300 DRUGS CHARGED TO PATIENTS	40, 392			0	0	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0			o	0	
	03610 SLEEP LAB	0	0	0	0	0	76.01
	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	6, 249					
	09100 EMERGENCY	20, 724	40, 259	33, 806	2, 881	4, 471	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		<u> </u>				92.00
H	SPECIAL PURPOSE COST CENTERS	1					4
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	406, 149	725, 293	396, 212	22, 622	51, 774	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	593		1, 552	0	205	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	26, 326				-	192.00
	19201 WELLNESS CENTER	2, 313					192.01
	07950 OTHER NONREI MBURSABLE COST CENTERS	0		0			194.00
	07951 MARKETI NG	4, 787	9, 300	5, 275	0		194.01
	07952 SENI OR CI RCLE	0	0	0	0		194.02
	07953 OTHER NONREI MBURSABLE COST CENTERS	1, 467	2, 850		0		194.03
	07955 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	599	0	194.05
200. 00 201. 00			_	_			200.00
	Negative Cost Centers TOTAL (sum lines 118-201)	441, 635	743, 087	0 775, 949	-		

ALLOC	ATION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 03/01/2015 o 02/29/2016	Worksheet B Part II Date/Time Pre 7/27/2016 2:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5.02
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						7.00
8.00 9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	105, 401					10.00
11.00	01100 CAFETERIA	105, 401	95, 303				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	5, 142				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 121		71, 935		14.00
15.00	01500 PHARMACY	0	2, 835			103, 437	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	3, 936			0	
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS		0,700	<u> </u>	202		
30.00	03000 ADULTS & PEDI ATRI CS	57,084	19, 144	21, 468	4, 281	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	9, 879	5, 388		1, 190	0	
43.00	04300 NURSERY	0	706		0	0	1
	ANCI LLARY SERVICE COST CENTERS	1 1					
50.00	05000 OPERATI NG ROOM	2,037	5, 699	7, 559	12, 777	0	50.00
51.00	05100 RECOVERY ROOM	0	2, 961	3, 942	840	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 069	1, 683	2, 482	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	10, 401	0	1, 452	0	54.00
54.01	05401 ULTRASOUND	0	C	0	0	0	54.01
54.02	05402 ONCOLOGY	0	3, 141	4, 425	542	0	54.02
56.00	05600 RADI OI SOTOPE	0	589		21	0	56.00
57.00	05700 CT SCAN	0	1, 375	0		0	
58.00	05800 MRI	0	1, 026		45	0	
60.00	06000 LABORATORY	0	9, 403		6, 080	0	
65.00	06500 RESPI RATORY THERAPY	0	2, 730		404	0	
66.00	06600 PHYSI CAL THERAPY	0	4, 710		464	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	254		68	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	
69.00	06900 ELECTROCARDI OLOGY	0	546			0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0			0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	29, 546	102 427	
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0	103, 437	
76.00	03930 OTHER ANGIELARY SERVICE COST CENTER	0	0			0	1
76.03	03951 OTHER ANCI LLARY SERVICE COST CENTER	0	0		0	0	1
70.05	OUTPATIENT SERVICE COST CENTERS	<u>Ч</u>	0	1 U	9	0	70.03
90.00	09000 CLINIC	0	3, 144	3, 205	1, 405	0	90.00
91.00	09100 EMERGENCY	0	7, 323			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 525	7,203	5, 404	0	92.00
, 2, 00	SPECIAL PURPOSE COST CENTERS	I					12.00
118.00		79,069	94, 257	63, 562	71, 189	103, 437	1118.00
	NONREI MBURSABLE COST CENTERS		,		,	,	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	266	0	291	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C				192.00
192. 0 <sup>-</sup>	19201 WELLNESS CENTER	0	C	0	0	0	192.01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194.00
194.0	07951 MARKETI NG	0	780	0	455		194.01
	07952 SENIOR CIRCLE	10, 339	0		0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	15, 993	C	0	0	0	194.03
10/ 0	07955 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0	0	194.05
174.0		1		1			200.00
200. 00	Cross Foot Adjustments				I		
	Negative Cost Centers	0 105, 401	0 95, 303	-	0 71, 935	0 103, 437	201.00

Cost Center Description           NERAL SERVICE COST CENTERS           1100         CAP REL COSTS-BLDG & FIXT           1200         CAP REL COSTS-BLDG & FIXT           1200         CAP REL COSTS-MVBLE EQUIP           1400         EMPLOYEE BENEFITS DEPARTMENT           1540         OTHER ADMINISTRATIVE AND GENERAL           1560         OTHER ADMINISTRATIVE AND GENERAL           1600         LAUNDRY & LINEN SERVICE           1900         HOUSEKEEPING           100         CAFETERIA           300         NURSING ADMINISTRATION           400         CENTRAL SERVICES & SUPPLY           500         PHARMACY           600         MEDICAL RECORDS & LIBRARY           PATI ENT ROUTINE SERVICE COST CENTERS	MEDI CAL RECORDS & LI BRARY 16.00	Subtotal 24.00	Intern & Residents Cos & Post Stepdown Adjustments 25.00	To 02/29/2016 t Total 26.00	Date/Time Prepare 7/27/2016 2:06 pm 1. 2. 4. 5. 5. 7. 8.
NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP 1400 EMPLOYEE BENEFITS DEPARTMENT 1540 OTHER ADMINISTRATIVE AND GENERAL 1560 OTHER ADMINISTRATIVE AND GENERAL 1560 OPERATION OF PLANT 1600 LAUNDRY & LINEN SERVICE 1900 HOUSEKEEPING 100 CAFETERIA 100 CAFETERIA	RECORDS & LI BRARY		Residents Cos & Post Stepdown Adjustments	t	2. 4. 5. 5. 7.
PI100       CAP       REL       COSTS-BLDG & FIXT         P200       CAP       REL       COSTS-MVBLE       EQUI P         P400       EMPLOYEE       BENEFITS       DEPARTMENT         P540       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P060       DERATI ON       OF       PLANT         P0700       DPERATI ON       OF       PLANT         P0800       LAUNDRY & LINEN       SERVICE       PO00         P000       HOUSEKEEPI NG       OOD       DI ETARY         1000       CAFETERI A       300       NURSI NG ADMI NI STRATI ON         4000       CENTRAL       SERVI CES & SUPPLY       SO0         500       PHARMACY       GO0       MEDI CAL       RECORDS & LI BRARY         600       MEDI CAL       RECORDS & LI BRARY       PATI ENT       ROUTI NE       SERVI CE       COST CENTERS		24.00	1	26.00	2. 4. 5. 5. 7.
PI100       CAP       REL       COSTS-BLDG & FIXT         P200       CAP       REL       COSTS-MVBLE       EQUI P         P400       EMPLOYEE       BENEFITS       DEPARTMENT         P540       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P560       OTHER       ADMI NI STRATI VE       AND GENERAL         P060       DERATI ON       OF       PLANT         P0700       DPERATI ON       OF       PLANT         P0800       LAUNDRY & LINEN       SERVICE       PO00         P000       HOUSEKEEPI NG       OOD       DI ETARY         1000       CAFETERI A       300       NURSI NG ADMI NI STRATI ON         4000       CENTRAL       SERVI CES & SUPPLY       SO0         500       PHARMACY       GO0       MEDI CAL       RECORDS & LI BRARY         600       MEDI CAL       RECORDS & LI BRARY       PATI ENT       ROUTI NE       SERVI CE       COST CENTERS	102, 596				2. 4. 5. 5. 7.
2200       CAP REL COSTS-MVBLE EQUIP         1400       EMPLOYEE BENEFITS DEPARTMENT         1540       OTHER ADMINISTRATIVE AND GENERAL         15560       OTHER ADMINISTRATIVE AND GENERAL         1560       OTHER ADMINISTRATIVE AND GENERAL         1700       OPERATION OF PLANT         1800       LAUNDRY & LINEN SERVICE         1900       HOUSEKEEPING         100       CAFETERIA         300       NURSING ADMINISTRATION         400       CENTRAL SERVICES & SUPPLY         500       PHARMACY         600       MEDICAL RECORDS & LIBRARY         PATIENT ROUTINE SERVICE COST CENTERS	102, 596				2. 4. 5. 5. 7.
0700       OPERATI ON OF PLANT         1800       LAUNDRY & LINEN SERVICE         1900       HOUSEKEEPING         000       DI ETARY         100       CAFETERIA         300       NURSING ADMINISTRATION         400       CENTRAL SERVICES & SUPPLY         500       PHARMACY         600       MEDICAL RECORDS & LIBRARY	102, 596				7.
100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY PATI ENT ROUTI NE SERVI CE COST CENTERS	102, 596				9.
500 PHARMACY 600 MEDICAL RECORDS & LIBRARY PATIENT ROUTINE SERVICE COST CENTERS	102, 596				10. 11. 13. 14.
PATIENT ROUTINE SERVICE COST CENTERS	102, 596				15.
			I		16.
000 ADULTS & PEDIATRICS	8, 666	1, 398, 776		0 1, 398, 776	30.
100 I NTENSI VE CARE UNI T 300 NURSERY	646 243			0 323, 664	31. 43.
	11 242	EOE 292	1		F0
					50. 51.
200 DELIVERY ROOM & LABOR ROOM	579	126, 310			52.
300 ANESTHESI OLOGY	0	0		-	53.
	4, 531	447,085			54.
	2, 267	378,043		-	54.
6600 RADI OI SOTOPE	1,627	25, 708			56.
700 CT SCAN	11, 343	97, 609			57.
					58. 60.
					65.
600 PHYSI CAL THERAPY	1, 459	304, 965			66.
700 OCCUPATI ONAL THERAPY	263	5, 761			67.
800 SPEECH PATHOLOGY	35	3, 546			68.
					69. 71.
					72.
300 DRUGS CHARGED TO PATIENTS	25, 707	248, 006			73.
	0	0			76.
	0	0			76. 76.
	0	0	<u> </u>	0 0	70.
000 CLINIC	1,034	131, 708		0 131, 708	90.
	7, 398	457, 354			91.
				0	92.
SUBTOTALS (SUM OF LINES 1-117)	102, 596	5, 232, 972	(	0 5, 232, 972	118.
	0	19, 059		0 19,059	190.
200 PHYSICIANS' PRIVATE OFFICES	0				192.
201 WELLNESS CENTER	0	328, 110			192.
	0	0			194.
	0				194. 194.
953 OTHER NONREI MBURSABLE COST CENTERS	0				194.
955 OTHER NONREI MBURSABLE COST CENTERS	0				194.
Cross Foot Adjustments		0			200.
		0 261 145			201. 202.
	100       INTENSI VE CARE UNIT         300       NURSERY         CILLARY SERVICE COST CENTERS         000       OPERATI NG ROOM         100       RECOVERY ROOM         200       DELIVERY ROOM & LABOR ROOM         300       ANESTHESI OLOGY         400       RADI OLOGY-DI AGNOSTI C         401       ULTRASOUND         402       ONCOLOGY         600       RADI OLOGY-DI AGNOSTI C         401       ULTRASOUND         402       ONCOLOGY         600       RADI OL SOTOPE         700       CT SCAN         800       MRI         000       LABORATORY         500       RESPI RATORY THERAPY         600       PHYSI CAL THERAPY         700       OCCUPATI ONAL THERAPY         800       SPEECH PATHOLOGY         900       ELECTROCARDI OLOGY         900       ELECTROCARDI OLOGY         900       ILECTROCARDI OLOGY         900	100         INTENSIVE CARE UNIT         646           300         NURSERY         243           CILLARY SERVICE COST CENTERS         243           000         OPERATING ROOM         11,363           100         RECOVERY ROOM         1,022           200         DELIVERY ROOM & LABOR ROOM         579           300         ANESTHESIOLOGY         0           400         RADIOLOGY-DI AGNOSTIC         4,531           401         ULTRASOUND         0           402         ONCOLOGY         2,267           600         RADIOLOGY-DI AGNOSTIC         4,531           401         ULTRASOUND         0           402         ONCOLOGY         2,267           600         RADIO ISOTOPE         1,627           700         CT SCAN         11,343           800         MRI         2,565           000         LABORATORY         11,614           500         LABORATORY         1,459           700         OCCUPATIONAL THERAPY         263           800         SPEECH PATHOLOGY         35           900         ELECTROCARDIOLOGY         584           100         MEDI CAL SUPPLIES CHARGED TO PATIENTS	100         I NTENSI VE CARE UNI T         646         323, 664           300         NURSERY         243         32, 621           000         OPERATI NG ROOM         11, 363         595, 282           100         RECOVERY ROOM         1, 022         53, 299           000         DELIVERY ROOM & LABOR ROOM         579         126, 310           300         ANESTHESI OLOGY         0         0           400         RADI OLOGY-DI AGNOSTI C         4, 531         447, 085           401         ULTRASOUND         0         0         0           402         ONCOLOGY         2, 267         378, 043         600           400         RADI OL SOTOPE         1, 627         25, 708         900           700         CT SCAN         11, 343         97, 609         900         NRI         2, 265         105, 319           000         LABORATORY         11, 614         277, 545         500         RESPI RATORY THERAPY         3, 440         109, 187           000         CAL THERAPY         2, 63         5, 761         300         SUCCARTI ONAL THERAPY         263         5, 761           100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         3, 056         19, 519<	100         INTENSI VE CARE UNI T         646         323, 664           300         NURSERY         243         32, 621           000         OPERATI NG ROOM         11, 363         595, 282           100         RECOVERY ROOM         1, 363         595, 282           100         RECOVERY ROOM & LABOR ROOM         579         126, 310           300         ANESTHESI OLOGY         0         0         0           401         ULTRASOUND         0         0         0         0           402         UNCLOGY         2, 267         378, 043         0         0           700         CT SCAN         11, 343         97, 609         0 </td <td>100   INTENSI VE CARE UNI T         646         323, 664         0         323, 664           300  NURSERY         243         32, 621         0         32, 664           000   OPERATI NG ROOM         11, 363         595, 282         0         595, 282           000   OPERATI NG ROOM         10, 22         53, 299         0         53, 299           200   DELI VERY ROOM &amp; LABOR ROOM         579         126, 310         0         126, 310           300 ANESTHESI OLOGY - DI AGNOSTI C         4, 531         447, 085         0         447, 085           401   ULTRASOUND         0         0         0         0         0         0           300 ARDI OLOGY - DI AGNOSTI C         2, 267         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         375, 055         306, 976, 509         0         976, 509         0         775, 545         0         50, 5761</td>	100   INTENSI VE CARE UNI T         646         323, 664         0         323, 664           300  NURSERY         243         32, 621         0         32, 664           000   OPERATI NG ROOM         11, 363         595, 282         0         595, 282           000   OPERATI NG ROOM         10, 22         53, 299         0         53, 299           200   DELI VERY ROOM & LABOR ROOM         579         126, 310         0         126, 310           300 ANESTHESI OLOGY - DI AGNOSTI C         4, 531         447, 085         0         447, 085           401   ULTRASOUND         0         0         0         0         0         0           300 ARDI OLOGY - DI AGNOSTI C         2, 267         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         378, 043         0         375, 055         306, 976, 509         0         976, 509         0         775, 545         0         50, 5761

	Financial Systems I LLOCATION - STATISTICAL BASIS	KOSCIUSKO COMMU		CCN: 150133 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
A				F	rom 03/01/2015 o 02/29/2016		
				,	0 02/29/2016	7/27/2016 2:0	pareu: 16 pm
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	OTHER	
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS		ADMI NI STRATI VE	
				DEPARTMENT (GROSS		AND GENERAL (ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS	204 704					1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	384, 704	384, 704				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	967			3		4.00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	18, 072	18, 072	1, 683, 284	-9, 506, 521	54, 816, 852	5.0
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	29, 118				4, 075, 945	
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	28, 975 600			0	2, 958, 333 323, 286	
9.00 9.00	00900 HOUSEKEEPING	1, 266			0	927, 899	
10.00	01000 DI ETARY	3, 478				448, 770	
11.00	01100 CAFETERI A	2, 922				649, 742	
	01300 NURSI NG ADMI NI STRATI ON	757				1, 542, 880	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 010 2, 333				593, 576 1, 453, 095	
	01600 MEDICAL RECORDS & LIBRARY	2, 333				951, 801	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	42, 058				5, 702, 671	
	03100 I NTENSI VE CARE UNI T	9, 401				1, 742, 795	
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	900	900	173, 247	0	251, 958	43.00
50.00	05000 OPERATING ROOM	17, 505	17, 505	1, 257, 561	0	3, 087, 595	50.00
51.00	05100 RECOVERY ROOM	825	825			903, 389	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 442	3, 442	412, 908		632, 077	52.00
53.00	05300 ANESTHESI OLOGY	0	12.020		0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	13, 038	13, 038	1, 831, 943		3, 031, 183 0	54.00 54.0
54.02	05402 ONCOLOGY	11, 802	11, 802	736, 081		1, 925, 915	
56.00	05600 RADI OI SOTOPE	511				397, 330	
57.00	05700 CT_SCAN	2, 527				633, 521	
58.00	05800 MRI 06000 LABORATORY	3, 352				434, 516	
50.00 55.00	06500 RESPI RATORY THERAPY	6, 095 3, 023				3, 512, 862 721, 650	
56.00	06600 PHYSI CAL THERAPY	9,078				2, 084, 086	
57.00	06700 OCCUPATI ONAL THERAPY	0	C	22, 407	0	217, 365	67.0
	06800 SPEECH PATHOLOGY	100			0	33, 409	
59.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	50 0				97, 391 456, 209	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0				2, 260, 272	
73.00	07300 DRUGS CHARGED TO PATIENTS	0					
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0 0	0 0	0	
	03610 SLEEP LAB	0	0		0	0	
76. 03	03951 OTHER ANCI LLARY SERVICE COST CENTER OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	η (	0 0	0	76.0
90.00	09000 CLINIC	3, 808	3, 808	533, 153	3 0	775, 635	90.00
	09100 EMERGENCY	13, 400				2, 572, 113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	224 102	224 103	22 592 041	0 504 521	E0 412 E72	1110 00
	NONREI MBURSABLE COST CENTERS	234, 183	234, 183	22, 583, 041	-9, 506, 521	50, 412, 573	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	29, 735	5 0	73, 560	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	128, 542	128, 542	c c	0 0	3, 267, 448	192.00
	19201 WELLNESS CENTER	11, 793	11, 793		0	287, 056	
	07950 OTHER NONREI MBURSABLE COST CENTERS 07951 MARKETI NG	0 2, 091	2, 091			0 594, 143	194.0
	07952 SENIOR CIRCLE	2,091	2,091	141, 557 0			194.0
	07953 OTHER NONREIMBURSABLE COST CENTERS	7, 480	7, 480		0	182, 072	
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	( C	0 0	0 0	0	194. 0
200.00							200.0
201.00 202.00		5, 654, 160	3, 709, 985	3, 393, 324		9, 506, 521	201.00
202.00	Part I)	5,054,100	3, 709, 985	3, 373, 324	r	7, 300, 321	202.0
203.00		14. 697430	9. 643739	0. 149129		0. 173423	203.00
204.00	Cost to be allocated (per Wkst. B,			23, 537	7	441, 635	204.00
	Part II) Unit cost multiplier (Wkst. B, Part			0. 001034		0. 008057	205 0
205.00							

