PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KOSCIUSKO COMMUNITY HOSPITAL (15-0133) for the cost reporting period beginning 03/01/2016 and ending 02/28/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	11, 153	-56, 470	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	11, 153	-56, 470	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

_		used in the prior cost reporting period? In column 2	2, enter "Y	' for yes c	r "N" for r	no.			
			In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
			Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
			paid days	eligible	Medi cai d	Medi cai d		days	
				unpai d	paid days	eligible			
				days		unpai d			
			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
2	24. 00	If this provider is an IPPS hospital, enter the	544	1, 081	1	0	276	78	24. 00
		in-state Medicaid paid days in column 1, in-state							
		Medicaid eligible unpaid days in column 2,							
		out-of-state Medicaid paid days in column 3,							
		out-of-state Medicaid eligible unpaid days in column							
		4, Medicaid HMO paid and eligible but unpaid days in							
		column 5, and other Medicaid days in column 6.							
2	25. 00	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
		Medicaid paid days in column 1, the in-state							
		Medicaid eligible unpaid days in column 2,							
		out-of-state Medicaid days in column 3, out-of-state							
		Medicaid eligible unpaid days in column 4, Medicaid							
		HMO paid and eligible but unpaid days in column 5.							
					•				•
		1 - 1 3 1	'		ı	•	'		•

method of identifying the days in this cost reporting period different from the method

Harlith Figure in Contains	KOCCITICAC		NI TV. HOCDI TAI				6	CMC (0550 10
Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I			NITY HOSPITAL Provider CC		Peri od:		u of For Workshe		
					From 03/01, To 02/28,		Part I Date/Ti	me Pre	pared:
					Urban/Rui		7/31/20	17 3: 1	4 pm
					1. 00		2.0		
26.00 Enter your standard geographic class cost reporting period. Enter "1" for				jinning of the	9	2			26. 00
27.00 Enter your standard geographic class reporting period. Enter in column 1,						2			27. 00
enter the effective date of the geog	raphic reclassifi	cati on	in column 2.						
35.00 If this is a sole community hospital effect in the cost reporting period.	(SCH), enter the	number	r of periods SC	SH status in		0			35. 00
					Begi nni 1. 00		Endi 2. 0		
36.00 Enter applicable beginning and ending			Subscript line	36 for number			2. 0	00	36. 00
of periods in excess of one and ente 37.00 If this is a Medicare dependent hosp			umber of period	ls MDH status		0			37. 00
is in effect in the cost reporting p	eri od.		•						
37.01 Is this hospital a former MDH that is accordance with FY 2016 OPPS final re					N				37. 01
instructions) 38.00 If line 37 is 1, enter the beginning	and ending dates	of MDH	Histatus Ifli	ne 37 is					38. 00
greater than 1, subscript this line									00.00
enter subsequent dates.					Y/N		Υ/		
39.00 Does this facility qualify for the i	nnatient hosnital	navmer	nt adjustment f	for Low volume	1. 00 e N		2. C N		39. 00
hospitals in accordance with 42 CFR	§412. 101(b)(2)(ii)? Ente	er in column 1	"Y" for yes	"		.,		37.00
or "N" for no. Does the facility mee CFR 412.101(b)(2)(ii)? Enter in colu									
40.00 Is this hospital subject to the HAC "N" for no in column 1, for discharge					N		N		40. 00
no in column 2, for discharges on or				es of IN Tol					
						1. OC	XVIII) 2.00	XI X 3. 00	
Prospective Payment System (PPS)-Cap 45.00 Does this facility qualify and recei	ital	t for (di sproporti opat	o charo in a	cordanco	N	N	N	45. 00
with 42 CFR Section §412.320? (see i	nstructions)							IN .	
46.00 Is this facility eligible for addition pursuant to 42 CFR §412.348(f)? If you Pt. III.						N	N	N	46. 00
47.00 Is this a new hospital under 42 CFR						N	N	N	47. 00
48.00 Is the facility electing full federa Teaching Hospitals	l capital payment	? Ente	er "Y" for yes	or "N" for no).	N	N	N	48. 00
56.00 Is this a hospital involved in train or "N" for no.	ing residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56. 00
57.00 If line 56 is yes, is this the first									57. 00
GME programs trained at this facilities "Y" did residents start training									
for yes or "N" for no in column 2.	lf column 2 is "Y	", comp	olete Worksheet						
"N", complete Wkst. D, Parts III & I' 58.00 If line 56 is yes, did this facility	elect cost reimb	ursemer	nt for physicia	ıns' servi ces	as	N			58. 00
defined in CMS Pub. 15-1, chapter 21 59.00 Are costs claimed on line 100 of Wor				Pt. I.		N			59. 00
60.00 Are you claiming nursing school and/provider-operated criteria under §41	or allied health	costs 1	for a program t	hat meets the		N			60.00
provider-operated Criteria under 941	3.65? EIILEI T	Y/N	IME	Direct GME	IME		Di rect	GME	
		1. 00	2. 00	3. 00	4.00)	5. C	00	
61.00 Did your hospital receive FTE slots section 5503? Enter "Y" for yes or "		N		-		0.00			61. 00
column 1. (see instructions)									
61.01 Enter the average number of unweighter FTEs from the hospital's 3 most received.			0.00	0.	00				61. 01
ending and submitted before March 23									
instructions) 61.02 Enter the current year total unweigh			0.00	0.	od				61. 02
FTE count (excluding OB/GYN, general and primary care FTEs added under se									
ACA). (see instructions)			0.00	_	20				(1.00
61.03 Enter the base line FTE count for pr and/or general surgery residents, wh			0.00	0.	50				61. 03
determining compliance with the 75% instructions)	test. (see								
61.04 Enter the number of unweighted prima			0.00	0.	od				61. 04
surgery allopathic and/or osteopathic current cost reporting period. (see i									
61.05 Enter the difference between the bas			0.00	0.	00				61. 05
primary care and/or general surgery	FTE counts (line								
61.04 minus line 61.03). (see instru	CTI ONS)	1							I

Health Financial Systems	KOSCLUSKO	COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL			Provi der CC		eri od:	Worksheet S-2	
				Fr To	rom 03/01/2016 0 02/28/2017	Part Date/Time Pre	pared:
		Y/N	IME	Direct GME	I ME	7/31/2017 3:14 Direct GME	4 pm
		1710	I WIL	DITECT GIVIE	TWE	Direct divic	
(1.04 5.1 11. 1. 5.404 55500		1. 00	2. 00	3. 00	4. 00	5. 00	(1.0)
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs to care or general surgery. (see ins	that are nonprimary		0.00	0.00			61. 06
	,	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE umn 4, direct GME				0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 3, the IME FTE unweighted count 4, direct GME FTE unweighted court	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 20
						1. 00	
ACA Provisions Affecting the Heal						1.00	
62.00 Enter the number of FTE residents your hospital received HRSA PCRE			l in this cost	reporting peri	od for which	0.00	62. 00
62.01 Enter the number of FTE residents during in this cost reporting per	s that rotated from a riod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0. 00	62. 01
Teaching Hospitals that Claim Res 63.00 Has your facility trained resider	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
"Y" for yes or "N" for no in colu	umn 1. If yes, comple	ete line	es 64-67. (see	instructions) Unweighted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
				1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju				This base year	is your cost r	eporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2)	yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trair n-primar all nor d non-pr n columr	ned residents Ty care Inprovider Timary care In 3 the ratio	0. 00	0. 00	0. 000000	64. 00
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2.00	3. 00	4.00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0.000000	65.00