COST ALLIGENTION - STRUISTICAL BASIS         Provider COX: 15/13         Provider	Health Financial Systems	KOSCI USKO COMMI	JNI TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description         Second II at its and Other A AUC CERNARY A AUC CERNARY A COSUME FEET)         LANDRY A INFORMATION INFORMATION (SOUME FEET)         LANDRY A INFORMATION (SOUME FEET)         LANDRY A INFORMATION (SOUME FEET)           1:00 000002 (AP ALL COST CENTERS 0:000000 (AP ALL COST CENTERS 0:0000000 (AP ALL COST CENTERS 0:00000000 (AP ALL COST CENTERS 0:0000000 (AP ALL COST CENTERS 0:00000000 (AP ALL COST CENTERS 0:000000000 (AP ALL COST CENTERS 0:000000000 (AP ALL COST CENTERS 0:000000000 (AP ALL COST CENTERS 0:000000000 (AP ALL COST CENTERS 0:0000000000 (AP ALL COST CENTERS 0:0000000000000000 (AP ALL COST CENTERS 0:00000000000000000000000000000000000			Provi der		eri od:		
Cost Centor: Description         Record H at low         OPEE NUM         CENTON Graphic LINERS (CENTON GRAPH CONSTRUCTION GRAPH CONST							
AND CREAKING         (CREAM CASE         (CREAM CASE <th(cream case<="" th=""> <th(cream case<="" th=""></th(cream></th(cream>	Cost Center Description	Reconciliation			LAUNDRY &	HOUSEKEEPI NG	
Exercise         54.02         7.00         8.00         9.00           1.00         50100 CAP R6L 005T - ALIC # ETT         0         0.00						(SQUARE FEET)	
Description         Description         Description         Description         Description           1.00         OUTOD CAP HILL COST CONTERS         FILL AND FILL COST CONTERS         FILL AND FILL COST CONTERS         FILL AND FILL COST CONTERS           2.00         DOSC OUTER ADM INTERATIVE AND CENERAL         -4, 782, 208         55, 706, 466         53, 617         5, 02           5.02         DOSC OUTER ADM INTERATIVE AND CENERAL         -4, 782, 208         55, 706, 466         7, 00         5, 02         00, 0000 CONTER ADM INTERATIVE AND CENERAL         -4, 782, 208         55, 706, 466         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 00         7, 77, 7, 0         7, 77, 1         7, 77, 77, 1         7, 77, 77, 1         7, 77, 77, 1         7, 77, 77, 77, 1<				(SQUARE TEET)			
1.00         00100         CAP RIL COSTS-MIRG & FIXT         1         1         1         0         2.00         00200         CAP RIL COSTS-MIRG & FIXT         1         0         2.00         4.00         00100         CAP RIL COSTS-MIRG & FIXT         1         0         2.00         4.00         00100         CAP RIL COSTS-MIRG & FIXT         0         2.00         0.00         00100         CAP RIL COSTS-MIRG & FIXT         0         2.00         0.00         00100         CAP RIL COSTS-MIRG & FIXT         0         3.471,376         300.7572         7.00         0.00         00000         HORD RAW IN STATT ON         0         1.008,818         1.266         0.00         2.9771         1.00<		5A. 02	5.02	7.00	8.00	9.00	
2.00         DOOD CORP FIEL CONSTS-MURLE EQUIP         2.00         A00         DOOD CAP FIEL CONSTS-MURLE EQUIP         4.00           5.01         DOOD CAP FIEL CONSTS-MURLE EQUIP         -4.782,803         55.70,446         57.70,446           5.01         DOOD CALMERY ALLINEN STRATUO         GLADARDY         -4.782,803         S0.7572         7.00           8.00         DOOD CLAMERY ALLINEN SERVICE         0         3.771,351         600         S22,612         8.00           9.00         DOOD CONSECRED IN OF PLANT MO         CENERAL         -4.782,803         S0.757,22         2.02         2.02,211         0.00           10.00         DITCOLLINERY ALLINEN SERVICE         0         1.767,605         2.333         0         2.222,11         0.00         2.222,11         0.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         1.00         2.333         0         2.333         1.00         2.333         0         2.333         1.00         2.333         1.00         2.333         0         2.333         0         3.333         0         3.777			1	1			1 1 00
5.01         00540         OTHER ADM INSTRATIVE AND CEMERAL.         -4, 782, 808         55, 706, 466         5, 707, 702         5, 707, 702         7, 00           00         00000         OPERATION OF FLANT         4, 782, 808         55, 706, 466         7, 00         60, 77, 702         60, 77, 702         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 77, 703         60, 72, 773         60, 72, 773         60, 72, 773         60, 72, 773         60, 72, 773         60, 72, 773         7, 703         7, 703         7, 775         7, 775         7, 775         7, 775         7, 775         7, 775         7, 775 <td>2.00 00200 CAP REL COSTS-MVBLE EQUIP</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>	2.00 00200 CAP REL COSTS-MVBLE EQUIP						1
5.02         00560[0THR ADM HISTRATUF ADD CENERAL         -4, 722, 208         55, 706, 468         -7, 702         7, 00           8.00         00800 LAUROFY & LINEN SERVICE         0         3, 77, 371         600         522, 012         7, 00           8.00         00800 LAUROFY & LINEN SERVICE         0         3, 77, 371         600         7, 00         7, 00           8.00         00800 LAUROFY & LINEN SERVICE         0         7, 00         7, 00         22, 721         1, 00           10.00         01300 URST KFPH MA         0         7, 00         2, 7, 00         2, 7, 70         2, 7, 70         1, 7, 00           11.00         01400 CENTRAL SERVICES & SUPLY         0         6, 66, 51, 62, 010         1, 10, 10, 10, 11, 7, 00         2, 7, 70         0         2, 7, 70         6, 30, 00         2, 7, 70         0         2, 7, 70         0         2, 7, 70         6, 30, 00         3, 00         3, 00         3, 00         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70         0         2, 7, 70							1
7.00         00700         DEPENTING FUNCTION         0         3, 471, 376         307, 571         007, 500         552, 512         8.0           9.00         000001         00		_1 782 808	55 706 466				1
9.00         00000         HOUSEREEPING         0         1.088.818         1.266         0         16.06         <							1
10.00         010000         010000         010000		C			532, 612		
11.00       01100       CAHETERIA       0       762,422       2,922       0       2,922       11.00         13.00       01300       MESING AMINISTRATION       0       1,810,451       757       0       777       13.00         14.00       01400       CENTRAL SERVICES & LIBRARY       0       1,765,065       2,010       18,433       2,010       14.00         15.01       01500       MARCILL RECORDS & LIBRARY       0       1,716,065       2,770       0       2,770       1.00         16.01       DISCOL FUNCL       COST CENTES       0       0.601       42,058       119,812       42,058       10.00         30.00       DISCOL FRATI RE COST CENTES       0       2,670       17.505       10.00       10.00       17.505       110.00       10.00       17.505       110.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00		0					1
13.00         01300         NURSI NG ZMMIN STRATION         0         1.910, 491         777         0         777         0         777         1.00           15.00         01500         PHARAL SERVICE SA SUPPLY         0         640, 510         2, 733         0         2, 333         15.00           15.00         01500         PHARTEENT ROUTLE SERVICE COST CENTERS         0         2, 770         0         2, 770         16.00           10.00         01500         PHARTEENT ROUTLE SERVICE COST CENTERS         0         6, 611, 644         42, 051         19, 612         42, 668         10, 012, 013, 014         013, 014, 014, 014, 014, 014, 014, 014, 014					5		
15:00         01500 PMARMACY         0         1.705,095         2.333         0         2.333         15.00           MART ENT ROUTINE SERVICE COST CENTERS		C			0		
16. 00         01000 HEDI CLA, RECORDS & LIBRARY         0         1.15, 865         2, 770         0         2, 770         16, 00           30. 00         03000 ADULTS & PEDI ATELCS         0         6, 6, 071, 644         42, 085         119, 812         42, 085         31, 00           43. 00         03000 HIRESNY CAURAY SERVICE COST CENTERS         0         2, 045, 036         9, 000         0         9, 001           50. 00         05000 OPERATING ROOM         0         3, 622, 055         117, 505         117, 508         17, 505         51, 00           50. 00         05000 OPERATING ROOM         0         3, 623, 055         117, 508         17, 508         17, 505         50, 00         52, 00         3, 85         0         0, 0         2, 85         0         53, 00         53, 00         53, 00         53, 00         53, 00         53, 00         54, 00         0, 0         5, 812         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80         54, 232         11, 80, 352         56, 00         0, 00         11, 83, 352         86, 00<		0					
INPART FERT ROUTINE SERVICE COST CENTERS         Impact of the service Cost Centers           0.00         03000 INUES & PENDARRICS         0         0.40 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>		-					
11.00       03100   INTENSIVE CARE UNIT       0       2, 245, 036       9, 401       32, 257       9, 401       31, 00         ANDILLARY SERVICE COST CENTERS       0       295, 653       900       0       900       17, 505       50, 00         0.00       05000 PERATING ROM       0       3, 622, 055       17, 505       17, 505       50, 00       17, 505       50, 00       17, 505       50, 00       17, 505       50, 00       17, 505       50, 00       120, 00       220, 05, 00       10, 00       10, 00       10, 00       10, 00       10, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       120, 00       110, 0			1, 110, 003	2,770	0	2,110	10.00
43. 00         04300 NURSERY         0         295, 653         900         0         900         43. 00           AMCLLARY SERVIC COST CENTERS         0         3. 623, 055         17. 505         177. 505         50. 00         5000 OPERATI NG. ROOM         0         1, 0660, 057         825         0         825, 51. 00         50. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         54. 00         0         0         0         0         54. 00         54. 00         0         0         0         0         0         0         0         54. 00         0. 0         0							
ANCILLARY SERVICE COST CENTERS         Image: Control of the contrel of the control of the con							
50. 00         65000 OPERATING ROOM         0         3, 623, 055         17, 505         117, 506         117, 506         17, 505         50. 00           51. 00         05000 DELUTERY ROOM         0         1, 060, 057         825         0         835         51. 00           52. 00         05300 DELUTERY ROOM         LABOR ROOM         0         14. 00         0 <t< td=""><td></td><td>(</td><td>295,055</td><td>900</td><td>0</td><td>900</td><td>43.00</td></t<>		(	295,055	900	0	900	43.00
52.00         05200         DELIVERY ROOM & LABOR ROOM         0         741.694         3.442         55.298         3.442         55.208           53.00         05300 MRSTHESIDLOGY         0         0         0.54.01         0.0         0         0.53.00         55.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         65.00         50.00         55.00         65.00         65.00         50.00         5		C	3, 623, 055	17, 505	117, 508	17, 505	50.00
53.00         OS300         ANSETHESI OLOGY         0         0         0         0         0         0         0         53.00         54.01         0         54.00         55.00         73.038         54.00         54.01         0.00         52.32         13.038         54.00         54.01         0.00         54.01         0.00         54.01         0.00         54.01         0.00         54.01         0.00         54.01         0.00         54.00         13.038         52.32         13.038         54.00         54.01         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         55.00         0.00         65.00         66.00		0			-		1
54.00         OS400         RADIOLOGY-DIAGNOSTIC         0         3,556,860         13,038         52,332         13,038         54,03         54,01           54.01         OS402         ONCOLOGY         0         2,259,913         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         11,802         5,812         10,813         5,800         00         5,800         6,005         6,005         6,005         6,005         6,005         6,005         6,005         6,005         6,005         6,005         6,005         6,005         0,000         13,038         9,078         31,433         9,078         6,005         6,005         6,000         6,000         6,000         6,000         6,000         6,000         6,000         6,000         6,000         6,000         6,000         0,000         0,000         0,000         0,000         0,000			/41,694	3, 442	55, 298 0		
54.02         OS402         ONCOLOGY         0         2.259.913         11.802         5.812         11.802         5.812           55.00         OS500 (RADI OISTOPE         0         466.236         511         5.01         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         3.352         55.00         3.352         55.00         55.00         66.00         67.00         0         71.00         71.00         71.00         71.00         71.00         71.00         72.00         73.00         73.00			3, 556, 860	13, 038	52, 332		
56 00         OSGOO RADIO SOTOPE         0         466.236         511         0         511         56.00           57 00         05700 CT SCAN         0         570         05700         2.527         50.00           58 00         06800 MRI         0         590         877         3.352         0         3.52         58.00           06 00         06000 LABORATORY         0         1.122.073         6.095         0         0         0.020         0         3.023         0         3.322         58.00         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         0         0         67.00         66.00         67.00         66.00         67.00         66.00         67.00         66.00         67.00         67.00         66.00         67.00         67.00         67.00         67.00         67.00         68.00         59.20         0         0         0         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.01         67.01         67.01 <t< td=""><td></td><td>C</td><td>0</td><td>0</td><td>0</td><td>0</td><td>54.01</td></t<>		C	0	0	0	0	54.01
57.00         057.00         057.00         057.00         057.00         0743.388         2.527         0         2.521         57.00           58.00         05800         05000         04000         LABORATORY         0         4.122.073         6.095         0         6.095         6.097         6.095         6.090 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
58.00         OSBOOL MAR         0         550.07         3.352         0         3.352         58.00         3.352         58.00         3.352         58.00         3.352         0         3.352         58.00         3.352         58.00         3.352         58.00         3.352         58.00         3.023         0         3.352         66.00         67.00         66.00         67.00         66.00         67.00         66.00         67.00         66.00         67.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         77.00         77.00         77.00 <td></td> <td></td> <td></td> <td></td> <td>5</td> <td></td> <td>1</td>					5		1
65:00         06500         PESPI RATORY THERAPY         0         846,801         3.023         0         3.023         65.00           66:00         06000         PHYSI CAL THERAPY         0         2.445,514         9,078         31,433         9,078         66.00           66:00         06000         PHYSI CAL THERAPY         0         2.55,061         0         0         0         0         67.00           68:00         DEEDEH PATHORY THERAPY         0         114,281         50         0         50         69.00         67.00         68.00         0         0         0         71.00         0         0.00         0 <td< td=""><td></td><td>0</td><td></td><td></td><td>0</td><td></td><td>1</td></td<>		0			0		1
66.00         06000         PHYSICAL THERAPY         0         2.445,514         9.078         31,433         9.078         66.00           67.00         06700         OCCUPATIONAL THERAPY         0         255,061         0 <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td> <td>1</td>		0			-		1
67:00         067:00         0CCUPATIONAL THERAPY         0         255:061         0					-		
69:00         06900         ELECTROCARDIOLOGY         0         114, 281         50         0         50         95.00         97.00           71:00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         535, 326         0         0         0         0         0         71.00         72.00							1
11.00       07100 MEDICAL SUPPLIES CHARGED TO PATIENT       0       535,326       0       0       0       72.00         72.00       07300 IMPL. DEV. CHARGED TO PATIENTS       0       2,652,255       0       0       0       72.00         73.00       07300 IMPL. DEV. CHARGED TO PATIENTS       0       5,882,726       0       0       0       73.00         76.00       03951 OTHER ANCILLARY SERVICE COST CENTER       0       0       0       0       0       76.00         0.01       03951 OTHER ANCILLARY SERVICE COST CENTER       0       0       0       0       0       76.00         0.00       09000 CLINIC       0       910.148       3,808       9.216       3,808       9.00         91.00       09000 CLINIC       0       910.148       3,808       9.216       3,808       90.00         92.00       09200 DESERVATION BEDS (NON-DISTINCT PART       0       3,018,177       13,400       645,515       13,400       91.00         91.00.01       SUBTOTALS (SUM OF LINES 1-117)       -4.782,808       54,372,483       157.051       506,616       155,185         118.00       VEBTORALS (SUM OF LINES 1-117)       -4.782,808       54,372,483       157.051       506,615       190.		C			0	100	1
72.00       07200       IVPL_DEV. CHARGED TO PATIENTS       0       2,652,255       0       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       5,882,726       0       0       0       73.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       0       0       0       0       76.00         76.01       03610       SLEEP LAB       0<		0			0		
73.00       DRUGS CHARGED TO PATIENTS       0       5,882,726       0       0       0       73.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0					0		
76. 01       03610       SLEEP LAB       0       0       0       0       0       0       76. 01         76. 03       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0		0			0		
76.03         03951         OTHER ANCILLARY SERVICE COST CENTER         0         0         0         0         76.03           00.00         OUTPATIENT SERVICE COST CENTERS         0         910.01 148         3.808         9.216         3.808         90.00           91.00         09000         CLINIC         0         3,018,177         13,400         64,515         13,400         91.00           92.00         0BSERVATION BEDS (NON-DISTINCT PART         0         3,018,177         13,400         64,515         13,400         91.00           92.00         0BSERVATION BEDS (NON-DISTINCT PART         0         3,018,177         13,400         64,515         13,400         91.00           90.01         SUBTOTALS (SUM OF LINES 1-117)         -4,782,808         54,372,483         157.051         506,616         155,185           118.00         NORRE IMBURSABLE COST CENTERS         0         336,838         11,793         12,580         11,793         192.00           192.01         19201         WELLNESS CENTER         0         336,838         11,793         12,580         11,793         192.00           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         0		C	0		0		1
OUTPATI ENT SERVICE COST CENTERS           90.00         OUTPATI ENT SERVICE COST CENTERS           90.00         OPODO CLINIC         0         910,148         3,808         9,216         3,808         90.00           92.00         OSDOD CLINIC         0         3,018,177         13,400         64,515         13,400         92.00           92.00         OBSECIAL PURPOSE COST CENTERS         90.00         3,018,177         13,400         64,515         30.018         92.00           SPECIAL PURPOSE COST CENTERS         90.00         SUBTALS (SUM OF LINES 1-117)         -4,782,808         54,372,483         157,051         506,616         155,185           100.00         19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         86,317         615         0         615         190.00           192.01         192.01         192.01         192.01         192.01         128,542         0         0         192.01           194.00         07950         OTHER NOREI MBURSABLE COST CENTERS         0         36,838         11,793         12,580         11,793         192.01           194.01         07951         MARKETI NG         0         697,181         2,091         0         2,091         144.01           19			0		0		
90.00       09000       CLINIC       0       910, 148       3, 808       9, 216       3, 808       90.00         91.00       09100       EMERGENCY       0       3, 018, 177       13, 400       64, 515       13, 400       92.00         92.00       OBSERVATI ON BEDS (NON-DISTINCT PART       0       3, 018, 177       13, 400       64, 515       13, 400       92.00         SPECIAL PURPOSE COST CENTERS			0		0	0	/0.03
92.00         OBSERVATION BEDS (NON-DISTINCT PART         92.00           SPECIAL PURPOSE COST CENTERS         -4,782,808         54,372,483         157,051         506,616         155,185         118.00           NONREL INBURSABLE COST CENTERS         -4,782,808         54,372,483         157,051         506,616         155,185         118.00           190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         -4,782,808         54,372,483         157,051         506,616         155,185         118.00           192.00         19200         GIFT, FLOWER, COFFEE SHOP & CANTEEN         -3,834,099         0         128,542         0         0192.00           192.01         WELLNESS CENTER         -3,834,099         0         128,542         0         0         192.01           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           194.02         07952         SENI OR CI RCLE         0         0         0         194.02         194.02         194.03         194.02         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194.03         194	90. 00 09000 CLI NI C						
SPECIAL PURPOSE COST CENTERS         Image: contract of the state of the stat		C	3, 018, 177	13, 400	64, 515	13, 400	
118.00         SUBTOTALS (SUM OF LINES 1-117)         -4,782,808         54,372,483         157,051         506,616         155,185         118.00           NONREI MBURSABLE COST CENTERS							92.00
190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       86,317       615       0       615       190.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       -3,834,099       0       128,542       0       0       192.00         192.01       19201       WELLNESS CENTER       0       336,838       11,793       12,580       11,793       192.01         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.01         194.01       07955       MARKETI NG       0       697,181       2,091       0       2,091       194.01         194.02       07952       SENI OR CI RCLE       0       0       0       0       194.02         194.03       07953       OTHER NONREI MBURSABLE COST CENTERS       0       213,647       7,480       0       194.03         194.05       07955       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.05       200.00         200.00       Cross Foot Adjustments       0       0       0       194.05       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       202.00 <td></td> <td>-4, 782, 808</td> <td>54, 372, 483</td> <td>157, 051</td> <td>506, 616</td> <td>155, 185</td> <td>118.00</td>		-4, 782, 808	54, 372, 483	157, 051	506, 616	155, 185	118.00
192.00       19200       PHYSICIANS' PRIVATE OFFICES       -3,834,099       0       128,542       0       0       192.00         192.01       19201       WELLNESS CENTER       0       336,838       11,793       12,580       11,793       192.01         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       194.00         194.01       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       194.00         194.02       07952       SENI OR CI RCLE       0       0       0       0       194.02         194.03       07953       OTHER NONREI MBURSABLE COST CENTERS       0       213,647       7,480       0       194.03         194.05       07955       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.03       0       194.03       0       194.03       0       194.03       0       194.03       0       194.03       0       194.03       0       0       194.03       0       0       194.03       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0		-	1	1=	_	=	
192.01       19201       WELLNESS CENTER       0       336,838       11,793       12,580       11,793       192.01         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       194.00         194.01       07951       MARKETI NG       0       697,181       2,091       0       2,091       194.01         194.02       07952       SENI OR CI RCLE       0       0       0       0       194.02         194.03       07953       OTHER NONREI MBURSABLE COST CENTERS       0       213,647       7,480       0       194.03         194.05       07955       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.03       0       194.03       0       194.03       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       194.03       0       0       0       0       0       0       0       0       0       0       0		2 924 000			0		
194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.00         194.01       07951       MARKETI NG       0       697,181       2,091       0       2,091       194.01         194.02       07952       SENIOR CIRCLE       0       0       0       0       0       194.02         194.03       07953       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       194.02         194.05       07953       OTHER NONREI MBURSABLE COST CENTERS       0       213,647       7,480       0       194.03         200.00       Cross Foot Adjustments       0       0       0       13,416       194.03         201.00       Negative Cost Centers       0       0       0       13,416       200.00         202.00       Cost to be allocated (per Wkst. B, Part I)       0.085857       12.255400       0.787203       7.059098       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.013339       2.522821       0.044654       0.333626       205.00		-3, 034, 099				11, 793	192.00
194.02       07952       SENIOR CIRCLE       0       0       0       0       194.02         194.03       07953       OTHER NONREIMBURSABLE COST CENTERS       0       213,647       7,480       0       0       194.03         194.05       07955       OTHER NONREIMBURSABLE COST CENTERS       0       0       0       13,416       0       194.05         200.00       Cross Foot Adjustments       0       0       0       13,416       0       194.05         201.00       Negative Cost Centers       0       0       0       194.05       200.00         202.00       Cost to be allocated (per Wkst. B, Part I)       4,782,808       3,769,418       419,274       1,197,816       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       0.085857       12.255400       0.787203       7.059098       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.013339       2.522821       0.044654       0.333626       205.00		C	0	0	0	0	194.00
194.03       07953       OTHER NONREIMBURSABLE COST CENTERS       0       213,647       7,480       0       0       194.03         194.05       07955       OTHER NONREIMBURSABLE COST CENTERS       0       0       0       13,416       0       194.05         200.00       Cross Foot Adjustments       0       0       0       13,416       0       194.05         201.00       Negative Cost Centers       0       0       0       13,416       0       200.00         202.00       Cost to be allocated (per Wkst. B, Part I)       4,782,808       3,769,418       419,274       1,197,816       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       0.085857       12.255400       0.787203       7.059098       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.013339       2.522821       0.044654       0.333626       205.00		0	697, 181	2, 091	0		
194.05       07955       OTHER NONREIMBURSABLE COST CENTERS       0       0       13,416       0       194.05         200.00       Cross Foot Adjustments       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       201.00       <			0 213 647	0 7 490			
201.00         Negative Cost Centers         201.00         203.00			0	0	13, 416		
202.00       Cost to be allocated (per Wkst. B, Part I)       4,782,808       3,769,418       419,274       1,197,816       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       0.085857       12.255400       0.787203       7.059098       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.013339       2.522821       0.044654       0.333626       205.00	200.00 Cross Foot Adjustments						200.00
203.00       Part I)       0.085857       12.255400       0.787203       7.059098       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.085857       743,087       775,949       23,783       56,611       204.00         205.00       Unit cost multiplier (Wkst. B, Part       0.013339       2.522821       0.044654       0.333626       205.00	5		1 702 000	2 760 410	110 274	1 107 014	1
203.00         Unit cost multiplier (Wkst. B, Part I)         0.085857         12.255400         0.787203         7.059098         203.00           204.00         Cost to be allocated (per Wkst. B, Part II)         743,087         775,949         23,783         56,611         204.00           205.00         Unit cost multiplier (Wkst. B, Part         0.013339         2.522821         0.044654         0.333626         205.00			4, / 62, 808	3, 709, 418	419,274	ι, ιγ/, δΙό	202.00
Part II)         0.013339         2.522821         0.044654         0.333626         205.00	203.00 Unit cost multiplier (Wkst. B, Part I)						
205.00         Unit cost multiplier (Wkst. B, Part         0.013339         2.522821         0.044654         0.333626         205.00			743, 087	775, 949	23, 783	56, 611	204.00
			0. 013339	2. 522821	0. 044654	0. 333626	205.00
				l			

Health Financial Systems	KOSCI USKO COMMUN	NI TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 03/01/2015	Worksheet B-1	
			Ť		Date/Time Pre 7/27/2016 2:0	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQUIS.)	
			(NURSING SA	(COSTED	integer of y	
	10.00	11.00	LARI ES) 13.00	REQUIS.) 14.00	15.00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 01 00540 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPING						9.00
10. 00 01000 DI ETARY	101, 914					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	33, 344 1, 799				11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	742		5, 503, 342		14.00
15. 00 01500 PHARMACY	0	992		141, 001		
16.00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1, 377	0	15, 462	0	16.00
30. 00 03000 ADULTS & PEDIATRICS	55, 195	6, 698	3, 571, 006	327, 489	0	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 552	1, 885	1, 151, 963	91, 062	0	31.00
43. 00 04300 NURSERY	0	247	173, 247	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1,970	1, 994	1, 257, 561	977, 515	0	50.00
51.00 05100 RECOVERY ROOM	0	1, 036		64, 251	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 736	589		0	-	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	) 3, 639	-	0 111, 098	0	
54. 01  05401  ULTRASOUND	0	3, 03,	0	0	0	
54. 02 05402 ONCOLOGY	0	1, 099		41, 450		
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0	206 481		1, 623 66, 395		
58. 00   05800 MRI	0	359		3, 443		
60. 00 06000 LABORATORY	0	3, 290	0	465, 165		60.00
65. 00 06500 RESPI RATORY THERAPY	0	955				
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 648 89		35, 518 5, 191	0	
68. 00 06800 SPEECH PATHOLOGY	0	C		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	191		3, 894		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		431, 956 2, 260, 272		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	2,200,272		
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0 0	0		
76.01 03610 SLEEP LAB 76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	(		0		76. 01 76. 03
OUTPATIENT SERVICE COST CENTERS	0	Ĺ	<u>/</u> 0	0	[0	70.03
90. 00 09000 CLINIC	0	1, 100				
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 562	1, 540, 989	264, 982	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	76, 453	32, 978	10, 573, 759	5, 446, 217	5, 013, 304	118.00
NONREI MBURSABLE COST CENTERS				00.00(		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	93 (		22, 296		190.00 192.00
192. 01 19201 WELLNESS CENTER	0	C	0	0		192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0	-	194.00
194. 01 07951 MARKETI NG 194. 02 07952 SENI OR CI RCLE	0 9, 997	273		34, 829		194. 01 194. 02
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	15, 464	0		0		194.02
194.0507955 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194.05
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	638, 985	884, 318	2, 028, 223	829, 329	1, 944, 107	201.00
Part I)		004, 010	2, 020, 223	027, 327		
203.00 Unit cost multiplier (Wkst. B, Part I)		26. 521053				203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	105, 401	95, 303	63, 562	71, 935	103, 437	204.00
205.00 Unit cost multiplier (Wkst. B, Part	1.034215	2. 858175	0. 006011	0. 013071	0. 020633	205.00

Heal th	Financial Systems	KOSCIUSKO COMMUN	NETY HOSPITAL	In Lie	u of Form CMS-2552-10
	LLOCATION - STATISTICAL BASIS		Provider CCN: 150		Worksheet B-1
				To 02/29/2016	
	Cost Center Description	MEDI CAL			7/27/2016 2:06 pm
		RECORDS &			
		LI BRARY (GROSS CHAR			
		GES)			
	GENERAL SERVICE COST CENTERS	16.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT				4.00
5. 01 5. 02	00540 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL				5. 01 5. 02
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY	504.054.057			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	504, 056, 357			16.00
30.00	03000 ADULTS & PEDIATRICS	42, 479, 072			30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 168, 605			31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 190, 690			43.00
50.00	05000 OPERATI NG ROOM	55, 701, 802			50.00
51.00	05100 RECOVERY ROOM	5, 009, 956			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 837, 827			52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 22, 211, 443			53.00 54.00
54.00 54.01	05401 ULTRASOUND	22, 211, 443			54.00
54.02	05402 ONCOLOGY	11, 110, 874			54.02
56.00	05600 RADI OI SOTOPE	7, 973, 892			56.00
57.00 58.00	05700 CT SCAN 05800 MRI	55, 601, 884 12, 572, 213			57.00 58.00
60.00	06000 LABORATORY	56, 932, 407			60.00
65.00	06500 RESPI RATORY THERAPY	16, 864, 998			65.00
66.00	06600 PHYSI CAL THERAPY	7, 153, 757			66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 291, 190 169, 967			67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	2, 861, 819			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 980, 250			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	15, 460, 802			72.00
	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTER	127, 147, 438			73.00 76.00
	03610 SLEEP LAB	0			76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0			76. 03
90.00	OUTPATIENT SERVICE COST CENTERS	5, 070, 078			90.00
	09100 EMERGENCY	36, 265, 393			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
110 00	SPECIAL PURPOSE COST CENTERS	504 054 257			110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	504, 056, 357			118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			192.00
	19201 WELLNESS CENTER 07950 OTHER NONREI MBURSABLE COST CENTERS	0			192. 01 194. 00
	07950 UTHER NORRET MOURSABLE COST CENTERS	0			194.00
194.02	07952 SENIOR CIRCLE	o			194. 02
	07953 OTHER NONREI MBURSABLE COST CENTERS	0			194.03
194.05 200.00	07955 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0			194. 05 200. 00
200.00					200.00
202.00	Cost to be allocated (per Wkst. B,	1, 305, 106			202.00
202 22	Part I)	0.000500			000.00
203.00 204.00		0. 002589 102, 596			203. 00 204. 00
204.00	Part II)	102, 370			204.00
205.00		0. 000204			205.00
	11)	I			

Heal th	Financial Systems	KOSCIUSKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	pared: 6 pm
			Titl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
30.00	03000 ADULTS & PEDIATRICS	9, 540, 855		9, 540, 8			
31.00	03100 I NTENSI VE CARE UNI T	2, 780, 361		2, 780, 3		_,	
43.00	04300 NURSERY	381, 286		381, 2	36 0	381, 286	43.00
	ANCI LLARY SERVICE COST CENTERS	-	1				
50.00	05000 OPERATI NG ROOM	4, 962, 701		4, 962, 7		4, 962, 701	
51.00	05100 RECOVERY ROOM	1, 342, 919		1, 342, 9	19 0	1, 342, 919	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 078, 599		1, 078, 5	99 0	1, 078, 599	52.00
53.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 326, 017		4, 326, 0	17 0	4, 326, 017	54.00
54.01	05401 ULTRASOUND	0		1	0 0	0	54.01
54.02	05402 ONCOLOGY	2, 891, 818		2, 891, 8	18 0	2, 891, 818	54.02
56.00	05600 RADI OI SOTOPE	542, 488		542, 4	38 0	542, 488	56.00
57.00	05700 CT SCAN	1,022,735		1,022,7	35 0	1, 022, 735	57.00
58.00	05800 MRI	660, 978		660, 9	78 0	660, 978	58.00
60.00	06000 LABORATORY	4, 898, 455		4, 898, 4		4, 898, 455	60.00
65.00	06500 RESPI RATORY THERAPY	1, 141, 007				1, 141, 007	1
66.00	06600 PHYSI CAL THERAPY	2, 923, 139		2, 923, 1		2, 923, 139	
67.00	06700 OCCUPATI ONAL THERAPY	283, 445		283, 4		283, 445	
68.00	06800 SPEECH PATHOLOGY	44, 941		44, 9		44, 941	
69.00	06900 ELECTROCARDI OLOGY	152, 450		152, 4		152, 450	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685, 165		685, 1		685, 165	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 260, 609		3, 260, 6		3, 260, 609	
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 661, 197		8, 661, 1		8, 661, 197	
	03950 OTHER ANCI LLARY SERVICE COST CENTER	0,001,197		0,001,1		0,001,197	
76.00	03610 SLEEP LAB	0			0	0	
		0			0 0		
76.03	03951 OTHER ANCI LLARY SERVICE COST CENTER	0		1	0 0	0	76.03
00.00	OUTPATIENT SERVICE COST CENTERS	4 000 011	1	1 000 0		1 000 011	00.00
90.00	09000 CLINIC	1, 229, 866		1, 229, 8			1
	09100 EMERGENCY	4,084,267		4,084,2		.,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 996, 397		1, 996, 3		1, 996, 397	
200.00		58, 891, 695					
201.00		1, 996, 397		1, 996, 3		1, 996, 397	
202.00	Total (see instructions)	56, 895, 298	0	56, 895, 2	98 0	56, 895, 298	202.00

Health Financial Systems	KOSCIUSKO COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	epared: )6 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	35, 007, 283		35, 007, 28			30.00
31. 00 03100 INTENSIVE CARE UNIT	3, 168, 605		3, 168, 60			31.00
43. 00 04300 NURSERY	1, 190, 690		1, 190, 69	90		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	17, 620, 619	38, 081, 183	55, 701, 80		0.00000	50.00
51.00 05100 RECOVERY ROOM	1, 631, 973	3, 377, 983			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 609, 237	228, 590	2, 837, 83		0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 892, 822	18, 318, 621	22, 211, 4		0.00000	54.00
54. 01 05401 ULTRASOUND	0	0		0 0.000000	0.00000	
54. 02 05402 ONCOLOGY	88, 888	11, 021, 986	11, 110, 8		0.00000	
56. 00 05600 RADI 0I SOTOPE	833, 568	7, 140, 324	7, 973, 8	92 0. 068033	0.00000	56.00
57.00 05700 CT SCAN	8, 687, 297	46, 914, 587	55, 601, 8	0. 018394	0.00000	
58. 00 05800 MRI	1, 017, 096	11, 555, 117	12, 572, 2	13 0. 052575	0.00000	58.00
60. 00 06000 LABORATORY	16, 020, 759	40, 911, 648	56, 932, 40	0. 086040	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	9, 991, 825	6, 873, 173			0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 119, 069	6, 034, 688	7, 153, 7	57 0. 408616	0.00000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	109, 903	1, 181, 287	1, 291, 19		0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	79, 384	90, 583	169, 90	67 0. 264410	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	100, 000	2, 761, 819		0. 053270	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 885, 814	9, 094, 436	14, 980, 2	50 0. 045738	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 835, 113	5, 625, 689	15, 460, 80	0. 210895	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 277, 011	78, 870, 427	127, 147, 43	38 0. 068119	0.00000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.00000	76.00
76.01 03610 SLEEP LAB	0	0		0 0.000000	0.00000	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	500, 514	4, 569, 564	5, 070, 0	78 0. 242573	0. 000000	90.00
91.00 09100 EMERGENCY	7, 109, 595	29, 155, 798	36, 265, 39	93 0. 112622	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 437, 116	5, 034, 673	7, 471, 78	0. 267191	0. 000000	92.00
200.00 Subtotal (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		202.00

Health Financial Systems	KOSCI USKO COMMUNI TY	' HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	L				
50. 00 05000 OPERATI NG ROOM	0.089094				50.00
51.00 05100 RECOVERY ROOM	0. 268050				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 380079				52.00
53.00 05300 ANESTHESI OLOGY	0.000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 194765				54.00
54. 01 05401 ULTRASOUND	0.000000				54.01
54. 02 05402 ONCOLOGY	0. 260269				54.02
56. 00 05600 RADI OI SOTOPE	0.068033				56.00
57.00 05700 CT SCAN	0.018394				57.00
58. 00 05800 MRI	0.052575				58.00
60. 00 06000 LABORATORY	0. 086040				60.00
65. 00 06500 RESPI RATORY THERAPY	0.067655				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 408616				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 219522				67.00
68.00 06800 SPEECH PATHOLOGY	0. 264410				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.053270				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045738				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210895				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.068119				73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.00
76.01 03610 SLEEP LAB	0. 000000				76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0.000000				76.03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 242573				90.00
91. 00 09100 EMERGENCY	0. 112622				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 267191				92.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

Heal th	Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I	pared:
			Tit	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 540, 855		9, 540, 8	55 0	9, 540, 855	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 780, 361		2, 780, 3	61 0	2, 780, 361	31.00
43.00	04300 NURSERY	381, 286		381, 2	86 0	381, 286	43.00
	ANCILLARY SERVICE COST CENTERS	<u>.</u>	•				1
50.00	05000 OPERATI NG ROOM	4, 962, 701		4, 962, 7	0 0	4, 962, 701	50.00
51.00	05100 RECOVERY ROOM	1, 342, 919		1, 342, 9	19 0	1, 342, 919	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,078,599		1, 078, 5	99 0	1, 078, 599	52.00
53.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 326, 017		4, 326, 0	17 0	4, 326, 017	54.00
54.01	05401 ULTRASOUND	0			0 0	0	54.01
54.02	05402 ONCOLOGY	2, 891, 818		2, 891, 8	18 0	2, 891, 818	54.02
56.00	05600 RADI OI SOTOPE	542, 488		542, 4	38 0	542, 488	56.00
57.00	05700 CT SCAN	1,022,735		1, 022, 7	35 0	1, 022, 735	57.00
58.00	05800 MRI	660, 978		660, 9	78 0	660, 978	58.00
60.00	06000 LABORATORY	4, 898, 455		4, 898, 4	55 0	4, 898, 455	60.00
65.00	06500 RESPI RATORY THERAPY	1, 141, 007		1, 141, 0	0 07	1, 141, 007	65.00
66.00	06600 PHYSI CAL THERAPY	2, 923, 139		2, 923, 1		2, 923, 139	
67.00	06700 OCCUPATI ONAL THERAPY	283, 445		283, 4		283, 445	67.00
68.00	06800 SPEECH PATHOLOGY	44, 941		44,9		44, 941	
69.00	06900 ELECTROCARDI OLOGY	152, 450		152, 4		152, 450	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685, 165		685, 1		685, 165	
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 260, 609		3, 260, 6		3, 260, 609	
	07300 DRUGS CHARGED TO PATIENTS	8, 661, 197		8, 661, 1		8, 661, 197	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0,001,17		0,001,1	0 0	0,001,17	1
	03610 SLEEP LAB	0			0 0		
	03951 OTHER ANCI LLARY SERVICE COST CENTER	0			0 0	-	76.03
70.05	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	/0.05
90.00	09000 CLINIC	1, 229, 866		1, 229, 8	56 0	1, 229, 866	90.00
	09100 EMERGENCY	4, 084, 267		4, 084, 2		.,,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 996, 397		1, 996, 3		1, 996, 397	
200.00		58, 891, 695					
200.00		1, 996, 397		1, 996, 3		1, 996, 397	
201.00		56, 895, 298					
202.00		00, 070, 290	I C	η 50, 0 <del>7</del> 5, Ζ	<sup>3</sup> 0  0	00, 070, 290	202.00

Health Financial Systems	KOSCIUSKO COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	epared: )6 pm
		Tit	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	35, 007, 283		35, 007, 28			30.00
31.00 03100 INTENSIVE CARE UNIT	3, 168, 605		3, 168, 60			31.00
43. 00 04300 NURSERY	1, 190, 690		1, 190, 69	90		43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17, 620, 619	38, 081, 183	55, 701, 80		0.00000	50.00
51.00 05100 RECOVERY ROOM	1, 631, 973	3, 377, 983			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 609, 237	228, 590	2, 837, 83		0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 892, 822	18, 318, 621	22, 211, 4		0.00000	54.00
54. 01 05401 ULTRASOUND	0	0		0 0.000000	0.00000	
54. 02 05402 ONCOLOGY	88, 888	11, 021, 986	11, 110, 8		0.00000	
56. 00 05600 RADI 0I SOTOPE	833, 568	7, 140, 324	7, 973, 8	92 0. 068033	0.00000	56.00
57.00 05700 CT SCAN	8, 687, 297	46, 914, 587	55, 601, 8	0. 018394	0.00000	
58. 00 05800 MRI	1, 017, 096	11, 555, 117	12, 572, 2	13 0. 052575	0.00000	58.00
60. 00 06000 LABORATORY	16, 020, 759	40, 911, 648	56, 932, 40	0. 086040	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	9, 991, 825	6, 873, 173	16, 864, 9	98 0. 067655	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 119, 069	6, 034, 688	7, 153, 7	57 0. 408616	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	109, 903	1, 181, 287	1, 291, 19	90 0. 219522	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	79, 384	90, 583	169, 9	67 0. 264410	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	100, 000	2, 761, 819	2, 861, 8	0. 053270	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 885, 814	9, 094, 436	14, 980, 2	50 0. 045738	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 835, 113	5, 625, 689	15, 460, 80	0. 210895	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 277, 011	78, 870, 427	127, 147, 43	38 0. 068119	0. 000000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0. 000000	76.00
76.01 03610 SLEEP LAB	0	0		0 0.000000	0.00000	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	500, 514	4, 569, 564	5, 070, 0	78 0. 242573	0. 000000	90.00
91.00 09100 EMERGENCY	7, 109, 595	29, 155, 798	36, 265, 39	93 0. 112622	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 437, 116	5, 034, 673	7, 471, 78	0. 267191	0. 000000	92.00
200.00 Subtotal (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		202.00

Health Financial Systems	KOSCI USKO COMMUNI TY	( HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	
		Title XIX	Hospi tal	PPS	
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
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 089094				50.00
51.00 05100 RECOVERY ROOM	0. 268050				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 380079				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 194765				54.00
54.01 05401 ULTRASOUND	0. 000000				54.01
54.02 05402 ONCOLOGY	0. 260269				54.02
56. 00 05600 RADI 0I SOTOPE	0. 068033				56.00
57.00 05700 CT SCAN	0. 018394				57.00
58. 00 05800 MRI	0. 052575				58.00
60. 00 06000 LABORATORY	0. 086040				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 067655				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 408616				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 219522				67.00
68.00 06800 SPEECH PATHOLOGY	0. 264410				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 053270				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045738				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210895				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 068119				73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.00
76.01 03610 SLEEP LAB	0. 000000				76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 242573				90.00
91.00 09100 EMERGENCY	0. 112622				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 267191				92.00
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 COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA			CCN: 150133	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 03/01/2015	Part II	
				To 02/29/2016		pared:
					7/27/2016 2:0	6 pm
	<b>T I I O I</b>			Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)		-	Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	4, 962, 701	595, 282	4, 367, 4	0	0	50.00
51. 00 05100 RECOVERY ROOM	1, 342, 919				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 078, 599				0	
53. 00 05300 ANESTHESI OLOGY	1,070,399	120, 310		0 0	0	52.00
54. 00  05400 RADI OLOGY-DI AGNOSTI C	4, 326, 017				0	54.00
54. 01 05400 KADI OLOGI - DI AGNOSTI C 54. 01 05401 ULTRASOUND	4, 320, 017	447,000	3, 0/0, 93	0 0	0	54.00
54. 02 05402 ONCOLOGY	2, 891, 818	378, 043	2, 513, 7		0	54.01
56. 00 05600 RADI 0I SOTOPE	542, 488				0	56.00
57. 00 05700 CT SCAN	1, 022, 735				0	57.00
58. 00  05800 MRI	660, 978				0	58.00
60. 00 06000 LABORATORY	4, 898, 455				0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 141, 007				0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 923, 139				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 923, 139				0	67.00
68. 00 06800 SPEECH PATHOLOGY	44, 941				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	152, 450				0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685, 165				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 260, 609				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 661, 197				0	73.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	0,001,197	240,000	0,413,11		0	76.00
76. 01 03610 SLEEP LAB	0			0 0	0	76.00
76.03 03951 OTHER ANCI LLARY SERVICE COST CENTER	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTER			/	0 0	0	70.03
90. 00 09000 CLINIC	1, 229, 866	131, 708	1, 098, 15	58 0	0	90.00
91. 00 09100 EMERGENCY	4, 084, 267				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 996, 397				0	
200.00 Subtotal (sum of lines 50 thru 199)	46, 189, 193				-	200.00
201.00 Less Observation Beds	1, 996, 397					200.00
202.00 Total (line 200 minus line 201)	44, 192, 796					201.00
	1 11, 12, 770	1 0, 177, 711	1 10, 14, 00	0	0	1-02.00

Health Financial Systems	KOSCI USKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provi der	CCN: 150133	Peri od:	Worksheet C
REDUCTIONS FOR MEDICAID ONLY				From 03/01/2015 To 02/29/2016	Part II Date/Time Prepared:
				10 02/29/2016	7/27/2016 2:06 pm
		Ti t	le XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	1 0/0 704	55 704 000		a.d	
50. 00 05000 OPERATING ROOM	4, 962, 701		1		50.00
51.00 05100 RECOVERY ROOM	1, 342, 919				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 078, 599				52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-			53.00 54.00
54. 01 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 ULTRASOUND	4, 326, 017		0. 1947		54.00
54. 02 05402 ONCOLOGY	2, 891, 818	, i i i i i i i i i i i i i i i i i i i			54.02
56. 00 05600 RADI 0I SOTOPE	542, 488				56.00
57. 00 05700 CT SCAN	1, 022, 735				57.00
58. 00 05800 MRI	660, 978				58.00
60. 00 06000 LABORATORY	4, 898, 455				60.00
65. 00 06500 RESPIRATORY THERAPY	1, 141, 007				65.00
66. 00 06600 PHYSI CAL THERAPY	2, 923, 139				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	283, 445				67.00
68.00 06800 SPEECH PATHOLOGY	44, 941				68.00
69.00 06900 ELECTROCARDI OLOGY	152, 450	2, 861, 819	0. 0532	70	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685, 165			38	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 260, 609	15, 460, 802	0. 2108	95	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 661, 197	127, 147, 438	0. 0681	19	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0.0000	00	76.00
76. 01 03610 SLEEP LAB	0	C	0.0000	00	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	C	0.0000	00	76. 03
OUTPATIENT SERVICE COST CENTERS	_				
90. 00 09000 CLI NI C	1, 229, 866				90.00
91.00 09100 EMERGENCY	4, 084, 267				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 996, 397			91	92.00
200.00 Subtotal (sum of lines 50 thru 199)	46, 189, 193		1		200.00
201.00 Less Observation Beds	1, 996, 397				201.00
202.00  Total (line 200 minus line 201)	44, 192, 796	464, 689, 779	1	I	202.00