Health Financial Systems KOSCIUSKO COMMU	UNITY HOSPITAL		11	n Lieu	ı of Form CMS∙	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		Period: From 03/01/	2014	Worksheet S-	2
			To 02/28/		Part I Date/Time Pr	
			V		7/31/2017 3:	14 pm
			1.00		2. 00	+
95.00 If line 94 is "Y", enter the reduction percentage in the ap	oplicable colum	 າ.	0. 00		0.00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N		N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the approximately Rural Providers		າ.	0.00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (0 106.00 If this facility qualifies as a CAH, has it elected the all 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 costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	mn 1. (see insti I. 25 and the p	ructions) If rogram is cos				107. 00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						108. 00
	Physi cal 1.00	0ccupati onal 2.00	Speec 3. 00		Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N		N N	109. 00
110.00 Did this hospital participate in the Rural Community Hospit		on project (4	10A Demo)fo	-	1. 00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N"	' for no.					
Miscellaneous Cost Reporting Information				1. 00	2.00 3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	2. If column 2 i ent for long tea	s "E", enter rm care (incli	in column udes	N	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insulate.	" for yes or "N' urance? Enter "'	' for no. /" for yes or	"N" for	Y N		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1 i	f the policy	is	1		118. 00
ordin made. Effer 2 11 the portey 13 decarrence.		Premi ums	Losses	S	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3, 263	3. 00	0110 01
110. OT LIST amounts of marpractice premi ums and pard rosses.		30, 8	10 23	3, 203		
						0 118. 01
118.02 Are mal practice premiums and paid losses reported in a cost			1. 00		2. 00	
Administrative and General? If yes, submit supporting sche and amounts contained therein.			1. 00 N		2.00	118. 02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments.	edule listing co ld Harmless prov in column 1, "Y' qualifies for tl	ost centers vision in ACA ' for yes or ne Outpatient	N		2.00 N	
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications.	edule listing co d Harmless provin column 1, "Y' qualifies for tl ents? (see inst	ost centers vision in ACA ' for yes or ne Outpatient ructions)	N			118. 02
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Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CC	N: 15-0133			u of Form CMS Worksheet S- Part I Date/Time Pr 7/31/2017 3:	-2 repared:
					1. 00	2. 00	_
33.00 If this is a Medicare certified other			cation date	:	1.00	2.00	133. 0
in column 1 and termination date, i 34.00 If this is an organ procurement org- and termination date, if applicable	anization (OPO), enter th		n column 1				134. 0
All Providers 40.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N	or home office costs as o " for no in column 1. If	yes, and home	office cost	s	Υ	449008	140. 0
are claimed, enter in column 2 the	nome office chain number.	•	ions)		3. 00		
If this facility is part of a chain			gh 143 the	name and		of the	
home office and enter the home offi 41.00 Name: CHS/COMMUNITY HEALTH SYSTEMS INC.				tor's Nu	ımber: 5228	30	141. 0
42.00 Street: 4000 MERIDIAN BLVD	PO Box:						142.0
43.00 City: FRANKLIN	State: TN		Zi p Cod	e:	3706	7	143. 0
						1.00	_
44.00 Are provider based physicians' cost	s included in Worksheet A	1?				1. 00 Y	144. 0
45 001 5					1. 00	2.00	4.5
45.00 f costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" for	for yes or "N" for no in ude Medicare utilization	column 1. If c	olumn 1 is		N	N	145. C
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the previous column 1. (See CMS Pub.			f	N		146. 0
						1.00	_
47.00 Was there a change in the statistic	al basis? Enter "Y" for y	yes or "N" for	no.			N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifie	d cost finding method? Er	nter "Y" for ye Part A	s or "N" fo Part B		itle V	N Title XIX	149. (
		1.00	2.00	<u> </u>	3.00	4.00	
Does this facility contain a provid							
or charges? Enter "Y" for yes or "N 55.00 Hospi tal	for no for each compone	ent for Part A	and Part B. N	(See 4.	Z CFR 9413 N	N N	155. (
56. 00 Subprovi der – TPF		N	N		N	N	156. 0
57.00 Subprovi der – IRF		N	N		N	N	157. (
58. 00 SUBPROVI DER			N		N	, ,	158. (
59.00 SNF 60.00 HOME HEALTH AGENCY		N I	N N		N N	N N	159. (160. (
51. OO CMHC		IN	N		N	N N	161. (
		'					
Mul +i compus						1.00	
Multicampus 65.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that has one	e or more campu	ses in diff	erent CE	BSAs?	N	165. 0
	Name	County		ip Code		FTE/Campus	
66.00 f ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	JU 166.
						1.00	-
Health Information Technology (HIT)	incentive in the America	an Recovery and	Rei nvestme	ent Act		1.00	
o7.00 Is this provider a meaningful user o8.00 If this provider is a CAH (line 105	under §1886(n)? Enter "\ is "Y") and is a meaninq	/" for yes or " gful user (line	N" for no.		- the	N	167. (0168. (
	t a meaningful user, does	s this provider			dshi p		168. (
reasonable cost incurred for the HI 168.01 If this provider is a CAH and is no	T assets (see instruction t a meaningful user, does Enter "Y" for yes or "N" er (line 167 is "Y") and	ns) s this provider for no. (see i	qualify fonstructions	or a hard ()	dshi p	0.1	