Heal th	Financial Systems	KOSCI USKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	pared: 6 pm
			Ti	tle V	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.540.055		0.540.0		0.540.055	
30.00	03000 ADULTS & PEDIATRICS	9, 540, 855		9, 540, 8			
	03100 INTENSIVE CARE UNIT	2, 780, 361		2, 780, 3		_,,	•
43.00	04300 NURSERY	381, 286		381, 2	36 0	381, 286	43.00
	ANCI LLARY SERVI CE COST CENTERS		I	T			
50.00	05000 OPERATING ROOM	4, 962, 701		4, 962, 7		.,	
51.00	05100 RECOVERY ROOM	1, 342, 919		1, 342, 9		.,	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 078, 599		1, 078, 5	99 0	1, 078, 599	
53.00	05300 ANESTHESI OLOGY	0			0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 326, 017		4, 326, 0	17 0	4, 326, 017	54.00
54.01	05401 ULTRASOUND	0			0 0	0	
54.02	05402 ONCOLOGY	2, 891, 818		2, 891, 8	18 0	2, 891, 818	54.02
56.00	05600 RADI OI SOTOPE	542, 488		542, 4	38 0	542, 488	56.00
57.00	05700 CT SCAN	1,022,735		1, 022, 7		1, 022, 735	57.00
58.00	05800 MRI	660, 978		660, 9	78 0	660, 978	58.00
60.00	06000 LABORATORY	4, 898, 455		4, 898, 4	55 0	4, 898, 455	60.00
65.00	06500 RESPI RATORY THERAPY	1, 141, 007	0	1, 141, 0	07 0	1, 141, 007	65.00
66.00	06600 PHYSI CAL THERAPY	2, 923, 139	0	2, 923, 1	39 0	2, 923, 139	66.00
67.00	06700 OCCUPATI ONAL THERAPY	283, 445	0	283, 4	45 0	283, 445	67.00
68.00	06800 SPEECH PATHOLOGY	44, 941		44, 9	41 0	44, 941	68.00
69.00	06900 ELECTROCARDI OLOGY	152, 450		152, 4	50 0	152, 450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685, 165		685, 1		685, 165	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 260, 609		3, 260, 6		3, 260, 609	
	07300 DRUGS CHARGED TO PATIENTS	8, 661, 197		8, 661, 1		8, 661, 197	•
	03950 OTHER ANCI LLARY SERVICE COST CENTER	0,001,177		0,001,1	0 0	0,001,177	
76.01	03610 SLEEP LAB	0			0 0	0	•
	03951 OTHER ANCI LLARY SERVICE COST CENTER	0			0 0		
70.03	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	70.03
90, 00	09000 CLINIC	1, 229, 866		1, 229, 8	56 0	1, 229, 866	90.00
	09100 EMERGENCY						•
		4,084,267		4,084,2		.,	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 996, 397		1, 996, 3		1, 996, 397	
200.00		58, 891, 695					
201.00		1, 996, 397		1, 996, 3		1, 996, 397	
202.00	Total (see instructions)	56, 895, 298	0	56, 895, 2	98 0	56, 895, 298	1202. UU

Health Fi	nancial Systems	KOSCI USKO COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES			CCN: 150133	Period: From 03/01/2015 To 02/29/2016		pared: 6 pm
				tle V	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
I N	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	000 ADULTS & PEDIATRICS	35, 007, 283		35, 007, 2	33		30.00
31.00 03	100 I NTENSI VE CARE UNI T	3, 168, 605		3, 168, 60	05		31.00
43.00 04	300 NURSERY	1, 190, 690		1, 190, 69	90		43.00
ANG	CILLARY SERVICE COST CENTERS	•					
50.00 05	000 OPERATING ROOM	17, 620, 619	38, 081, 183	55, 701, 80	0. 089094	0.00000	50.00
51.00 05	100 RECOVERY ROOM	1, 631, 973	3, 377, 983	5, 009, 9	0. 268050	0. 000000	51.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	2, 609, 237	228, 590	2, 837, 83	0. 380079	0. 000000	52.00
53.00 05	300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	3, 892, 822	18, 318, 621	22, 211, 4	43 0. 194765	0. 000000	54.00
54.01 05	401 ULTRASOUND	0	0		0 0.000000	0. 000000	54.01
54.02 05	402 ONCOLOGY	88, 888	11, 021, 986	11, 110, 8	0. 260269	0. 000000	54.02
56.00 05	600 RADI OI SOTOPE	833, 568	7, 140, 324	7, 973, 8	0. 068033	0. 000000	56.00
57.00 05	700 CT SCAN	8, 687, 297	46, 914, 587	55, 601, 8	0. 018394	0. 000000	57.00
58.00 05	800 MRI	1, 017, 096	11, 555, 117		13 0. 052575	0.00000	58.00
60.00 06	000 LABORATORY	16, 020, 759	40, 911, 648	56, 932, 40	0. 086040	0.00000	60.00
	500 RESPI RATORY THERAPY	9, 991, 825	6, 873, 173	16, 864, 9	98 0. 067655	0.00000	65.00
66.00 06	600 PHYSI CAL THERAPY	1, 119, 069	6, 034, 688	7, 153, 7	57 0. 408616	0.00000	66.00
	700 OCCUPATI ONAL THERAPY	109, 903	1, 181, 287	1, 291, 19	90 0. 219522	0.00000	
	800 SPEECH PATHOLOGY	79, 384	90, 583	169, 90	67 0. 264410	0.00000	
	900 ELECTROCARDI OLOGY	100, 000	2, 761, 819			0.00000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 885, 814	9, 094, 436	14, 980, 2	50 0. 045738	0.00000	
	200 IMPL. DEV. CHARGED TO PATIENTS	9, 835, 113	5, 625, 689	15, 460, 80	0. 210895	0.00000	
	300 DRUGS CHARGED TO PATIENTS	48, 277, 011	78, 870, 427	127, 147, 43		0.00000	
	950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.00000	
	610 SLEEP LAB	0	0		0 0.000000	0.00000	
76.03 03	951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.00000	76.03
	TPATIENT SERVICE COST CENTERS						
	000 CLINIC	500, 514	4, 569, 564				
	100 EMERGENCY	7, 109, 595	29, 155, 798			0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART	2, 437, 116	5,034,673			0. 000000	
200.00	Subtotal (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	177, 214, 181	326, 842, 176	504, 056, 3	57		202.00

Health Financial Systems	KOSCIUSKO COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/27/2016 2:0	
		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
ANCI LLARY SERVI CE COST CENTERS					1
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 ONCOLOGY	0. 000000				54.02
56. 00 05600 RADI OI 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 RESPI RATORY 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 CENTER	0. 000000				76.00
76.01 03610 SLEEP LAB	0. 000000				76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.03
OUTPATIENT SERVICE COST CENTERS	1				
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0.000000				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000				92.00
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 COMML	INI TY HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 03/01/2015		
				To 02/29/2016	Date/Time Pre 7/27/2016 2:0	pared: 6 nm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing 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						
30. 00 ADULTS & PEDIATRICS	1, 398, 776	0	1, 398, 77	6 12, 478	112.10	30.00
31.00 INTENSIVE CARE UNIT	323, 664		323, 66	4 1, 558	207.74	31.00
43.00 NURSERY	32, 621		32, 62	1 1, 011	32.27	43.00
200.00 Total (lines 30-199)	1, 755, 061		1, 755, 06	1 15, 047		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 726					30.00
31.00 INTENSIVE CARE UNIT	681		1			31.00
43. 00 NURSERY	C	0				43.00
200.00 Total (lines 30-199)	4, 407	559, 156				200.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS		CCN: 150133	Period: From 03/01/2015 To 02/29/2016	7/27/2016 2:0	pared: 6 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	595, 282					
51.00 05100 RECOVERY ROOM	53, 299	5, 009, 956	0. 01063	39 434, 952	4, 627	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	126, 310	2, 837, 827			287	
53. 00 05300 ANESTHESI OLOGY	0	C	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	447,085	22, 211, 443	0. 02012	29 3, 251, 192	65, 443	54.00
54. 01 05401 ULTRASOUND	0	C	0.0000	0 0	0	54.01
54. 02 05402 ONCOLOGY	378, 043	11, 110, 874	0. 03402	25 50, 399	1, 715	54.02
56. 00 05600 RADI OI SOTOPE	25, 708	7, 973, 892	0.00322	24 349, 873	1, 128	56.00
57.00 05700 CT SCAN	97,609	55, 601, 884	0.00175	55 4, 526, 980	7, 945	57.00
58. 00 05800 MRI	105, 319	12, 572, 213	0.00837	77 357, 552	2, 995	58.00
60. 00 06000 LABORATORY	277, 545	56, 932, 407	0.00487	75 7, 196, 513	35, 083	60.00
65. 00 06500 RESPI RATORY THERAPY	109, 187	16, 864, 998	0.00647	4, 598, 108	29, 768	65.00
66. 00 06600 PHYSI CAL THERAPY	304, 965	7, 153, 757	0. 04263	466, 383	19, 882	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 761	1, 291, 190	0.00446	52 54, 262	242	67.00
68.00 06800 SPEECH PATHOLOGY	3, 546			43, 531	908	68.00
69. 00 06900 ELECTROCARDI OLOGY	5,376	2, 861, 819	0.00187	79 46, 218	87	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 519	14, 980, 250	0.00130	1, 852, 751	2, 414	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 289	15, 460, 802	0.00558	3, 366, 293	18, 787	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	248,006	127, 147, 438	0.00195	51 18, 294, 765	35, 693	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0.0000	0 00	0	76.00
76. 01 03610 SLEEP LAB	0	C	0.0000	0 00	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	C			0	76.03
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	131, 708	5, 070, 078	0. 02597	78 122,090	3, 172	90.00
91.00 09100 EMERGENCY	457, 354					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	292, 690					92.00
200.00   Total (lines 50-199)	3, 770, 601			53, 511, 954		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 150133       Period: From 03/01/2015 To 02/29/2016       Worksheet D Part III Date/Time Prepared: 7/27/2016 2:06 pm <ul> <li></li></ul>
Cost Center Description       Nursing School       Allied Health Cost       All Other Medical Education Cost       Swing-Bed Adjustment Amount (see instructions)       Total Costs (sum of cols. 1 through 3, minus col. 4)         30.00       0000 ADULTS & PEDIATRICS 03000 ADULTS & PEDIATRICS       0       0       0       0       30.00         31.00       03100 INTENSIVE CARE UNIT       0       0       0       0       0       31.00         43.00       04300 NURSERY       0       0       0       0       0       0       43.00
INPATIENT ROUTINE SERVICE COST CENTERS         O
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         0         0         0         0         0         30.00
INPATIENT ROUTINE SERVICE COST CENTERS         0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS         0         3.00         4.00         5.00           30.00         03000         ADULTS & PEDI ATRI CS         0         0         0         0         30.00           31.00         03100         INTENSI VE CARE UNI T         0         0         0         0         31.00           43.00         04300         NURSERY         0         0         0         0         43.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         0         0         0         0         30. 00           31. 00         03100         INTENSI VE CARE UNI T         0         0         0         0         31. 00           43. 00         04300         NURSERY         0         0         0         0         43. 00
30. 00         03000         ADULTS & PEDIATRICS         0         0         0         0         30. 00           31. 00         03100         INTENSI VE CARE UNIT         0         0         0         0         31. 00           43. 00         04300         NURSERY         0         0         0         0         43. 00
31.00         03100         INTENSIVE CARE UNIT         0         0         0         31.00           43.00         04300         NURSERY         0         0         0         0         43.00
43. 00 04300 NURSERY 0 0 0 0 43. 00
200.00 Total (lines 30-199) 0 0 0 0 0 0 0 200.00
Cost Center Description Total Patient Per Diem (col. Inpatient Inpatient
Days 5 ÷ col. 6) Program Days Program
Pass-Through
Cost (col. 7 x
col. 8)
6.00 7.00 8.00 9.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS 12, 478 0. 00 3, 726 0 30. 00
31.00 03100 INTENSIVE CARE UNIT 1,558 0.00 681 0 31.00
43. 00 04300 NURSERY 1, 011 0, 00 0 43. 00
200.00 Total (lines 30-199) 15,047 4,407 0 200.00

Health Financial Systems	KOSCIUSKO COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Pre 7/27/2016 2:0	pared: 6 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	· · · · ·					
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 05401 ULTRASOUND	0	0		0 0	0	54.01
54. 02 05402 ONCOLOGY	0	0		0 0	0	54.02
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0	0		0 0	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	
200.00  Total (lines 50-199)	0	0	1	0 0	0	200.00

Health Financial Systems	KOSCIUSKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 03/01/2015	Part IV	
				To 02/29/2016	Date/Time Pre 7/27/2016 2:0	pared:
		Titl	e XVIII	Hospi tal	PPS	o pili
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of			. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ū	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0				4, 817, 372	1
51.00 05100 RECOVERY ROOM	0	5, 009, 956			434, 952	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2, 837, 827			6, 451	
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0.000000	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	22, 211, 443	0.00000	0 0.000000	3, 251, 192	54.00
54. 01 05401 ULTRASOUND	0	0	0.00000		0	54.01
54. 02 05402 ONCOLOGY	0	11, 110, 874	0.00000	0.000000	50, 399	54.02
56. 00 05600 RADI OI SOTOPE	0	7, 973, 892	0.00000	0 0.000000	349, 873	56.00
57.00 05700 CT SCAN	0	55, 601, 884	0.00000	0.000000	4, 526, 980	57.00
58. 00 05800 MRI	0	12, 572, 213	0.00000	0.000000	357, 552	58.00
60. 00 06000 LABORATORY	0	56, 932, 407	0.00000	0.000000	7, 196, 513	60.00
65. 00 06500 RESPI RATORY THERAPY	0	16, 864, 998	0.00000	0.000000	4, 598, 108	65.00
66. 00 06600 PHYSI CAL THERAPY	0	7, 153, 757	0.00000	0.000000	466, 383	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 291, 190	0. 00000	0 0. 000000	54, 262	67.00
68.00 06800 SPEECH PATHOLOGY	0	169, 967	0. 00000	0 0. 000000	43, 531	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 861, 819	0. 00000	0 0. 000000	46, 218	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14, 980, 250	0. 00000	0 0. 000000	1, 852, 751	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 460, 802	0. 00000	0 0. 000000	3, 366, 293	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	127, 147, 438	0.00000	0.000000	18, 294, 765	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0. 00000	0.000000	0	76.00
76.01 03610 SLEEP LAB	0	0	0. 00000	0.000000	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.00000	0 0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	5, 070, 078	0.00000	0 0. 000000	122, 090	90.00
91. 00 09100 EMERGENCY	0	36, 265, 393	0.00000	0 0. 000000	2, 791, 807	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 471, 789	0. 00000	0 0. 000000	884, 462	92.00
200.00 Total (lines 50-199)	0	464, 689, 779	,		53, 511, 954	200.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	5 Provi der	CCN: 150133	Peri od:	Worksheet D
THROUGH COSTS				From 03/01/2015	
				To 02/29/2016	Date/Time Prepared: 7/27/2016 2:06 pm
			e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpatient		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8	5	Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0	5, 108, 985		0	50.00
51.00 05100 RECOVERY ROOM	0	366, 381		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	216		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 586, 875		0	54.00
54. 01 05401 ULTRASOUND	0	0		0	54.01
54. 02 05402 ONCOLOGY	0	2, 634, 270		0	54.02
56. 00 05600 RADI OI SOTOPE	0	1, 826, 434		0	56.00
57.00 05700 CT SCAN	0	7, 336, 884		0	57.00
58. 00 05800 MRI	0	2, 103, 381		0	58.00
60. 00 06000 LABORATORY	0	3, 902, 763		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 342, 066		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 533		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 364		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	419		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	768, 549		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 046, 292		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	595, 369		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 965, 960		0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0	76.00
76. 01 03610 SLEEP LAB	0	0		0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0	76.03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	700, 486		0	90.00
91. 00 09100 EMERGENCY	0	3, 829, 658		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 003, 393		0	92.00
200.00 Total (lines 50-199)	0	56, 125, 278		0	200.00

	KOSCIUSKO COMML	INI TY_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150133	Period: From 03/01/2015	Worksheet D Part V	
				To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS				-		
50.00 O5000 OPERATING ROOM	0. 089094			0 0	455, 180	
51.00 05100 RECOVERY ROOM	0. 268050			0 0	98, 208	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 380079			0 0	82	
53.00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 194765			0 0	1, 088, 128	
54. 01 05401 ULTRASOUND	0. 000000			0 0	0	54.01
54. 02 05402 ONCOLOGY	0. 260269			0 0	685, 619	
56. 00 05600 RADI OI SOTOPE	0. 068033			0 0	124, 258	
57.00 05700 CT SCAN	0. 018394			0 0	134, 955	
58. 00 05800 MRI	0. 052575			0 0	110, 585	
60. 00 06000 LABORATORY	0. 086040				335, 794	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 067655				90, 797	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 408616			0 0	2, 261	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 219522			0 0	299	
68.00 06800 SPEECH PATHOLOGY	0. 264410			0 0	111	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 053270			0 0	40, 941	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045738			0 0	47, 855	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 210895			0 0	125, 560	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 068119		1	0 34, 640	1, 223, 823	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000			0 0	0	
76.01 03610 SLEEP LAB	0. 000000			0 0	0	76.01
76. 03 03951 OTHER ANCI LLARY SERVI CE COST CENTER OUTPATI ENT SERVI CE COST CENTERS	0.000000	0	1	0 0	0	76.03
90. 00 09000 CLINIC	0. 242573	700, 486		0 0	169, 919	90.00
91. 00 09100 EMERGENCY	0. 112622			0 0	431, 304	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 267191			0 0	268, 098	
200.00 Subtotal (see instructions)	1	56, 125, 278		34, 640		
201.00 Less PBP Clinic Lab. Services-Program				0 0	-,,	201.00
0nl y Charges 202.00 Net Charges (line 200 +/- line 201)		56, 125, 278	3, 94	34, 640	5, 433, 777	202.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Pro 7/27/2016 2:0	epared: 06 pm
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	4			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
54. 01 05401 ULTRASOUND	0	C				54.01
54. 02 05402 ONCOLOGY	0	C				54.02
56. 00 05600 RADI OI SOTOPE	0	C				56.00
57.00 05700 CT SCAN	0	C				57.00
58. 00 05800 MRI	0	C	1			58.00
60. 00 06000 LABORATORY	315	C				60.00
65. 00 06500 RESPI RATORY THERAPY	20	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00
68.00 06800 SPEECH PATHOLOGY	0	C	1			68.00
69.00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 360	1			73.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTER	0	0	1			76.00
76.01 03610 SLEEP LAB	0	0	•			76.01
76. 03 03951 OTHER ANCI LLARY SERVICE COST CENTER OUTPATI ENT SERVICE COST CENTERS	0	C	0			76.03
90. 00 09000 CLINIC	0	C	)			90.00
91. 00 09100 EMERGENCY	0	C	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ő				92.00
200.00 Subtotal (see instructions)	335	2, 360				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	2, 500				201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	335	2, 360				202.00

Health Financial Systems	KOSCI USKO COMMU	JNI TY_HO	SPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E CAPITAL COSTS	Pr	rovi der		Peri od:	Worksheet D	
					From 03/01/2015		
					To 02/29/2016	Date/Time Pre	pared:
			<b>T</b> · ·			7/27/2016 2:0	6 pm
					Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng		Reduced		Per Diem (col.	
	Related Cost		tment	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 CEN	-						
30. 00 ADULTS & PEDIATRICS	1, 398, 776	5	0	1, 398, 77	76 12, 478	112.10	30.00
31.00 INTENSIVE CARE UNIT	323, 664	1		323, 66	4 1, 558	207.74	31.00
43.00 NURSERY	32, 621	1		32, 62	1, 011	32.27	43.00
200.00 Total (lines 30-199)	1, 755, 061	1		1, 755, 06	15, 047		200.00
Cost Center Description	I npati ent	Inpat	tient				
	Program days	Prog	gram				
		Capi ta	I Cost				
		(col. 5					
		6					
	6,00	7.	00	1			
INPATIENT ROUTINE SERVICE COST CEN	FERS						
30. 00 ADULTS & PEDI ATRI CS	1,290	)	144, 609				30.00
31.00 INTENSIVE CARE UNIT	247		51, 312	1			31.00
43.00 NURSERY	483		15, 586				43.00
200.00 Total (lines 30-199)	2,020		211, 507				200.00
	2,020	1	211, 307	İ.			1200.00

Health Financial Systems	KOSCI USKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150133	Peri od:	Worksheet D	
				From 03/01/2015		
				To 02/29/2016	Date/Time Pre 7/27/2016 2:0	pared:
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	595, 282					
51.00 05100 RECOVERY ROOM	53, 299					
52.00 05200 DELIVERY ROOM & LABOR ROOM	126, 310	2, 837, 827			3, 882	
53. 00 05300 ANESTHESI OLOGY	0	C	0.0000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	447, 085	22, 211, 443			2, 067	54.00
54. 01 05401 ULTRASOUND	0	C	0.0000		0	54.01
54. 02 05402 ONCOLOGY	378, 043				0	54.02
56. 00 05600 RADI OI SOTOPE	25, 708					56.00
57.00 05700 CT SCAN	97, 609					57.00
58. 00 05800 MRI	105, 319					58.00
60. 00 06000 LABORATORY	277, 545					60.00
65. 00 06500 RESPI RATORY THERAPY	109, 187					65.00
66. 00 06600 PHYSI CAL THERAPY	304, 965					66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 761					67.00
68.00 06800 SPEECH PATHOLOGY	3, 546					68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 376					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 519	14, 980, 250	0. 00130	99, 382	129	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 289	15, 460, 802	0. 0055	31 114, 697	640	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	248, 006	127, 147, 438			2, 110	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0.0000		0	76.00
76.01 03610 SLEEP LAB	0	C	0.0000		0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	C	0.0000	0 00	0	76.03
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLI NI C	131, 708					
91. 00 09100 EMERGENCY	457, 354					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	292, 690					
200.00   Total (lines 50-199)	3, 770, 601	464, 689, 779	2	2, 932, 355	21, 643	200. 00

Health Financial Systems	KOSCIUSKO COMML	JNI TY HOSPI TA	L	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS		er CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
			itle XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Healt	h All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Co	st Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	)	0	0 C	0 0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0	0	0	31.00
43. 00 04300 NURSERY	0		0	0	0	43.00
200.00 Total (lines 30-199)	0		o	0	0	200.00
Cost Center Description	Total Patient	Per Diem (co	I. Inpatient	I npati ent		
	Days	5 ÷ col. 6)				
				Pass-Through		
				Cost (col. 7 x	,	
				col . 8)		
	6.00	7.00	8,00	9.00	1	
INPATIENT ROUTINE SERVICE COST CENTERS					1	
30. 00 03000 ADULTS & PEDI ATRI CS	12, 478	0.	00 1, 2	90 0	)	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 558			47 C		31.00
43. 00 04300 NURSERY	1,011			B3 C		43.00
200.00 Total (lines 30-199)	15, 047		2, 0		Ś	200.00
200.00 10101 (11105 30-177)	15,047	1	2, 0.	201 0	1	I∠00. 00

Health Financial Systems	KOSCIUSKO COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der	CCN: 150133	Peri od:	Worksheet D	
THROUGH COSTS				From 03/01/2015 To 02/29/2016		norod.
				10 02/29/2010	7/27/2016 2:0	
			le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician N	lursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
	1.00				4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	54.00
54. 01 05401 ULTRASOUND	0	0			0	54.00
54. 02 05402 ONCOLOGY	0	0		0 0	0	54.02
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.00
76.01 03610 SLEEP LAB	0	0		0 0	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	1 1		1	1		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0		0 0	0	
200.00  Total (lines 50-199)	0	0	1	0 0	0	200.00

APPORDIT ONMENT OF LIPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 150133         Period: To 02/2/2/2016         Worksheet D Part IV Date/Time Prepared: 7/2/2/016           Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Outpatient Cost Center Description         Inpatient Program Cost Center Description         Inpatient Program Cost Center Description         Inpatient Cost Center Description         Inpatient Center Description         Inpatient Center Description           50:00         05000 DELIVERY ROOM Cost Center RoOM Cost Ob DELIVERY ROOM Cost OB CAD ALBOR COST         0	Health Financial Systems	KOSCIUSKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Antiol and output         To         0.2/29/2016         Date/Time Prepared: 17/27/27/2016 2:06 pm           Cost Center Description         Total Outpatient col. 2, 3 and 4)         Total Cost Center Description         Total Cost Center Description         Total Cost Center Description         Total Cost Center Description         Date/Time Prepared: Total Charges Col. 5 + col.         Pospital to Charges Col. 5 + col.         Pospital Total controls         Program Charges Col. 5 + col.           50:00         0         55:000         0         7.00         8.00         9.00         10.00           50:00         0         05000         0PERATING ROOM 0         0         55:701,802         0.000000         0.000000         29,182         51:00           51:00         055000         DELIVERY NOOM ALBOR ROOM 0         0         55:701,802         0.000000         0.000000         29,182         51:00           52:00         05300         DELIVERY NOOM ALBOR ROOM 0         0         2,2211,443         0.000000         0.000000         0         53:00           54:01         05401         ULTRASUND         0         7,73;892         0.000000         0.000000         0         54:01           54:02         05402         05400         RADI ILTRASUND         0         11:110;874         0.000000		RVICE OTHER PAS	S Provi der				
Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and a)         Total (frm Wkst. C, b)         Total (col. 5 + col. 7)         Data (concern) (col. 6 + col. 7)         Inpatient (col. 6 + col. 7)         Inpatient (col. 6 + col. 7)           ANCILLARY SERVICE COST CENTERS         0         0         0.00000         0.00000	THROUGH COSTS						norod.
Cost Center Description         Title XIX         Hospital         PPS           Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Outpatient Cost (sum of col. 5, col. 8)         Hospital ent Ratio of Cost (col. 5, col. 7)         Inpatient Ratio of Cost (col. 5, col. 7)         Inpatient Cost Outpatient (col. 5, col. 7)         Cost Outpatient Ratio of Cost (col. 5, col. 7)         Inpatient (col. 5, col. 7)         Cost Outpatient (col. 5, col. 7)         Cost Outpatient (col. 5, col. 7)         Cost Outpatient (col. 5, col. 7)         Cost (col. 6, col. 7)         Inpatient (col. 5, col. 7)         Cost (col. 6, col. 7)         Cost (					10 02/29/2016		
Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total (from Wkst. C, 8)         Ratio of Cost (sol. 6 + col. 7)         Inpatient Ratio of Cost (sol. 6 + col. 7)         Inpatient (sol. 6 + col. 7)         Inpatient (sol. 6 + col. 7)           ANCILLARY SERVICE COST CENTERS         0         70         8.00         9.00         10.00           50.00         05000 (PECPATI NG ROOM 00 RECOVERY ROM 3.00         0         55.701, 802         0.000000         0.000000         29, 812         50.00           52.00         05300 RECUCERY ROM 4.00         0         55.701, 802         0.000000         0.000000         29, 812         51.00           54.00         05300 ANESTHESI OLGY         0         0         0.000000         0.000000         0         53.00           54.01         05400 RADI OLGY-01 AGNOSTI C         0         11, 110, 874         0.000000         0.000000         0         54.00           54.00         05600 RADI OLGY-01 AGNOSTI C         0         11, 110, 874         0.000000         0.000000         0         54.00           54.00         05600 RADI OLGY-01 AGNOSTI C         0         773, 892         0.000000         0.000000         0         54.02           55.00         05600 RADI OLGY-01 AGNOSTI C         0         773, 892			Ti t	le XIX	Hospi tal		<u>o p</u>
ANCILLARY SERVICE COST CENTERS         Cost (sum of col. 2, 3 and 4)         Part 1, col. 8)         Cosl. 5 + col. 7)         to Charges (col. 6 + col. 7)         Charges (col. 6 + col. 7)           ANCILLARY SERVICE COST CENTERS         0         55, 701, 802         0.000000         0.000000         312, 027         50. 00           51.00         05000         PERATING ROOM         0         55, 701, 802         0.000000         0.000000         29, 827         50. 00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         28, 837, 827         0.000000         0.000000         0.000000         29, 825         51. 00           53.00         05300         DELIVERY ROOM & LABOR ROOM         0         22, 211, 443         0.000000         0.000000         0.000000         102, 690         54. 00           54.01         05401         UTRASOUND         0         11, 110, 874         0.000000         0.000000         1448         56. 00           55.000 GROU OLOGY         0         11, 110, 874         0.000000         0.000000         18, 645. 00         55. 601, 884         0.000000         0.000000         14495         66. 00           65.00         06500 RADI OLSOTOPE         0         7.973, 892         0.0000000         0.000000         0.000	Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
4)         7)         7)           ANCILLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           ANCILLARY SERVICE COST CENTERS         0         55.701,802         0.000000         0.000000         312,027         50.00           50.00         05000         PERATING ROOM         0         55.009,956         0.000000         0.000000         312,027         50.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         2,837,827         0.000000         0.000000         0.000000         0         53.00           54.00         OS400 RADI LOGV-DI AGNOSTI C         0         2,211,443         0.000000         0.000000         0         54.00           54.01         05401         ULTRASOUND         0         11,110,874         0.000000         0.000000         0         54.02           56.00         05600 RADI OLSTOPE         0         7,973,892         0.000000         0.000000         18,048         56.00           60.00         06500 RADI OLSTOPE         0         7,973,892         0.000000         0.000000         18,048         56.00           61.00         06500 RESPI RATORY THERAPY         0         16,864,998         0.000000 <td></td> <td>Cost (sum of</td> <td>Part I, col.</td> <td>(col. 5 ÷ col</td> <td>. to Charges</td> <td>Charges</td> <td></td>		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000         OPERATI NG ROM         0         55,701,802         0.000000         0.000000         29,182         51.00           51.00         05300         DELI VERY ROM & LABOR ROOM         0         2,837,827         0.000000         0.000000         29,182         51.00           53.00         05300         ANESTHESI OLOGY         0         0.000000         0.000000         0.000000         0.000000         0.000000         102,690         54.00           54.00         05400         RADI ULGY-DI AGNOSTI C         0         22,211,443         0.000000         0.000000         0         54.00           54.01         US401         ULTASSOUND         0         0         0.000000         0.000000         0         54.01           54.02         05402         ONCLOGY         0         11,110,874         0.000000         0.000000         102,690         54.01           55.00         05600         RADI DI SOTOPE         0         7,73,892         0.000000         0.000000         29,245         58.00           65.00         06500         RESPI RATORY         0         56,932,4			8)	7)			
ANCLILLARY SERVICE COST CENTERS         0         0           50.00         05000 DPERATING ROOM         0         55,701,802         0.000000         0.000000         312,027         50.00           51.00         05100 RECOVERY ROOM         0         5,009,956         0.000000         0.000000         29,132         51.00           53.00         05300 ANESTHESI OLOGY         0         0         0.000000         0.000000         102,699         53.00           54.01         05400 RADI OLOGY-DI AGNOSTI C         0         22,211,443         0.000000         0.000000         102,699         54.01           54.01         05401 ULTRASOUND         0         0         0.000000         0.000000         0         54.01           54.02         05402 ONCLOCY         0         11,110,874         0.000000         0.000000         0         54.01           54.00         05600 RADI OLSTOPE         0         7,973,892         0.000000         0.000000         18,048         56.00           55.00         05600 RADI RATORY         0         12,572,213         0.000000         0.000000         29,247         65.00           65.00         06500 RESPI RATORY THERAPY         0         16,864,996         0.000000         0.0					• /		
50.00       05000       OPERATI NG ROOM       0       55, 701, 802       0.000000       0.000000       312, 027       50.00         51.00       05100       RECOVERY ROOM & LABOR ROOM       0       2, 837, 827       0.000000       0.000000       29, 182       51.00         52.00       05200       DEL/VERY ROOM & LABOR ROOM       0       2, 837, 827       0.000000       18, 048       6.00       0.000000       0.000000       18, 048       6.00       0.000000       0.000000       18, 048       6.00       0.000000       0.000000       18, 048       66.00       0.000000       0.000000       18, 048       66.00       0.000000       0.000000       2.9, 245       58.00       0.000000       0.0000000       2.9		6.00	7.00	8.00	9.00	10.00	
51.00       05100       RECOVERY ROOM       0       5,009,956       0.000000       0.000000       29,182       51.00         52.00       DELIVERY ROOM & LABOR ROOM       0       2,837,827       0.000000       0.000000       87,227       52.00         53.00       OS5400       RADI OLOGY-DI AGNOSTI C       0       22,211,443       0.000000       0.000000       102,690       54.00         54.01       05401       ULTRASOUND       0       0       0.000000       0.000000       154.01         54.02       OS600       RADI OLOGY-DI AGNOSTI C       0       1,110,874       0.000000       0.000000       154.02         55.00       05600       RADI OLOGY       0       7,973,892       0.000000       0.000000       187,603       57.00         60.00       06000       LABORATORY       0       56,932,407       0.000000       0.000000       29,245       58.00         61.00       06000       LABORATORY       0       16,864,998       0.000000       0.000000       21,433       67.00         65.00       OCULAT INAL THERAPY       0       1,59,67       0.000000       0.000000       21,433       67.00         67.00       06700       CCULAT ITERAPY       <			1	1			
52.00       05200       DELIVERY ROM & LABOR ROOM       0       2, 837, 827       0.000000       0.000000       87, 227       52.00         53.00       ANESTHESI OLOGY       0       0       0.000000       0.000000       0       53.00         54.00       O5400       RADI LOGY-DI AGNOSTI C       0       22, 211, 443       0.000000       0.000000       102, 690       54.00         54.01       05401       ULTRASOUND       0       0.000000       0.000000       0       54.00         54.02       05402       ONCLOGY       0       11, 110, 874       0.000000       0.000000       102, 690       54.00         57.00       05700       CT SCAN       0       55, 601, 884       0.000000       0.000000       187, 603       57.00         58.00       05600       RADI NTY       0       55, 601, 884       0.000000       0.000000       29, 245       58.00         66.00       06600       HYSI CAL THERAPY       0       16, 864, 998       0.000000       0.000000       22, 92, 77       65.00         66.00       06600       PHYSI CAL THERAPY       0       1, 291, 190       0.000000       0.000000       21, 438       60.00         67.00       06700 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
53.00       05300       ANESTHESI OLOGY       0       0       0       0.000000       0.000000       102,690       54.00         54.01       05400       RADI OLOGY-DI AGNOSTI C       0       0.000000       0.000000       102,690       54.00         54.01       05400       RADI ASSOUND       0       0.000000       0.000000       0       54.00         54.02       05402       NCOLOGY       0       11,110,874       0.000000       0.000000       54.02         56.00       05500       RADI OLSOTOPE       0       7,973,892       0.000000       0.000000       18,648       56.00         57.00       05800       MRI       0       12,572,213       0.000000       0.000000       29,245       58.00         66.00       06600       PHSPI RATORY       0       16,864,998       0.000000       0.000000       29,277       65.00         67.00       06700       CCUPATI ONAL THERAPY       0       1,291,190       0.000000       0.000000       29,277       65.00         68.00       08600       SPECH PATHOLOGY       0       2,861,819       0.000000       0.000000       54.02         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0					
54.00       05400       RADI OLOGY - DI AGNOSTI C       0       22, 211, 443       0.000000       0.000000       102, 690       54.01         54.01       05401       ULTRASUND       0       0       0.000000       0.000000       54.01         54.02       05402       ONCOLOGY       0       11, 110, 874       0.000000       0.000000       18, 048       56.02         56.00       05600       RADI OI SOTOPE       0       7, 973, 892       0.000000       0.000000       187, 603       57.00         58.00       05800       MRI       0       12, 572, 213       0.000000       0.000000       229, 277       65.00         60.00       06500       RESPI RATORY       THERAPY       0       7, 153, 757       0.000000       0.000000       229, 277       65.00         66.00       06600       PHYSI CAL THERAPY       0       7, 153, 757       0.000000       0.000000       249       68.00         67.00       06700       OCCUPATI ONAL THERAPY       0       1, 291, 190       0.000000       0.000000       34, 445       60.00         69.00       06900       ELECTROCARDI OLOGY       0       1, 291, 190       0.000000       0.000000       3, 508       69.00 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
54.01       05401       ULTRASOUND       0       0.000000       0.000000       0       54.01         54.02       05402       ONCOLOGY       0       11,110,874       0.000000       0.000000       16,002         57.00       05700       CT SCAN       0       55,601,884       0.000000       0.000000       187,603       57.00         58.00       05800       RAI       0       12,572,213       0.000000       0.000000       29,245       58.00         60.00       06500       RATORY       0       56,932,407       0.000000       0.000000       29,245       56.00         65.00       06500       RESPI RATORY       16,844,998       0.000000       0.000000       29,247       65.00         66.00       06600       PHYSI CAL THERAPY       1,291,190       0.000000       0.000000       21,438       66.00         67.00       06700       0C2UPATI ONAL THERAPY       1,291,190       0.000000       0.000000       390       48.00         69.00       06900       ELECTROCARDI OLOGY       2,861,819       0.000000       0.000000       3,508       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       15,460,802       0.000000		0	, i				
54.02       05402       ONCOLOGY       0       11, 110, 874       0.000000       0.000000       18, 048       56.00         56.00       05600       RADI OI SOTOPE       0       7, 973, 892       0.000000       0.000000       18, 048       56.00         57.00       05700       CT SCAN       0       55, 601, 884       0.000000       0.000000       187, 603       57.00         58.00       05800       MRI       0       12, 572, 213       0.000000       0.000000       29, 245       58.00         60.00       06000       LABORATORY       0       16, 864, 998       0.000000       0.000000       29, 277       65.00         65.00       06500       RESPI RATORY THERAPY       0       16, 864, 998       0.000000       0.000000       21, 438       60.00         66.00       06700       OCUPATI ONAL THERAPY       0       1,291, 190       0.000000       0.000000       394       45.00         67.00       06400       PHYSI CAL THERAPY       0       169, 967       0.000000       0.000000       54.02         68.00       06900       ELECTROCARDI OLOGY       0       2, 861, 819       0.000000       0.000000       390       68.00         71.00		0	22, 211, 443				•
56.00         05600         RADI 0I SOTOPE         0         7,973,892         0.00000         0.00000         18,048         56.00           57.00         05700         CT SCAN         0         55,601,884         0.00000         0.000000         127,603         57.00           68.00         06000         LABORATORY         0         12,572,213         0.00000         0.000000         29,245         58.00           65.00         06500         RESPI RATORY THERAPY         0         16,864,998         0.000000         0.000000         29,245         60.00           65.00         06500         RESPI RATORY THERAPY         0         16,864,998         0.000000         0.000000         21,438         66.00           67.00         06700         0CUPATI IONAL THERAPY         0         1,291,190         0.000000         0.000000         394,495         66.00           68.00         SPECH PATHOLOGY         0         1,291,190         0.000000         0.000000         396         69.00           69.00         Of000         ELECTROCARDI OLOGY         0         2,861,819         0.000000         0.000000         396         69.00           71.00         07100         MEL CAL SUPPLI ES CHARGED TO PATI ENT		0	0				
57.00       05700       CT SCAN       0       55, 601, 884       0.000000       0.000000       187, 603       57.00         58.00       05800       MRI       0       12, 572, 213       0.000000       0.000000       29, 245       58.00         60.00       LABORATORY       0       56, 932, 407       0.000000       0.000000       29, 245       58.00         65.00       06000       LABORATORY       THERAPY       0       16, 864, 998       0.000000       0.000000       29, 217       65.00         64.00       06600       PHYSI CAL THERAPY       0       7, 153, 757       0.000000       0.000000       29, 217       65.00         65.00       06700       OCCUPATI ONAL THERAPY       0       1, 291, 190       0.000000       0.000000       543       67.00         68.00       06800       SPECH PATHOLOGY       0       2, 861, 819       0.000000       0.000000       3, 508       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       14, 980, 250       0.000000       0.000000       114, 697       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       15, 460, 802       0.000000       0.000000       114, 697		0					
58.00       05800       MRI       0       12, 572, 213       0.000000       0.000000       29, 245       58.00         60.00       06000       LABORATORY       0       56, 932, 407       0.000000       0.000000       394, 495       60.00         65.00       06500       RESPI RATORY THERAPY       0       16, 864, 998       0.000000       0.000000       229, 277       65.00         66.00       06600       PHYSI CAL THERAPY       0       7, 153, 757       0.000000       0.000000       243       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1, 291, 190       0.000000       0.000000       390       68.00         68.00       06800       SPEECH PATHOLOGY       0       169, 967       0.000000       0.000000       390       68.00         69.00       D6900       ELECTROCARDI OLOGY       0       2, 861, 819       0.000000       0.000000       3,508       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       15, 460, 802       0.000000       0.000000       14, 697       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       127, 147, 438       0.0000000       0.000000 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
60.00       06000       LABORATORY       0       56, 932, 407       0.00000       0.000000       394, 495       60.00         65.00       06500       RESPI RATORY THERAPY       0       16, 864, 998       0.000000       0.000000       229, 277       65.00         66.00       06600       PHYSI CAL THERAPY       0       7, 153, 757       0.000000       0.000000       21, 438       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       1, 291, 190       0.000000       0.000000       543       67.00         68.00       06800       SPEECH PATHOLOGY       0       169, 967       0.000000       0.000000       3906       68.00         69.00       O6900       ELECTROCARDI OLOGY       0       2, 861, 819       0.000000       0.000000       3, 508       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       14, 980, 250       0.000000       0.000000       114, 697       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       127, 147, 438       0.000000       0.000000       1, 081, 278       73.00         76.01       033510       THER ANCI LLARY SERVI CE COST CENTER       0       0       0.000000		0					•
65.00       06500       RESPI RATORY THERAPY       0       16,864,998       0.000000       0.000000       229,277       65.00         66.00       06600       PHYSI CAL THERAPY       0       7,153,757       0.000000       0.000000       21,438       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1,291,190       0.000000       0.000000       543       67.00         68.00       06800       SPEECH PATHOLOGY       0       169,967       0.000000       0.000000       3,508       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       14,980,250       0.000000       0.000000       14,697       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       127,147,438       0.000000       0.000000       1,081,278       73.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0.000000       0       76.00         76.01       03410       SLEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.0000000		0					
66.00       06600       PHYSI CAL THERAPY       0       7, 153, 757       0.000000       0.000000       21, 438       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1, 291, 190       0.000000       0.000000       543       67.00         68.00       06800       SPEECH PATHOLOGY       0       169, 967       0.000000       0.000000       390       68.00         69.00       06900       ELECTROCARDI OLOGY       0       2, 861, 819       0.000000       0.000000       3,508       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       14, 980, 250       0.000000       0.000000       144, 697       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       15, 460, 802       0.000000       0.000000       1, 081, 278       73.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0.0000000       0.0000000       0		0					
67.00       06700       OCCUPATIONAL THERAPY       0       1,291,190       0.000000       0.000000       543       67.00         68.00       06800       SPEECH PATHOLOGY       0       169,967       0.000000       0.000000       390       68.00         69.00       06900       ELECTROCARDIOLOGY       0       2,861,819       0.000000       0.000000       3,508       69.00         71.00       O7100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       14,980,250       0.000000       0.000000       114,697       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       15,460,802       0.000000       0.000000       1,081,278       73.00         73.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       127,147,438       0.000000       0.000000       1,081,278       73.00         76.01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76.00         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0.000000       0.000000       <		0					
68.00       06800       SPEECH PATHOLOGY       0       169,967       0.000000       0.000000       390       68.00         69.00       06900       ELECTROCARDIOLOGY       0       2,861,819       0.000000       0.000000       3,508       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       14,980,250       0.000000       0.000000       99,382       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       15,460,802       0.000000       0.000000       1,081,278       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       127,147,438       0.000000       0.000000       1,081,278       73.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         77.02       07000       CLINIC       0       0.000000       0.000000       0       76.01         76.01       03610       SLEEP LAB       0       0       0.000000       0       76.01         76.03       03951		0					•
69.00       06900       ELECTROCARDIOLOGY       0       2,861,819       0.000000       0.000000       3,508       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       14,980,250       0.000000       0.000000       99,382       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       15,460,802       0.000000       0.000000       114,697       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       127,147,438       0.000000       0.000000       1,081,278       73.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCILLARY SERVICE COST CENTER       0       0       0.000000       0       76.01         76.03       03951       OTHER ANCILLARY SERVICE COST CENTER       0       0       0.000000       0       76.01         76.03       03951       OTHER ANCILLARY SERVICE COST CENTER       0       0       0.000000       0       76.01 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       14, 980, 250       0.000000       0.000000       99, 382       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       15, 460, 802       0.000000       0.000000       114, 697       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       127, 147, 438       0.000000       0.000000       1, 081, 278       73.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       0		0					
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       15,460,802       0.000000       0.000000       114,697       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       127,147,438       0.000000       0.000000       1,081,278       73.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03401       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       0       76.01         76.03       03900       CLINIC       0       5,070,078       0.000000       0.000000       6       76.03         71.00       09100       EMERGENCY       0       36,265,393       0.000000       0.000000       163,838       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       7,471,789       0.000000       0.000000       48,525		0					
73.00       07300       DRUGS CHARGED TO PATIENTS       0       127, 147, 438       0.000000       0.000000       1, 081, 278       73.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.00         76.01       03410       SLEEP LAB       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76.01         76.03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       0       76.03         0UTPATIENT SERVICE COST CENTERS       0       0       0.000000       0.000000       0       76.03         90.00       09000       CLINIC       0       5,070,078       0.000000       0.000000       8,962       90.00         91.00       09100       EMERGENCY       0       36,265,393       0.000000       0.000000       163,838       91.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       7,471,789       0.000000       0.000000       48,525       92.00		0					
76. 00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76. 00         76. 01       03610       SLEEP LAB       0       0       0.000000       0.000000       0       76. 01         76. 03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       76. 01         76. 03       03951       OTHER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0       76. 03         0UTPATI ENT SERVICE COST CENTERS       0       5,070,078       0.000000       0.000000       8,962       90. 00         90. 00       09000       CLINIC       0       36,265,393       0.000000       0.000000       163,838       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       7,471,789       0.000000       0.000000       48,525       92. 00		0					
76. 01         0.3610         SLEEP LAB         0         0         0.000000         0.000000         0         76. 01           76. 03         03951         0THER ANCI LLARY SERVICE COST CENTER         0         0         0.000000         0         76. 01         76. 03           0UTPATI ENT SERVICE COST CENTERS         0         5, 070, 078         0.000000         0.000000         8, 962         90. 00           90. 00         09100         EMERGENCY         0         36, 265, 393         0.000000         0.000000         163, 838         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         7, 471, 789         0.000000         0.000000         48, 525         92. 00		0					
76. 03       03951       0THER ANCI LLARY SERVICE COST CENTER       0       0       0.000000       0.000000       0       76. 03         0UTPATI ENT SERVICE COST CENTERS       0       5,070,078       0.000000       0.000000       8,962       90. 00         90. 00       09100       EMERGENCY       0       36,265,393       0.000000       0.000000       163,838       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       7,471,789       0.000000       0.000000       48,525       92.00		0					
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLI NI C         0         5,070,078         0.000000         0.000000         8,962         90.00           91. 00         09100         EMERGENCY         0         36,265,393         0.000000         163,838         91.00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT_PART         0         7,471,789         0.000000         48,525         92.00		0	-				
90. 00         09000         CLINIC         0         5,070,078         0.000000         0.000000         8,962         90.00           91. 00         09100         EMERGENCY         0         36,265,393         0.000000         0.000000         163,838         91.00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0         7,471,789         0.000000         0.000000         48,525         92.00		0	0	0.00000	0.000000	0	76.03
91. 00         09100         EMERGENCY         0         36, 265, 393         0. 000000         0. 000000         163, 838         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DISTINCT PART         0         7, 471, 789         0. 000000         0. 000000         48, 525         92. 00		-	5 070 070			0.0/0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 7, 471, 789 0. 000000 0. 000000 48, 525 92. 00		-					
		-					
200. 00   10tal (11nes 50-144)   0  464, 689, 779    2, 932, 355 [200. 00		-			0.00000		
	200.00  10tal (11nes 50-199)	0	404,089,779	1		2, 932, 355	1200. OU