Health Financial Systems	KOSCIUSKO COMMUNIT	TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DATA	Provider CCN: 15-0133	Peri od:	Worksheet S-2	!
			From 03/01/2016	Part I	
			To 02/28/2017		
				7/31/2017 3:1	4 pm
	Begi nni ng	Endi ng			
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begingeriod respectively (mm/dd/yyyy)	10/01/2014	12/29/2014	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provide	N	C	171. 00		
section 1876 Medicare cost plans repo	rted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter		İ	
"Y" for yes and "N" for no in column	1. If column 1 is yes, en	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)			İ	

OSPI T	Financial Systems KOSCIUSKO COMMUNICAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0133	Peri od:	u of Form CMS Worksheet S	
				From 03/01/2016 To 02/28/2017	Part II Date/Time P	
	· · · · · · · · · · · · · · · · · · ·			Y/N	7/31/2017 3 Date	: 14 piii
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyyy format.	for all NO re	esponses. Ent	er all dates in t	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				
			1. 00	2. 00	V/I 3. 00	
. 00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide	ffices, drug	Y			3. (
	officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other	f the board				
	relationships? (see instructions)		\/ /hI	T	D-+-	
			1. 00	7ype 2. 00	3. 00	
	Financial Data and Reports			2.00	0.00	
. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date available.	or Compiled,	N			4.0
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit recommendations are total recommendations.		N			5. (
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6. (
00 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	N N		7. (8. (
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. (
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10. (
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N	V /N	11. (
	Bad Debts				Y/N 1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	, see instruct	tions.		Υ	12. (
	If line 12 is yes, did the provider's bad debt collection properiod? If yes, submit copy.				N	13. (
	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement Did total beds available change from the prior cost reportion				N N	14. (
5. 00	Total beds available change It oil the piror cost reporti		rt A		t B	15. (
		Y/N	Date	Y/N	Date	
	DCAD 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	Υ	06/22/2017	Y	06/22/2017	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	N		N		17. (
3. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. (