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150133 Period: Worksheet D THROUGH COSTS Provider CCN: 150133 Period: Part IV	
TURQUAL 20070	
To 02/29/2016 Date/Time Pre 7/27/2016 2:0	pared: 6 pm
Title XIX Hospital PPS	
Cost Center Description Inpatient Outpatient Outpatient	
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	
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 0 0	50.00
51.00 05100 RECOVERY ROOM 0 0 0	51.00
52. 00 OS200 DELIVERY ROOM & LABOR ROOM O O O	52.00
53.00   05300  ANESTHESI OLOGY 0 0 0	53.00
54. 00   05400  RADI 0L0GY-DI AGNOSTI C 0 0 0	54.00
54.01   05401   ULTRASOUND 0 0 0	54.01
54. 02 05402 ONCOLOGY 0 0 0	54.02
56. 00 05600 RADI 0I SOTOPE 0 0 0	56.00
57. 00 05700 CT SCAN 0 0 0	57.00
	58.00
	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	72.00
	73.00
76. 00         03950         OTHER ANCI LLARY SERVICE COST CENTER         0         0         0         0           76. 01         03610         SLEEP LAB         0         0         0         0	76. 00 76. 01
76. 01         03610         SLEEP         LAB         0         0         0           76. 03         03951         OTHER         ANCI LLARY SERVICE COST CENTER         0         0         0	76.01
OUTPATIENT SERVICE COST CENTER OF OF OF OF	76.03
90. 00 09000 CLINIC 0 0 0	90.00
91. 00 09100 EMERGENCY 0 0 0	90.00 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0	91.00 92.00
200.00 Total (Lines 50-199) 0 0 0	200.00
	200.00

APPORTI ONM	ancial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	NITY HOSPITAL Provider	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	u of Form CMS- Worksheet D Part V Date/Time Pre	
						7/27/2016 2:0	6 pm
			Tit	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	DO OPERATING ROOM	0. 089094			0 461, 017		
	DO RECOVERY ROOM	0. 268050	0		0 52, 637	0	
	DO DELIVERY ROOM & LABOR ROOM	0. 380079	0		0 16, 332	0	
53.00 0530	DO ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0. 194765	0		0 557, 636	0	54.00
54.01 0540	01 ULTRASOUND	0. 000000	0		0 0	0	54.01
54.02 0540	D2 ONCOLOGY	0. 260269	0		0 126, 462	0	54.02
56.00 0560	DO RADI OI SOTOPE	0. 068033	0		0 75, 469	0	56.00
57.00 0570	DO CT SCAN	0. 018394	0		0 1, 129, 797	0	57.00
	DO MRI	0.052575	0		0 174,092	0	1
	DOLABORATORY	0. 086040	0		0 939, 146		
	DO RESPIRATORY THERAPY	0. 067655	0		0 146,065		
	DO PHYSI CAL THERAPY	0. 408616	0		0 86, 753		
	DO OCCUPATI ONAL THERAPY	0. 219522			0 30, 050		
	DO SPEECH PATHOLOGY	0. 264410			0 4,832	0	
	DO ELECTROCARDI OLOGY	0. 053270			0 34,825	-	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045738	0		0 157, 159		1
	DO IMPL. DEV. CHARGED TO PATIENTS	0. 210895	0		0 65,002		1
	DO DRUGS CHARGED TO PATIENTS	0. 210893	0		0 1, 249, 762	0	
	50 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0		0 1, 249, 762	0	
			0		0 0	-	
	10 SLEEP LAB	0. 000000			0 0	0	1 / 0/ 0/
	51 OTHER ANCI LLARY SERVICE COST CENTER	0. 000000	0		0 0	0	76.03
	PATIENT SERVICE COST CENTERS	0.040570		1			
90.00 0900		0. 242573			0 80, 969		
	DO EMERGENCY	0. 112622	0		0 1,054,104		
	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 267191	0		0 121, 420		
200.00	Subtotal (see instructions)		0		0 6, 563, 529	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)	1	0		0 6, 563, 529	0	202.00

Health Financial Systems	KOSCIUSKO COMML	INI TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Pre 7/27/2016 2:0	
		Ti t	le XIX	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	41,074				50.00
51. 00 05100 RECOVERY ROOM	0	14, 109				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 207	•			52.00
53. 00 05300 ANESTHESI OLOGY		0,207				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		108, 608				54.00
54. 01 05401 ULTRASOUND		100,000	1			54.00
54. 02 05402 ONCOLOGY		32, 914				54.02
56. 00 05600 RADI OI SOTOPE	0	5, 134				56.00
57. 00 05700 CT SCAN	0	20, 781				57.00
58. 00 05800 MRI	0	9, 153	•			58.00
60. 00 06000 LABORATORY	0	80, 804				60.00
65. 00 06500 RESPI RATORY THERAPY	0	9, 882				65.00
66. 00 06600 PHYSI CAL THERAPY	0	35, 449				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	6, 597	,			67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 278				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 855				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 188				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 709				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	85, 133	6			73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C				76.00
76. 01 03610 SLEEP LAB	0					76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	C				76.03
OUTPATIENT SERVICE COST CENTERS	1	1	-			
90. 00 09000 CLI NI C	0		•			90.00
91.00 09100 EMERGENCY	0	118, 715				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	32, 442				92.00
200.00 Subtotal (see instructions)	0	650, 673				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		(50 (72				202.00
202.00 Net Charges (line 200 +/- line 201)	0	650, 673	9			202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	7/27/2016 2:0 PPS	6 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			40.470	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			12, 478 12, 478	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		9, 867	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	9,007	
~~	reporting period		21 -6	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) arter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5.		-	
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	3, 726	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruc		and dave) ofter	0	1 1 1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	X onlv (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	e)	_	
	Medically necessary private room days applicable to the Progratotal nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	os through Docombor 21 a	f the cost	0.00	1 17
. 00	reporting period	es thiough becember 51 0	the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
	reporting period				
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	9, 540, 855 0	
	5 x line 17)		0 1 1		
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 9, 540, 855	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· 1		
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 2 x line 25)	ne 31)		0. 00 0	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	9, 540, 855	
	27 minus line 36)	•			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJI	USTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		764.61	
	Program general inpatient routine service cost (line 9 x line	38)		2, 848, 937	39
	Medically necessary private room cost applicable to the Progra	-		2,010, 707	

UNPU	TATION OF INPATIENT OPERATING COST	Provi der		Period: From 03/01/2015	Worksheet D-1	l
				o 02/29/2016		
		Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description Total Inpatient Co	Total stInpatient Days	Average Per Diem (col. 1 = col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00		0 0	0.00	0 0	0	42.
	Intensive Care Type Inpatient Hospital Units	/1 1 550	1 704 5	/01	1 015 003	1 42
3.00		61 1, 558	1, 784. 57	681	1, 215, 292	
4.00 5.00						44.
	SURGI CAL INTENSIVE CARE UNI T					46.
	OTHER SPECIAL CARE (SPECIFY)					47.
	Cost Center Description				1.00	
. 00	Program inpatient ancillary service cost (Wkst. D-3, col.	3. Line 200)			1.00 5,088,425	48.
0.00			ons)		9, 152, 654	
	PASS THROUGH COST ADJUSTMENTS	/ 、	,		· · · ·	
0. 00	5 11 5 1	ne services (from	n Wkst. D, sum	of Parts I and	559, 156	50.
1.00	<pre>    ) Pass through costs applicable to Program inpatient ancill</pre>	ary sorvices (fr	om What D a	m of Parts II	351, 513	51
	and IV)	ary services (II	UM WKSL D, SL	01 10115 11	351, 515	, J.
2.00	Total Program excludable cost (sum of lines 50 and 51)				910, 669	52.
3. 00		related, non-phy	vsician anesthe	etist, and	8, 241, 985	53.
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION					-
I. 00					C	54.
. 00	5 5				0.00	
. 00	5 I 5				0	56
. 00	j i i j	target amount (I	ine 56 minus l	ine 53)	0	
. 00					0	
. 00	1 51	od ending 1996, ι	pdated and com	pounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report,	updated by the m	arket basket		0.00	60.
. 00				he amount by	0	
	which operating costs (line 53) are less than expected co		60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see instructions)	1			_	
2.00		ructions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					03.
. 00	Medicare swing-bed SNF inpatient routine costs through De	ecember 31 of the	e cost reportir	ng period (See	0	64.
- 00	instructions) (title XVIII only)					
5.00	Medicare swing-bed SNF inpatient routine costs after Dece instructions)(title XVIII only)	ember 31 of the c	cost reporting	period (See	0	65.
5.00		ne 64 plus line 6	5)(title XVIII	onlv). For	0	66.
	CAH (see instructions)					
7.00		ugh December 31 c	of the cost rep	orting period	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after	December 31 of	the cost repor	ting period	C C	68.
5.00	(line 13 x line 20)	December 31 01	the cost repor	ting period		/ 00.
9. 00		s (line 67 + line	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILI				1	
0.00	5 5 5 5					70.
2.00			2)			71.
B. 00		am (line 14 x li	ne 35)			73.
. 00	3 31 11 3	•	,			74
6. 00	5 5 1			rt II, column		75
	26, line 45)					
5.00 7.00						76.
. 00 3. 00						78.
. 00		n provider record	ls)			79
. 00		•		ıs line 79)		80
. 00						81
. 00						82
. 00		ons)				83
. 00	5 1 5	i onc)				84
. 00 . 00						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COS				1	- 30.
7.00					2, 611	87.
					1 744 41	88.
3. 00	Adjusted general inpatient routine cost per diem (line 27 Observation bed cost (line 87 x line 88) (see instruction				764. 61 1, 996, 397	

Health Financial Systems	KOSCIUSKO COMMU	INITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 03/01/2015	Worksheet D-1	
				To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 398, 776	9, 540, 855	0. 14660	9 1, 996, 397	292, 690	90.00
91.00 Nursing School cost	0	9, 540, 855	0. 00000	1, 996, 397	0	91.00
92.00 Allied health cost	0	9, 540, 855	0.00000	1, 996, 397	0	92.00
93.00 All other Medical Education	0	9, 540, 855	0.00000	1, 996, 397	0	93.00

	Financial Systems KOSCIUSKO COMMUNIT TION OF INPATIENT OPERATING COST	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Pre	
		Title XIX		7/27/2016 2:0	
	Cost Center Description		Hospi tal	PPS	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			12, 478 12, 478	
	Private room days (excluding private room days, excluding swing-		ivate room davs.	12, 478	
	do not complete this line.				
.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	9, 867 0	4. 5.
. 00	reporting period	Jiii uays) thi ough beceilibe	a si oi the cost	0	5.
. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7.
	reporting period			0	
. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed and	1, 290	9.
	newborn days)		Sinnig bed and	1,270	
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.
1.00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	•	Ū.	
2.00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	<pre>&lt; only (including privat</pre>	e room days)	0	12.
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI	(only (including privat	e room davs)	0	13.
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	ie)		
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 1, 011	14.
	Nursery days (title V or XIX only)				16.
ĺ	SWING BED ADJUSTMENT				1
7.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0.00	17.
8.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.
	reporting period			0.00	10
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.
1 00	reporting period	-)		9, 540, 855	21
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	9, 540, 855	
	5 x line 17)		31 (		
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23.
	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24.
	7 x line 19)	· · · · · · · · · · · · · · · · · · ·			
5.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25.
6. 00	Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 540, 855	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bea	and observation bed ch	arges)	0	28.
	Private room charges (excluding swing-bed charges)		u goo,	0	29.
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 · Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 9, 540, 855	36. 37.
	27 minus line 36)			7, 540, 655	] "
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			764.61	38.
	Program general inpatient routine service cost (line 9 x line			986, 347	
D. 00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.
1 00	Total Program general inpatient routine service cost (line 39	+ line 40)		986, 347	41

OMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 150133 Period: From 03/01/	2015	Worksheet D-1	
	To 02/29/		Date/Time Pre 7/27/2016 2:0	
	Title XIX Hospital		PPS	
	Cost Center Description Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)		Program Cost col. 3 x col. 4)	
	1.00 2.00 3.00 4.00		5.00	
. 00		483	182, 159	42.
. 00	Intensive Care Type Inpatient Hospital Units           INTENSIVE CARE UNIT         2,780,361         1,558         1,784.57	247	440, 789	43
. 00		247	440, 707	44
. 00				45
. 00	SURGICAL INTENSIVE CARE UNIT			46
. 00	OTHER SPECIAL CARE (SPECIFY)			47
	Cost Center Description	-	1.00	
. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		289, 597	48
. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		1, 898, 892	49
	PASS THROUGH COST ADJUSTMENTS		044 507	1 50
. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I III)	and	211, 507	50
. 00			21, 643	51
	and IV)			
2.00			233, 150	
8. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		1, 665, 742	53
	TARGET AMOUNT AND LIMIT COMPUTATION			
. 00			0	54
. 00			0.00	
. 00	5		0	
. 00	j 1 1 5 5 V		0	
. 00		the	0.00	
	market basket			
0.00			0.00	
. 00	If line $53/54$ is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount I which operating costs (line 53) are less than expected costs (lines $54 \times 60$ ), or 1% of the target		0	61
	amount (line 56), otherwise enter zero (see instructions)			
2. 00			0	62
. 00			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (	500	0	64
. 00	instructions) (title XVIII only)	566	0	04
5.00		e	0	65
~~	instructions) (title XVIII only)		0	
. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	r	0	66
. 00		i od	0	67.
	(line 12 x line 19)			
3. 00		d	0	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY			
. 00	5 5 5			70
. 00				71
. 00				72
. 00				74
. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, colu	umn		75
00	26, line 45) Per diem conital related costs (line 75 + line 2)			_,
. 00 . 00				76
. 00				78
. 00	Aggregate charges to beneficiaries for excess costs (from provider records)			79
. 00	5			80
. 00				81
. 00				82
. 00				84
. 00	Utilization review - physician compensation (see instructions)			85
. 00				86
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)		2, 611	87
			764.61	
3.00	Aujusteu general inpatrent routine cost per ureni (The 27 - The 2)			

Health Financial Systems	KOSCIUSKO COMML	INITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 03/01/2015 To 02/29/2016	Date/Time Pre 7/27/2016 2:0	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 398, 776	9, 540, 855	0. 14660	9 1, 996, 397	292, 690	90.00
91.00 Nursing School cost	0	9, 540, 855	0.00000	0 1, 996, 397	0	91.00
92.00 Allied health cost	0	9, 540, 855	0.00000	0 1, 996, 397	0	92.00
93.00 All other Medical Education	0	9, 540, 855	0. 00000	0 1, 996, 397	0	93.00

Health Financial Systems KOSCIUSKO COMMUNITY				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150133	Period: From 03/01/201	Worksheet D-3	3
			To 02/29/201		epared.
			10 02/2//201	7/27/2016 2:0	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Co		I npati ent	
		To Charge		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		a	1
30. 00 03000 ADULTS & PEDI ATRI CS			8, 421, 84		30.0
31. 00 03100 I NTENSI VE CARE UNI T			2, 366, 20	0	31.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVICE COST CENTERS		0.000	0.4	0 400 400	1 50 0
50. 00 05000 OPERATING ROOM		0.089			
51.00 O5100 RECOVERY ROOM		0.268			
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.380			
53.00 05300 ANESTHESI OLOGY		0.000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 194			
54. 01 05401 ULTRASOUND		0.000			
54. 02 05402 0NCOLOGY		0.260			
56. 00 05600 RADI OI SOTOPE		0.068			
57.00 05700 CT SCAN		0.018			
58.00 05800 MRI		0.052			
		0.086			
65. 00 06500 RESPI RATORY THERAPY		0.067			
66.00 O6600 PHYSI CAL THERAPY		0.408			
67.00 06700 OCCUPATIONAL THERAPY		0.219			
68.00 06800 SPEECH PATHOLOGY		0.264			
69. 00 06900 ELECTROCARDI OLOGY		0.053			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.045			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.210			
73.00 07300 DRUGS CHARGED TO PATIENTS		0.068			
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTER		0.000		0 0	
76.01 03610 SLEEP LAB		0.000		0 0	
76. 03 03951 OTHER ANCI LLARY SERVICE COST CENTER		0.000	000	0 0	0 76.0
OUTPATIENT SERVICE COST CENTERS		0.010			
90. 00 09000 CLINIC		0.242			
91.00 09100 EMERGENCY		0. 112			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0. 267			
200.00 Total (sum of lines 50-94 and 96-98)			53, 511, 95		
201.00 Less PBP Clinic Laboratory Services-Program only charges (	IINE 61)			0	201.0
202.00 Net Charges (line 200 minus line 201)		1	53, 511, 95	4	202.0

leal th Financial Systems KOSCIUSKO COMMUNITY NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150133	Dor	i od:	u of Form CMS- Worksheet D-3	
NFATTENT ANGIELART SERVICE COST AFFORTIONWENT	FIOVICEI	CCN. 150155		m 03/01/2015	WULKSHEEL D-3	)
			To	02/29/2016	Date/Time Pre	
					7/27/2016 2:0	06 pm
	lit	tle XIX	<u> </u>	Hospi tal	PPS	
Cost Center Description		Ratio of Co		Inpati ent	Inpatient	
		To Charges	5		Program Costs	
				Charges	(col. 1 x col. 2)	
		1.00		2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1		392, 456		30.0
31. 00 03100 I NTENSI VE CARE UNI T				170, 348		31.0
13. 00 04300 NURSERY				105, 665		43.0
ANCI LLARY SERVI CE COST CENTERS				100,000		10.0
50. 00 05000 0PERATI NG ROOM		0.0890	)94	312, 027	27,800	50.0
51.00 O5100 RECOVERY ROOM		0. 2680		29, 182	7, 822	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3800		87, 227	33, 153	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1947		102, 690	20,000	54.0
54. 01 05401 ULTRASOUND		0.0000		0	0	54.0
54. 02 05402 ONCOLOGY		0. 2602	269	0	0	54.0
56. 00 05600 RADI 0I SOTOPE		0.0680	)33	18, 048	1, 228	56.0
57.00 05700 CT SCAN		0.0183	394	187, 603	3, 451	57.0
58. 00 05800 MRI		0.0525	575	29, 245	1, 538	58.0
50. 00 06000 LABORATORY		0. 0860	)40	394, 495	33, 942	60.0
55. 00 06500 RESPI RATORY THERAPY		0.0676	55	229, 277	15, 512	65.0
56. 00 06600 PHYSI CAL THERAPY		0. 4086	516	21, 438	8, 760	66.0
57.00 06700 OCCUPATI ONAL THERAPY		0. 2195	522	543	119	67.0
58.00 06800 SPEECH PATHOLOGY		0. 2644	10	390	103	68.0
59. 00 06900 ELECTROCARDI OLOGY		0. 0532	270	3, 508	187	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0457	'38	99, 382	4, 546	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2108	395	114, 697	24, 189	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0.0681	19	1, 081, 278	73, 656	73.0
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER		0.0000	000	0	0	76. C
76.01 03610 SLEEP LAB		0.0000	000	0	0	76. C
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER		0.0000	000	0	0	76. C
OUTPATIENT SERVICE COST CENTERS						
00. 00 09000 CLI NI C		0. 2425	573	8, 962	2, 174	90.0
21. 00 09100 EMERGENCY		0. 1126	22	163, 838	18, 452	91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2671	91	48, 525	12, 965	92.0
200.00 Total (sum of lines 50-94 and 96-98)				2, 932, 355	289, 597	
201.00 Less PBP Clinic Laboratory Services-Program only charges (	ine 61)			0		201.0
202.00 Net Charges (line 200 minus line 201)				2, 932, 355		202.0