records? If yes, see Instructions. 1.00		Financial Systems KOSCIUSKO COMMU		ON 45 0400		u of Form CMS-		
20.00 If I line 16 or 17 is yes, were adjustments made to PSSR N N N 20.00	HUSPII	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (.CN: 15-0133	From 03/01/2016	Part II Date/Time Pre	epared:	
20.00 If I line 16 or 17 I is yes, were adjustments ander to PSSR N Date PSSR N Date PSSR N Date PSSR Date Date PSSR Date Da				_				
Report data for Other? Describe the other adjustments: Y/N Date	20.00	If line 16 or 17 is yes were adjustments made to DCOD		Ü			20.00	
1.00	20.00				IN	IN	20.00	
21.00 Was the cost report prepared only using the provider's N N 21.00 Precord's If yes, see instructions. 1.00			Y/N	Date	Y/N	Date		
COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLET CHILDRENS HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CONTROL (EXCEPT CHILDRENS HOSPITALS) CO				2.00		4. 00		
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Completed By COST RELIBBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Lapital Related CoSt Lapital Related CoSt Lapital Related CoSt Lapital Related CoSt N 22.0 (Dever assets been relife for Medicare purposes? If yes, see instructions N 22.0 (Deverages occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 11 yes, see instructions. 12.0 (Deverage instructions) 12.0 (Deverage instructions) 13.0 (Have the relations) 14.0 (Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 25.0 (Deverages instructions) 15.0 (Deverage) 16.0 (Deverage) 17.0 (Deverage) 18.0 (Deverage)						1 00		
Capital Related Cost 2.0.0 Have changes occurred in the Medicare purposes? If yes, see instructions 3.0.0 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 2.2.0 Nere new leases and/or amendments to existing leases entered into during this cost reporting period? N 2.1.0 Nere new leases and/or amendments to existing leases entered into during this cost reporting period? N 2.2.0 Nere new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see N 2.0.0 Nere describes subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, see N 2.0.0 Nere assets subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, see N 2.0.0 Nere assets subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, see N 2.0.0 Nere assets subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, see N 2.0.0 Nere assets subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, see instructions of the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 2.0.0 Nere new Loans, mortgage agreements or Letters of credit entered into during the cost reporting to the cost credit entered into during the cost reporting to the cost credit entered into during the cost reporting to the cost credit entered into during the Cost credit entered into during the Cost credit entered into during the		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)		1.00		
Sample S				ĺ				
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.0 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.0 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.0 27.00 Have the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.0 28.00 Deases Expense 28.00 Deases Expense 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.0 30.00 Have salting debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.0 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.0 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 37.0 33.00 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 32.0 34.00 Are services furnished. 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based Physicians? 36.00 Were home office costs claimed on the cost report? 37.00 If I ine 36 is yes, has a home office cost statement been prepared by the home office? Y 11.00 2.00 38.00 Were home office costs claimed on the cost report? 39.00 If I ine 36 is yes, and the provider render services to other chain components? If yes, see Instructions. 40.00 Were home office costs claimed on the cost report? 39.00 If I ine 36 is yes, did the provider render services to other chain components? If yes, see Instructions. 40.00 Were home office costs claimed on the cost report? 30.00 Were home office costs claimed on the cost report? 30.00 Were home office costs claimed on the cost report? 30.00 Were home office costs, did the provider render services to other chain components? If yes, see Instructions. 40.00 Wer	22. 00					N	22. 00	
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.0	23.00		due to apprais	sals made dur	ing the cost	N	23. 00	
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see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost (615) 925-4497 COREY_WATKINS@CHS.NET 43.00	30 00				N		30 00	
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report preparer. 42.00 Enter the telephone number and email address of the cost (615) 925-4497 42.00 Enter the telephone number and email address of the cost (615) 925-4497	37.00		a Charn Compo	nents: II yes	, IN		37.00	
Cost Report Preparer Contact Information 1.00 2.00	40. 00							
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41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost (615) 925-4497 WATKINS 41.00 COREY WATKINS 42.00 COREY_WATKINS@CHS.NET 43.00			1	. 00	2.	00		
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42.00 Enter the employer/company name of the cost report COMMUNITY HEALTH SYSTEM 42.00 Enter the telephone number and email address of the cost (615) 925-4497 COREY_WATKINS@CHS.NET 43.00								
preparer. 43.00 Enter the telephone number and email address of the cost (615) 925-4497 COREY_WATKINS@CHS.NET 43.00	42 00	'	COMMUNITY HEAD	TH SYSTEM			42.00	
43.00 Enter the telephone number and email address of the cost (615) 925-4497 COREY_WATKINS@CHS.NET 43.00	00					50		
	43.00		(615) 925-449°	7	COREY_WATKI NS@	CHS. NET	43.00	

Heal th	Financial Systems KOSCIUSKO COMMU	JNITY HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0133	Peri od: From 03/01/2016	Worksheet S-2 Part II			
				Date/Time Pre 7/31/2017 3:1	pared: 4 pm		
		3. 00					
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position	ASST MANAGER, REVENUE			41. 00		
	held by the cost report preparer in columns 1, 2, and 3,	MANAGEMENT					
	respectively.						
	Enter the employer/company name of the cost report				42. 00		
	preparer.						
	Enter the telephone number and email address of the cost				43. 00		
ļ	report preparer in columns 1 and 2, respectively.						