ALCUL	Financial Systems KOSCIUSKO COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150133	In Lie Period: From 03/01/2015 To 02/29/2016	Worksheet E Part A Date/Time Pre 7/27/2016 2:0	pared:
		Title XVIII	Hospi tal	PPS	o pili
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments			0	1.00
. 01	DRG amounts other than outlier payments for discharges occurrin	ng prior to October 1 (	see	4, 020, 668	1.0
. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	3, 288, 551	1.0
	instructions)			-,,	
. 03	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	prior to October	0	1.0
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	on or after	0	1.0
	October 1 (see instructions)				
. 00	Outlier payments for discharges. (see instructions)			89, 411	2.0
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	one)		0	
. 02	Managed Care Simulated Payments	0113)		4, 290, 853	
. 00	Bed days available divided by number of days in the cost repor	ting period (see instru	ıcti ons)	64.87	
~~	Indirect Medical Education Adjustment				1
. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs which meet the	he criteria for an add-	on to the cap	0.00	6.0
	for new programs in accordance with 42 CFR 413.79(e)				
. 00	MMA Section 422 reduction amount to the IME cap as specified un			0.00	
. 01	ACA Section 5503 reduction amount to the IME cap as specified u If the cost report straddles July 1, 2011 then see instructions		)(I)(IV)(B)(2)	0.00	7.0
. 00	Adjustment (increase or decrease) to the FTE count for allopat		grams for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7	9(c)(2)(iv), 64 FR 2634	Ю́ (May 12,		
01	1998), and 67 FR 50069 (August 1, 2002).	to under contian EEO2 a		0.00	
. 01	The amount of increase if the hospital was awarded FTE cap slot the cost report straddles July 1, 2011, see instructions.	ts under section 5503 c	OF THE ACA. IT	0.00	8.0
. 02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0.00	8.0
	under section 5506 of ACA. (see instructions)				
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	s (8, 8,01 and 8,02) (	see	0.00	9.0
0. 00	FTE count for allopathic and osteopathic programs in the curre	nt year from your recor	ds	0.00	10.0
1.00	FTE count for residents in dental and podiatric programs.	5		0.00	11. (
2.00	Current year allowable FTE (see instructions)				12.0
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	r anded on or after Ser	tember 30 1007		13.0 14.0
4.00	otherwise enter zero.	i ended on of arter sep	100, 1777,	0.00	14.0
5.00	Sum of lines 12 through 14 divided by 3.				15.0
6.00	Adjustment for residents in initial years of the program				16.0
7.00 8.00	Adjustment for residents displaced by program or hospital close Adjusted rolling average FTE count	ure			17.0 18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
0. 00	Prior year resident to bed ratio (see instructions)			0.000000	20.0
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00 2.01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0	
2.01	Indirect Medical Education Adjustment for the Add-on for Section	on 422 of the MMA		0	22.0
3.00	Number of additional allopathic and osteopathic IME FTE residen		Sec. 412.105	0.00	23.0
	(f)(1)(iv)(C).			0.00	
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	ower of line 23 or line	21 (500	0.00 0.00	
5.00	instructions)	ower of the 23 of the	24 (366	0.00	25.0
6.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00 8.01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	
9. 00 9. 00	Total IME payment ( sum of lines 22 and 28)			0	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	)		0	
	Disproportionate Share Adjustment				1
0.00	Percentage of SSI recipient patient days to Medicare Part A pai	tient days (see instruc	ctions)	2. 12 17. 86	30.0
1.00 2.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			17.80	
3.00	Allowable disproportionate share percentage (see instructions)			5.74	
4 00	Disproportionate share adjustment (see instructions)			104, 888	34.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150133	Peri od:	Worksheet E	2552-
			From 03/01/2015 To 02/29/2016	Date/Time Pre	
		Title XVIII	Hospi tal	7/27/2016 2:0 PPS	6 pm
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	tor zoro on this line)	0. 000071948	0. 000070003	
5. 02	(see instructions)	iter zero on this time)	550, 233	448, 447	35.
5. 03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	322, 602	186, 240	35.
5.00	Total uncompensated care (sum of columns 1 and 2 on line 35.	03)	508, 842		36.
	Additional payment for high percentage of ESRD beneficiary d				
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40.
1 00	652, 682, 683, 684 and 685 (see instructions)	492 494 ap 495 (coo	0		11
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	065, 064 all 065. (See	0		41.
1. 01	Total ESRD Medicare covered and paid discharges excluding MS	-DRGs 652, 682, 683, 684	0		41.
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	82, 683, 684 an 685. (see	0		43
1 00	instructions)	by Lips 11 divided by 7	0,00000		44.
4. 00	Ratio of average length of stay to one week (line 43 divided days)	by The 41 divided by /	0.000000		44
5.00	Average weekly cost for dialysis treatments (see instruction	s)	0.00		45.
6. 00	Total additional payment (line 45 times line 44 times line 4		0		46
7.00	Subtotal (see instructions)		8, 012, 360		47
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			A	
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instruction	s)		8, 012, 360	49.
0. OO	Payment for inpatient program capital (from Wkst. L, Pt. I a	nd Pt. II, as applicable)		595, 480	50
1.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	
2.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52
3.00	Nursing and Allied Health Managed Care payment			0	
4.00 5.00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	60)		0	54 55
5.00	Cost of physicians' services in a teaching hospital (see int			0	
7.00	Routine service other pass through costs (from Wkst. D, Pt.	-	hrouah 35).	0	57
3. 00	Ancillary service other pass through costs from Wkst. D, Pt.		5 ,	0	58
9.00	Total (sum of amounts on lines 49 through 58)			8, 607, 840	59
0. 00	Primary payer payments			10, 978	
1.00	Total amount payable for program beneficiaries (line 59 minu	is Line 60)		8, 596, 862	
2.00	Deductibles billed to program beneficiaries			1, 107, 824	
3.00 4.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			3, 822 117, 123	
+. 00 5. 00	Adjusted reimbursable bad debts (see instructions)			76, 130	
6.00		tructions)		19, 903	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	<i>`</i>		7, 561, 346	
3. 00	Credits received from manufacturers for replaced devices for			0	68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	. (For SCH see instruction	s)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
0.50	RURAL DEMONSTRATION PROJECT			0	70
D. 88 D. 89	SCH or MDH volume decrease adjustment	tructions)		0	
J. 89 J. 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)			0	
0.90 0.91	HSP bonus payment HRR adjustment amount (see instructions)			0	
D. 92	Bundled Model 1 discount amount (see instructions)			0	
	HVBP payment adjustment amount (see instructions)			18, 870	
D. 93					1
0. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-73, 025	70

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPIT				u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Period: From 03/01/2015 To 02/29/2016	Worksheet E Part A Date/Time Pre 7/27/2016 2:00	
	T	<u>fitle</u>	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
70.96 Low volume adjustment for federal fis the corresponding federal year for th	cal year (yyyy) (Enter in column e period prior to 10/1)	0		0	0	70.96
70.97 Low volume adjustment for federal fis the corresponding federal year for th	cal year (yyyy) (Enter in column			0	0	70. 97
70.98 Low Volume Payment-3	s period ending on or ditter to, i)	·			0	70.98
70.99 HAC adjustment amount (see instructio	ns)				0	70.99
71.00 Amount due provider (line 67 minus li					7, 507, 191	
71.01 Sequestration adjustment (see instruc					150, 144	
72.00 Interim payments					7, 291, 534	
73.00 Tentative settlement (for contractor	use only)				0	73.00
74.00 Balance due provider (Program) (line					65, 513	
75.00 Protested amounts (nonal lowable cost					818, 016	
CMS Pub. 15-2, chapter 1, §115.2	· · ·					
TO BE COMPLETED BY CONTRACTOR (lines		<u> </u>			-	
90.00 Operating outlier amount from Wkst. E		5)			0	
91.00 Capital outlier from Wkst. L, Pt. I,					0	91.00
92.00 Operating outlier reconciliation adju					0	92.00
93.00 Capital outlier reconciliation adjust					0	93.00
94.00 The rate used to calculate the time v					0.00	
95.00 Time value of money for operating exp					0	95.00
96.00 Time value of money for capital relat	ed expenses (see instructions)			D: 10/1	0	96.00
				Prior to 10/1		
UCD Dames Designed American				1.00	2.00	
HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions)				0	0	100.00
HVBP Adjustment for HSP Bonus Payment				0	0	100.00
101.00 HVBP adjustment factor (see instructi				0.000000000	0.000000000	101 00
102.00 HVBP adjustment amount for HSP bonus				0.0000000000000000000000000000000000000		101.00
HRR Adjustment for HSP Bonus Payment				U	0	102.00
103.00 HRR adjustment factor (see instructio	ns)			0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus p	· · · · · · · · · · · · · · · · · · ·			0		104.00

CALCULATION OF RELINBURSEMENT SETTLEMENT         Provider CD::15013
PART B - MEDICAL AND OTHER HEALTH SERVICES         1.00           0         Medical and other services (see instructions)         2.695           2.00         Medical and other services (see instructions)         5.433, 77           7.70         PFS payments         5.697, 735           6.00         Duttiar payment (see instructions)         0.00           7.01         PFS payments         4.80           8.00         Transitional corridor payment (see instructions)         0.00           7.00         Sam of Lines J plus line 4 divided by line 6         0.00           8.00         Transitional corridor payment (see instructions)         0.00           9.00         Ancelliary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200         0.00           10.00         Transitional corridors (markets)         2.665           0.00         Data cost (sum of lines 1 and 10) (see instructions)         2.665           0.00         Transitional corridors (markets)         0.00           10.00         Transitional corridors (markets)         0.00           11.00         Total cost (see Corr OC OT OR CHARGES         0.00           10.00         Total cost (see Corr OC OT OR CHARGES         0.00           10.00         Total costane charges (sum of lines 12 and 13)         0.00
PART B - MEDICAL AND OTHER HEALTH SERVICES           100         Medical and other services (see instructions)         2,695           200         Medical and other services (see instructions)         5,433,777           300         Dullier payment (see instructions)         6,691,253           400         Dullier payment (see instructions)         0,000           500         Enter the hespital specific payment to cost ratio (see instructions)         0,000           600         Line 2 Lines line 3         0,000           600         Ancillary service other payment (see instructions)         0,000           700         Ancillary service charges         0,000           7000         Ancillary service charges         2,0495           7000         Program acquisition         1,000         0,000           7000         Organ acquisition stime submetized from patients liable for payment for services on a charge basis         0,000           7000         Organ acquisition stime stime liable for payment for services on a charge basis         0,000           7000         The second stime stime liable for payment for services on a charge basis         0,000000           7000         The second stime liable for payment for services on a charge basis         0,000000           7000         The second stime liable for payment for services on a charge basi
1.00       Hedical and other services (see instructions)       2,665         2.00       Hedical and other services (see instructions)       5,633,777         3.00       PPS payments       0,000         4.00       Outline 2 times line 5       0,000         5.00       Enter the hespital specific payment to cost ratio (see instructions)       0,000         7.00       Sum of line 3 plus line 4 divided by line 6       0,000         8.00       Cost of the payment (see instructions)       0         9.00       Ancillary service other pass through costs from Wst. 0, Pt. IV, col. 13, line 200       0         9.00       Ancillary service other pass       2,665         COMPUTATION OF LESSEN OF COST OR CHARGES       0       0         0.00       Ancillary service charges       38,588         0.00       Ancillary service charges (sum of lines 12 and 13)       38,588         0.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0         1.00       Intel second line 11 and to exceed in compasies (complete only if line 18 exceeds line 11) (see instructions)       0         1.00       Page act amount actually collected from patients liable for payment for services on a charge basis       0         1.00       Reasonable charges (sum of lines 12 and 13)       0       <
2:00       Wedical and other services reimbursed under OPS (see instructions)       5,433,777         3:00       PPS payments       5,641,735         4:00       Outlier payment (see instructions)       4,897         5:00       Enter the hospital specific payment to cost ratio (see instructions)       0,000         6:00       Line 2 times line 5       0,000         0:00       Organ acquisitions       0,000         0:00       Organ acquisitions       0,000         0:00       Organ acquisitions       2,2665         0:00       Organ acquisitions       2,2665         0:00       Organ acquisition of LESER OF COST OR CHARGES       88,588         0:00       Organ acquisition charges (from West, 0-4, Pt, 111, col. 4, line 69)       38,588         0:00       Organ acquisition charges (from West, 0-4, Pt, 111, col. 4, line 69)       38,588         0:00       Amounts that would have been realized from patients liable for payment for services on a chargebasis had soutpayments (breassonable cocrdance with 42 CFR 5413,13(e)       0.000000         0:00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000       38,588         0:00       Castomary charges over reasonable cost (complete only if line 18 exceeds line 11) (see linstructions)       0.000000         0:00       Excess of reasonable cost over customary c
3:00       PPS payments       5,691,735         00       Outline payment (see instructions)       4,897         0:00       Enter the hospital specific payment to cost ratio (see instructions)       0,000         0:00       Cancel and a payment to cost ratio (see instructions)       0,000         0:00       Grans tional corridor payment (see instructions)       0         0:00       Maniliary service other pass through costs from Wst. D. Pt. IV, col. 13, line 200       0         0:00       Maniliary service other payment (see instructions)       2,695         0:00       Maniliary service charges (sem of times)       2,695         0:00       Reasonable charges (sem of times 1 and 10) (see instructions)       0         0:00       Reasonable charges (sem of times 1 and 13)       0         0:00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment beem made in accordance with 42 (CFK \$413,13(e)       0         0:00       Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)       0         0:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0         0:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0 <t< td=""></t<>
5.00     Inter the frospital specific payment to cost ratio (see instructions)     0.000       6.00     Lite 2 times 1 ine 5     0.000       7.00     Sum of line 3 plus line 4 divided by line 6     0.000       7.01     Sum of line 3 plus line 4 divided by line 6     0.000       7.01     Sum of line 3 plus line 4 divided by line 6     0.000       7.01     Out Cransitional corridor payment (see instructions)     0.000       7.02     Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200     0.000       7.00     Total cost (sum of lines 12 and 13)     2.665       Comparing the acount actually collected from patients liable for payment for services on a charge basis     0       16.00     Amounts that would have been realized from patients liable for payment for services on a charge basis     0       16.00     Total cust may charges     0     0.00000       17.00     Total cust may charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)     0.00000       10.0     Total acoust cost or charges (line 11 minus line 20) (for CAH see instructions)     2.665       10.0     Loss of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)     0.00000       10.0     Loss of reasonable cost over customary charges (complete only if line 10 exceeds line 18) (see instructions)     0.000000       10.0     Loss of
6.00       Line 2 times line 5       0       0         00       Sum of line 3 plus line 4 divided by line 6       0.00         00.00       Ancil lary service other pass through costs from Wst. 0, Pt. IV, col. 13, line 200       0         01.00       Organ acquisitions       2.695         COMPUTATION OF LESSER OF COST OR CHARGES       2.695         Reasonable charges       38,588         Customary charges       0         11:00       Total reasonable charges (sum of lines 12 and 13)       38,588         Customary charges       0         12:00       Reparament for services on a charge basis had such payment bactually collected from patients liable for payment for services on a charge basis on that such payment been made in accordance with 42 CFR §413.13(e)       0         10:00       Exect of customary charges (see instructions)       0       0.000000         10:01       Exect of customary charges (see instructions)       2.695       0         10:02       Exect of customary charges (see instructions)       2.695       0         10:02       Exect of cu
7.00     Sum of Line 3 plus Line 4 divided by Line 6     0.00       8.00     Transitional corridor payment (see instructions)     0.0       9.00     Ancillary service other pass through costs from West. D, Pt. IV, col. 13, Line 200     0       9.00     Dital cost (sum of Lines 1 and 10) (see instructions)     2, 695       COMPUTATION OF LESER OF COST OR CHARGES     2, 695       COMPUTATION OF LESER OF COST OR CHARGES     38, 588       13.00     Organ acquisition charges (from West. D-4, Pt. 111, col. 4, Line 69)     38, 588       Customary charges     (see instructions)     38, 588       Customary charges     (see instructions)     0       15.00     Aggregate anount actually collected from patients Liable for payment for services on a charge basis     0       16.00     Namounts that would have been realized from patients 1, 13(e)     0     0.000000       17.00     Ratio of Line 15 to Line 16 (not to exceed 1,00000)     38, 588       19.00     Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)     0       21.00     Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)     0     0       23.00     Cost of physicians' services in a teaching nospital (see instructions)     0     0       23.00     Cost of physicians' services in a teaching nospital (see instructions)     1.23, 400
9.00     Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200     0       0100     Organ acquistions     2.065       COMPUTATION OF LESSER OF COST OR CHARGES     2.065       Reasonable charges     38,588       13.00     Organ acquistion charges (from Wkst. D.4, Pt. III, col. 4, line 69)     38,588       14.00     Total reasonable charges (sum of lines 12 and 13)     38,588       Coustomary charges     0     38,588       Coustomary charges     0     0       16.00     Amounts that would have been real rad from patients liable for payment for services on a charge basis of acting accurations with 42 CFR \$413,13(e)     0       17.00     Ratio of line 15 to line 16 (not to exceed 1.000000)     38,588       19.00     Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)     0       21.00     Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)     2.695       22.00     Cost of physicians' services in a teaching hospital (see instructions)     5.696,632       21.00     Deductibles and coinsurance (for CAH, see instructions)     5.88       22.00     Discust medical education payments (from Wkst. E-4, line 36)     0       23.00     Deductibles and coinsurance (from Wkst. E-4, line 36)     0       24.00     Total gain tinus 310     5.88       25.0
10.00       Organ acquisitions       0         11.00       Total cost (sum of lines 1 and 10) (see instructions)       2.065         COMPUTATION OF LESSER OF COST OR CHARGES       38.588         20.00       Ancillary service charges (sum of lines 12 and 13)       38.588         Custemary charges       38.588         Custemary charges       38.588         Custemary charges       0         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0         16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment pharges (see instructions)       0.000000         18.00       Total customary charges (see instructions)       0.000000         19.00       Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 11) (see instructions)       0.000000         19.00       Excess of reasonable cost over customary charges (see instructions)       0.00000         20.00       Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions)       0.00000         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       0.00000         22.00       Total prospective payment (sum of lines 24 and 24 (por CAH, see instr
11.00       Total cost (sum of Lines 1 and 10) (see instructions)       2.695         COMPARTION OF LESSER OF COST OR CHARGES         Reasonable charges         200       Ancillary service charges (from West, D-4, Pt, III, col. 4, line 69)       38,588         Comparing the charges (from West, D-4, Pt, III, col. 4, line 69)       38,588         Comparing the charges (sum of lines 12 and 13)       38,588         Comparing the charges (sum of lines 12 and 13)         Comparing the charges (sum of lines 12 and 13)         Comparing the colspan="2">Comparing the colspan="2"         Compar
COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable charges           12.00         Ancillary service charges         38,588           Comparing the charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         0           Of Total reasonable charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         38,588           Construction charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         0           Of Total reasonable charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         0           Of Total reasonable charges (from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)         0           Of Total customary charges (see instructions)         0           0         Occupation of the total customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions)           0         Occupation of the total customary charges (line 11 mius line 20) (for CAH see instructions)         2,665           0         Other customary charges in a teaching hospital (see instructions)         0           OUP duct bias and col insurance (for CAH, see instructions)         0         0           OUP duct bias and col insurance serial ta gin a mount on line 24 (for CAH, see instructions)         1,288,490         0
12 00       Ancillary service charges       38,588         300       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       38,588         Customary charges       38,588         Customary charges       38,588         Customary charges       0         15:00       Aggregate amount actually collected from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)       0         17:00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000         18:00       Excess of customary charges (see instructions)       0.000000         18:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 11) (see instructions)       0         20:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       2,695         21:00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       0         23:00       Cost of physicians' services in a teaching hospital (see instructions)       0         24:00       Total prospective payment for services       1         20:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 19)       2,696,632         20:01       Interns and residents (see instructions)       0       2,696,632
13.00       Organ acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69)       0         14.00       Total reasonable charges (sum of lines 12 and 13)       38,588         Customary charges       0         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000         18.00       Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0.400000         10.00       Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see instructions)       2,695         11.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       2,695         12.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       5,696,632         12.00       Lost of physicians' services in a teaching hospital (see instructions)       5         12.00       Deductibles and colnsurance (for CAH, see Instructions)       5         13.00       Subtotal ((lines 21 and 24 minus the sum of lines 22 and 26) plus the sum of lines 22 and 23] (see instructions)       1,238,490         12.00       Subtotal (sum of lines 27 through 29)       4,460,779         13.00       Subtotal (sum of lines 1
14.00       Total resonable charges (sum of lines 12 and 13)       38,588         Customary charges       0         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis on a dwargebasis had such payment been made in accordance with 42 CFR §413.13(e)       0         16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis on a dwargebasis on a dwargebasis on a chargebasis on a dwargebasis of a dwargebasis
15:00       Aggregate amount actually collected from patients Liable for payment for services on a charge basis had such payment been realized from patients Liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)       0         17:00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.000000         18:00       Total customary charges (see instructions)       0.000000         18:00       Excess of customary charges (see instructions)       0.000000         20:00       Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)       0.000000         21:00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       2.695         22:00       Interns and residents (see instructions)       0.00000         24:00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0.00000         00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       5.86         25:00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       0         00       Direct graduate medical education costs (from PROFESSIONAL SERVICES)       0       0         00       Direct graduate medical education costs (from PS&R       0       0       0         00       Direct graduate medical education costs (
16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e)       0         17.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.000000         18.00       Total customary charges (see instructions)       0.000000         18.00       Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0.000000         10.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       2.695         21.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0.00000         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0.00         23.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       5.696,632         25.00       Deductibles and coinsurance (for CAH, see instructions)       5.86         26.00       Detuctibles and coinsurance (for CAH, see instructions)       1, 238,490         27.00       External readical education payments (from Wkst. E-4, line 50)       0         28.00       Direct graduate medical education payments (from Wkst. E-4, line 36)       0         20.00       External addets for (see instructions)       1, 338,490         21.01       <
had such payment been made in accordance with 42 CFR §413.13(e)       0         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000         18.00       Total customary charges (see instructions)       0.000000         19.00       Excess of customary charges (see instructions)       0.000000         20.00       Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)       0.000000         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       0.000000         22.00       Interns and residents (see instructions)       0.000000         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0.000000         24.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       5, 696, 632         COMPUTATION OF REIMBURSEMENT SETTLEMENT       58         25.00       Deductibles and coinsurance (for CAH, see instructions)       1, 238, 490         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       1, 238, 490         27.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       0         28.00       Direct medical education costs (From Wkst. E-4, line 36)       0       0         20.01       Subtotal (see ins
18.00       Total customary charges (see instructions)       38,588         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       38,588         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       2,695         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       2,695         22.00       Interns and residents (see instructions)       2,695         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0         24.00       Total curves/memory charges (complete only if line 11 exceeds line 18) (see instructions)       5,696,632         25.00       Deductibles and coinsurance (for CAH, see instructions)       5         26.00       Deductibles and Coinsurance (for CAH, see instructions)       1,238,490         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       1,328,490         27.00       Subtotal (sum of lines 11 mode costs (from Wkst. E-4, line 50)       0         29.00       Direct graduate medical education costs (from Wkst. E-4, line 50)       0         29.00       Subtotal (sum of lines 27 through 29)       4,460,779         31.00       Composite rate ESRD (from Wkst. I-5, line 11)       23,980<
19.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)35,89320.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)021.00Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)2,69521.00Interns and residents (see instructions)022.00Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT5,696,63225.00Deductibles and coinsurance (for CAH, see instructions)5826.00Deductibles and coinsurance for CAH, see instructions)1,238,49027.00Deductibles and coinsurance for CAH, see instructions)5826.00Deductible and coinsurance (for CAH, see instructions)1,238,49027.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.00Direct graduate medical education costs (from Wkst. E-4, line 36)030.00Subtotal (line 30 minus line 31)4,460,77941.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)4,460,70931.00Composite rate ESRD (from Wkst. I-5, line 11)031.00Composite lines (see instructions)153,38732.00OPTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)033.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)033.00Composite rate ESRD (from Wkst. I-5, line 11)033.00Composite rate ESRD (from BSR033.00Composite rate ESRD (from
Instructions)Instructions)Instructions)20.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)021.00Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)2, 69522.00Interns and residents (see instructions)023.00Cost of physicians' services in a teaching hospital (see instructions)024.00Total prospective payment (sum of lines 3, 4, 8 and 9)5, 696, 632COMPUTATION OF REIMBURSEMENT SETTLEMENT5825.00Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)1, 238, 49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)4, 460, 77928.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (line 30 minus line 31)4, 460, 001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)031.00Composite rate ESRD (from Wst. 1-5, line 11)235, 98031.00Allowable bad debts for dual eligible beneficiaries (see instructions)153, 38733.00Allowable bad debts for dual eligible beneficiaries (see instructions)153, 38733.00Allowable bad debts for dual eligible beneficiaries (see instructions)039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS)039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS)039.00
instructions)2, 69521.00Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)2, 69522.00Interns and residents (see instructions)023.00Cost of physicians' services in a teaching hospital (see instructions)024.00Total prospective payment (sum of lines 3, 4, 8 and 9)5, 696, 632COMPUTATION OF REIMBURSEMENT SETTLEMENT525.00Deductibles and coinsurance (for CAH, see instructions)526.00Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)1, 238, 49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)1, 238, 49028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)000.00Subtotal (sum of lines 27 through 29)7,7831.00Primary payer payments7,7832.00Composite rate ESRD (from Wkst. I-5, line 11)0ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.00Composite rate ESRD (from Wkst. (see instructions)153, 38735.00Adjusted reimbursable bad debts (see instructions)235, 69035.00Adjusted reimbursable bad debts (see instructions)153, 38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)153, 38737.00Allowable bad debts for dual eligible beneficiaries (see instructions)039.90Ofter AL
21.00Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)2,69522.00Interns and residents (see instructions)023.00Cost of physicians' services in a teaching hospital (see instructions)024.00Total prospective payment (sum of lines 3, 4, 8 and 9)5,696,632COMPUTATION OF REIMBURSEMENT SETTLEMENT5825.00Deductibles and coinsurance (for CAH, see instructions)5826.00Deductibles and coinsurance (for CAH, see instructions)1,238,49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)4,460,77931.00Primary payer payments77832.00Composite rate ESRD (from Wkst. I-5, line 11)041.00wable Bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Miowable bad debts (see instructions)153,38836.00Miowable bad debts (see instructions)037.00Subtotal (see instructions)153,38838.00MSP-LCC reconciliation amount from PS&R039.00Priner Maximum From PS&R039.00Pinter ADU BERNEND SEE INSTRUCTIONS) (SPECIFY)039.90Pinter ADU Benstration Payment adjustment (see instructions)
22.00       Interns and residents (see instructions)       0         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0         24.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       5,696,632         COMPUTATION OF REIMBURSEMENT SETTLEMENT       58         25.00       Deductibles and coinsurance (for CAH, see instructions)       1,238,490         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       1,238,490         27.00       Bubtotal [(lines 21 through 29)       4,460,779         28.00       Direct graduate medical education costs (from Wkst. E-4, line 36)       0         29.00       Subtotal (sum of lines 27 through 29)       4,460,779         21.00       Subtotal (line 30 minus line 31)       4,460,001         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       0         31.00       Composite rate ESRR (from Wkst. 1-5, line 11)       0         34.00       Allowable bad debts (see instructions)       153,387         35.00       Adjusted reimbursable bad debts (see instructions)       153,387         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       151,224         37.00       Subtotal (see instructions)       151,224      <
24.00Total prospective payment (sum of lines 3, 4, 8 and 9)5,696,632COMPUTATION OF REIMBURSEMENT SETTLEMENTCOMPUTATION OF REIMBURSEMENT SETTLEMENT25.00Deductibles and coinsurance (for CAH, see instructions)5826.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1,238,49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see1,238,49028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)020.00Subtotal (sum of lines 27 through 29)4,460,77931.00Primary payer payments77832.00Subtotal (line 30 minus line 31)4,460,001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)153,38735.00All owable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)038.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.90OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.98RecoVERY OF ACCELERATED DEPRECIATION040.00Subt
COMPUTATION OF REIMBÜRSEMENT SETTLEMENT25.00Deductibles and coinsurance (for CAH, see instructions)5826.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1,238,49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see1,238,49028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)4,460,77931.00Primary payer payments77832.00Subtotal (sum of lines 11)4,460,001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)25,98033.00Composite rate ESRD (from Wkst. 1-5, line 11)0All owable bad debts (see instructions)153,38735.00Adj usted reimbursable bad debts (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99Recovery of ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)039.99Recovery of ACCELERATED DEPRECIATION041.00Subtotal (see instructions)042.01S
25.00Deductibles and coinsurance (for CAH, see instructions)5826.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1, 238, 49027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see1, 238, 49028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)4, 460, 77971.00Primary payer payments77832.00Subtotal (line 30 minus line 31)4, 460, 001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)235, 98033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00All owable bad debts (see instructions)153, 38735.00Adjusted reimbursable bad debts (see instructions)151, 22437.00Subtotal (see instructions)151, 22438.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 413, 38340.01Interim payments4, 43, 783
27.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)4,460,77928.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)4,460,77931.00Primary payer payments77832.00Subtotal (line 30 minus line 31)778ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)155,38735.00Adjusted reimbursable bad debts (see instructions)155,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)038.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38840.01Sequestration adjustment (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38841.00Interim payments4,643,783
instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 20.00 Subtotal (sum of lines 27 through 29) 778 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 79.50 Pioneer AC0 demonstration payment adjustment (see instructions) 39.99 RecovERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 41.00 41.00 40.00 Interim payments 40.01 40.00
29.00ESRD direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)4, 460, 77931.00Primary payer payments77832.00Subtotal (line 30 minus line 31)4, 460, 001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.00Composite rate ESRD (from Wkst. I-5, line 11)034.00Allowable bad debts (see instructions)235, 98035.00Adjusted reimbursable bad debts (see instructions)153, 38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151, 22437.00Subtotal (see instructions)4, 613, 38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Sequestration adjustment (see instructions)039.92Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Interim payments4, 613, 783
30.00Subtotal (sum of lines 27 through 29)4,460,77931.00Primary payer payments77832.00Subtotal (line 30 minus line 31)4,460,001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)35.00Adjusted reimbursable bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38840.01Sequestration adjustment (see instructions)041.00Interim payments4,43,783
31.00Primary payer payments77832.00Subtotal (line 30 minus line 31)4,460,001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38341.00Interim payments4,443,783
32.00Subtotal (line 30 minus line 31)4,460,001ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLEY)039.90Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38840.01Interim payments4,443,783
33.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,88838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38341.00Interim payments4,443,783
34.00Allowable bad debts (see instructions)235,98035.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)4,613,38841.00Interim payments92,268
35.00Adjusted reimbursable bad debts (see instructions)153,38736.00Allowable bad debts for dual eligible beneficiaries (see instructions)151,22437.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)92,26841.00Interim payments4,443,783
37.00Subtotal (see instructions)4,613,38838.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4,613,38840.01Sequestration adjustment (see instructions)92,26841.00Interim payments4,443,783
38.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Sequestration adjustment (see instructions)92, 26841.00Interim payments4, 443, 783
39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Sequestration adjustment (see instructions)92, 26841.00Interim payments4, 443, 783
39.98 39.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99 RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Sequestration adjustment (see instructions)92, 26841.00Interim payments4, 443, 783
39.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)4, 613, 38840.01Sequestration adjustment (see instructions)92, 26841.00Interim payments4, 443, 783
40.00         Subtotal (see instructions)         4, 613, 388           40.01         Sequestration adjustment (see instructions)         92, 268           41.00         Interim payments         4, 443, 783
41.00 Interim payments 4,443,783
43.00 Balance due provider/program (see instructions) 77,337
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0
§115.2 TO BE COMPLETED BY CONTRACTOR
90.00     Original outlier amount (see instructions)     0
91.00 Outlier reconciliation adjustment amount (see instructions) 0
92.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)0
94.00 Total (sum of lines 91 and 93) 0

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		7, 291, 53	34 O	4, 443, 783 0	
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3. 02				0	0	
3.03				0	0	
3.04				0	0	
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	
3.52				0	0	3.52
3.53				0	0	
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.54 3.99
5. 77	3. 50-3. 98)			0	0	5.7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 291, 53	34	4, 443, 783	4.00
	TO BE COMPLETED BY CONTRACTOR	1	1		1	
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	
5.03				0	0	5.03
F F A	Provider to Program			0		
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
6.00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.00
5. 01	SETTLEMENT TO PROVIDER		65, 51	13	77, 337	6.0 <sup>.</sup>
5. 02	SETTLEMENT TO PROGRAM			0	0	6. 0
7.00	Total Medicare program liability (see instructions)		7, 357, 04		4, 521, 120	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
			C	1.00	2.00	

Heal th	Financial Systems KOSCIUSKO	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150133	Period: From 03/01/2015 To 02/29/2016		
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
		20272		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RE				
1.00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAL Total hospital discharges as defined in AARA §4102 fr		20.14	3, 703	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of li		10 14	4, 407	2.00
2.00	Medicare HMO days from Wkst. S-3, Pt. 1, col. 6. line	-		2, 530	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of li			11, 425	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lin	-		504, 056, 357	5.00
6.00	Total hospital charity care charges from Wkst. S-10,			1, 167, 322	6.00
7.00	CAH only - The reasonable cost incurred for the purch line 168		y Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instruc	tions)		382, 018	8.00
9.00	Sequestration adjustment amount (see instructions)	,		7,640	9.00
10.00	Calculation of the HIT incentive payment after seques	tration (see instructions)		374, 378	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructi	ons)		358, 295	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instruction	ons)	16, 083	32.00

	Financial Systems KOSCIUSKO COMMU E SHEET (If you are nonproprietary and do not maintain	Provi der	CCN: 150133	Peri od:	u of Form CMS- Worksheet G	-
und-ty	ype accounting records, complete the General Fund column onl	y)		From 03/01/2015 To 02/29/2016	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	7/27/2016 2:0 Plant Fund	06 pm
			Purpose Func			
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	-268, 396		0 0	0	1.0
. 00	Temporary investments	-200, 390		0 0	0	
	Notes receivable	0		0 0	0	
	Accounts receivable	25, 938, 993		0 0	0	
	Other receivable	0		0 0	0	
	Allowances for uncollectible notes and accounts receivable	-7, 793, 845		0 0	0	
	Inventory	1, 816, 752		0 0	0	
	Prepaid expenses Other current assets	733, 748 451, 085		0 0	0	
	Due from other funds	0		0 0	0	
1.00	Total current assets (sum of lines 1-10)	20, 878, 337		0 0	0	
	FIXED ASSETS					
	Land	2, 768, 505		0 0	0	
	Land improvements	1, 160, 268		0 0	0	
	Accumulated depreciation	-687, 684		0 0	0	
	Buildings Accumulated depreciation	35, 723, 757 -8, 647, 402		0 0	0	
	Leasehold improvements	14, 400, 835		0 0	0	
	Accumulated depreciation	-4, 329, 304		0 0	0	
	Fixed equipment	2, 411, 781		0 0	0	19.0
	Accumulated depreciation	-1, 375, 600		0 0	0	
	Automobiles and trucks	110, 970		0 0	0	
	Accumulated depreciation	-93, 329 18, 209, 912		0 0	0	
	Major movable equipment Accumulated depreciation	-14, 224, 581			0	
	Mi nor equipment depreciable	5, 063, 654		0 0	0	
	Accumul ated depreciation	-3, 704, 350		0 0	0	
	HIT designated Assets	0		0 0	0	27.0
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	46, 787, 432		0 0	0	30.0
	OTHER ASSETS Investments	0		0 0	0	31.0
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	33.0
4.00	Other assets	3, 078, 708		0 0	0	
	Total other assets (sum of lines 31-34)	3, 078, 708		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	70, 744, 477		0 0	0	36.0
	CURRENT LIABILITIES Accounts payable	2, 631, 722		0 0	0	37.0
	Salaries, wages, and fees payable	2, 716, 945		0 0	0	
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	33, 340		0 0	0	40.0
	Deferred income	0		0 0	0	
	Accel erated payments	0				42.0
	Due to other funds	-300, 393, 033		0 0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 736, 851 -293, 274, 175			0	
5.00	LONG TERM LIABILITIES	-273, 274, 175		0 0	0	45.0
6. 00	Mortgage payable	0		0 0	0	46.0
	Notes payable	166, 660		0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	2,086,435		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	2, 253, 095		0 0	0	
	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	-291, 021, 080		0 0	0	51.0
	General fund balance	361, 765, 557				52.0
	Specific purpose fund			0		53.0
	Donor created - endowment fund balance - restricted			0		54.0
	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance			0		56.0
	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement,				0	58. C
9.00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	361, 765, 557		0 0	0	59. C
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	70, 744, 477			0	
J. UU	59)	, , , , , , , , , , , , , , , , , , ,			0	1 00.0

		KOSCIUSKO COMMUN		CON 150100		u of Form CMS-2	
	IENT OF CHANGES IN FUND BALANCES			CCN: 150133	Period: From 03/01/2015 To 02/29/2016	7/27/2016 2:0	pared: 6 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1 00	Fund heleness at heginning of noried	1.00	2.00	3.00	4.00	5.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		319, 077, 004 42, 688, 553 361, 765, 557 0 361, 765, 557			0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 Endowment Fund	0 361, 765, 557 Pl ant	Fund	0 0 0	0	16.00 17.00 18.00 19.00
		( 00	7.00	0.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00 0	7.00 0 0 0 0 0	8.00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

SIVIEN						2552-10
STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet G-2 Parts I & II Date/Time Pre 7/27/2016 2:0	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					-
	General Inpatient Routine Services				04 407 070	1
1.00	Hospi tal		36, 197, 9	73	36, 197, 973	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	Ű	7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		36, 197, 9	73	36, 197, 973	10.00
	Intensive Care Type Inpatient Hospital Services		1			
11.00	INTENSIVE CARE UNIT		3, 168, 6	05	3, 168, 605	•
12.00	CORONARY CARE UNIT					12.00
13.00 14.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					13.00
14.00	OTHER SPECIAL CARE (SPECIFY)					14.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	3, 168, 6	05	3, 168, 605	
10.00	11-15)	TTHES	3, 100, 0	00	3, 100, 003	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		39, 366, 5	78	39, 366, 578	17.00
18.00	Ancillary services		127, 800, 3	78 288, 082, 141	415, 882, 519	18.00
19.00	Outpatient services		10, 047, 2	25 38, 760, 035	48, 807, 260	19.00
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00 24.00	AMBULANCE SERVICES CMHC					23.00
24.00	AMBULATORY SURGICAL CENTER (D. P. )					24.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	177, 214, 1	81 326, 842, 176		•
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			66, 386, 473		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00 33.00				0		32.00 33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
40.0-						
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	)(transter		66, 386, 473		43.00

Heal th	Financial Systems KOSCIUSKO COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 150133	Peri od:	Worksheet G-3	
			From 03/01/2015 To 02/29/2016	Date/Time Pre	arod.
			10 02/27/2010	7/27/2016 2:00	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			504, 056, 357	1.00
2.00	Less contractual allowances and discounts on patients' account	ts		395, 976, 786	2.00
3.00	Net patient revenues (line 1 minus line 2)			108, 079, 571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		66, 386, 473	4.00
5.00	Net income from service to patients (line 3 minus line 4)			41, 693, 098	5.00
	OTHER I NCOME		1	-	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other the	han patrents		0	16.00
17.00				0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			995, 455	
25.00	Total other income (sum of lines 6-24)			995, 455	
26.00				42, 688, 553	
	OTHER EXPENSES (SPECIFY)			0	27.00
28.00				42 (00 552	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		ļ	42, 688, 553	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet L Parts I-III Date/Time Pre 7/27/2016 2:00	
	Title XVIII	Hospi tal	PPS	o pili
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			579, 985	
01 Model 4 BPCI Capital DRG other than outlier			0 15 405	
00 Capital DRG outlier payments 01 Model 4 BPCI Capital DRG outlier payments			15, 495 0	
01 Model 4 BPCI Capital DRG outlier payments 00 Total inpatient days divided by number of days in the cos	st reporting pariod (see inst	ructions)	31.22	
00 Number of interns & residents (see instructions)	st reporting period (see thist	ructrons)	0.00	
00 Indirect medical education percentage (see instructions)			0.00	
00 Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	
1.01) (see instructions)			0	0.
00 Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	t A patient days (Worksheet E	, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	8.
00 Sum of lines 7 and 8	,		0.00	9.
.00 Allowable disproportionate share percentage (see instruct	tions)		0.00	10.
.00 Disproportionate share adjustment (see instructions)			0	11.
.00 Total prospective capital payments (see instructions)			595, 480	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST 00 Program inpatient routine capital cost (see instructions)	<u>)</u>		0	1 1.
00 Program inpatient routine capital cost (see instructions) 00 Program inpatient ancillary capital cost (see instruction			0	
00 Total inpatient program capital cost (line 1 plus line 2)	<i>,</i>		0	
	)		0	
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)			0	
00 [10tal_inpatient program capital cost (inte 5 x inte 4)			0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	
00 Program inpatient capital costs for extraordinary circums			0	
00 Net program inpatient capital costs (line 1 minus line 2)	)		0	
00 Applicable exception percentage (see instructions)			0.00	
00 Capital cost for comparison to payments (line 3 x line 4)			0	
00 Percentage adjustment for extraordinary circumstances (se	,		0.00	
Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 x	line 6)	0	
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12, as a .00 Current year comparison of capital minimum payment level		Loca Line ()	0	
<ul> <li>.00 Current year comparison of capital minimum payment level</li> <li>.00 Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)</li> </ul>			0	
.00 Net comparison of capital minimum payment level to capita	al navments (line 10 plus lin	o 11)	0	12.
			0	
			0	
.00 Current year exception payment (if line 12 is positive, e		ollowing period !		
.00 Current year exception payment (if line 12 is positive, e .00 Carryover of accumulated capital minimum payment level ov		ollowing period	0	14.
<ul> <li>.00 Current year exception payment (if line 12 is positive, e</li> <li>.00 Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)</li> </ul>	ver capital payment for the f	ollowing period	-	
.00 Current year exception payment (if line 12 is positive, e .00 Carryover of accumulated capital minimum payment level ov	ver capital payment for the f e instructions)	ollowing period	0 0	15.