Health Financial Systems KOSCIUSKO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0133

				To	02/28/2017	Date/Time Prep 7/31/2017 3:14	
						I/P Days / 0/P	, p
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1.00		1.00	2.00	3.00	4. 00	5. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	58	21, 170	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		58	21, 170	0. 00	0	7. 00
	beds) (see instructions)			- 440			
8.00	INTENSIVE CARE UNIT	31. 00	14	5, 110	0. 00	0	8. 00
9. 00 10. 00	CORONARY CARE UNIT						9.00
11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				o	13. 00
14. 00	Total (see instructions)	10.00	72	26, 280	0. 00		14. 00
15.00	CAH visits					O	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00 23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	50.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		72				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF		_				31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33 00	LTCH non-covered days						33. 00
55.50	2. 3 33vor ou days	l	I	1			1 55. 55

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

outpatient days (see instructions)

33.00 LTCH non-covered days

Provider CCN: 15-0133

Peri od: Worksheet S-3 From 03/01/2016 Part I To 02/28/2017 Date/Time Prepared:

7/31/2017 3:14 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3, 116 1, 080 8, 757 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 2.547 236 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 3, 116 1,080 8,757 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 629 229 1,540 8.00 CORONARY CARE UNIT 9.00 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 435 969 13.00 14.00 Total (see instructions) 3,745 1,744 11, 266 0.00 421.19 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10 25. 00 CMHC - CMHC 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26. 25 0 Ω 0 26.25 27.00 Total (sum of lines 14-26) 0.00 421.19 27.00 28.00 Observation Bed Days 2, 151 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 Total ancillary labor & delivery room 0 32.01 32.01

| Period: | Worksheet S-3 | From 03/01/2016 | Part | To 02/28/2017 | Date/Time Prepared: Provider CCN: 15-0133

				To	02/28/2017	Date/Time Prep 7/31/2017 3:14	
		Full Time Equivalents	<u>'</u>	Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14. 00	Pati ents 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		453	3, 309	1. 00
1.00	B exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		Č	1, 661	100	3,307	1. 00
2.00	HMO and other (see instructions)			680	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospi tal Adul ts & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0.00	0	1, 054	453	3, 309	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00 23. 00	HOME HEALTH AGENCY						22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33.00	Eron non-covered days	l		1	I		33.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0133

| Peri od: | Worksheet S-3 | From 03/01/2016 | Part II | To 02/28/2017 | Date/Time Prepared:

					To	02/28/2017	Date/Time Pre 7/31/2017 3:1	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	·
		1. 00	2. 00	<u>Worksheet A-6)</u> 3.00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1. 00	2.00	0.00	1. 00	0.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	22, 093, 487	0	22, 093, 487	876, 072. 00	25. 22	1.0
	instructions)	200. 00			,,			
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00		
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0.00	3.0
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4. 0
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	· -	1	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 0
7. 00	services Interns & residents (in an	21. 00	0	0	О	0.00	0.00	7. 0
7. 01	approved program) Contracted interns and residents (in an approved		0	О	О	0.00	0.00	7.0
8. 00	programs) Home office and/or related organization personnel		0	0	О	0.00	0.00	8. 0
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 33, 971	0 144, 966	0 178, 937	0. 00 7, 740. 00	•	
10.00	instructions) OTHER WAGES & RELATED COSTS		33, 771	144, 700	170, 737	7,740.00	25. 12	10.0
11. 00	Contract Labor: Direct Patient		172, 579	0	172, 579	2, 326. 00	74. 20	11.0
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12. 0
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		199, 163	0	199, 163	1, 689. 00	117. 92	13. 0
14. 00	Home office and/or related orgainzation salaries and wage-related costs		2, 303, 509	О	2, 303, 509	70, 241. 00	32. 79	14.0
14. 01	Home office salaries		0	О	0	0.00		14.0
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	•	
16. 00	- Administrative Home office and Contract		0	0	0	0.00		
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		5, 278, 020	0	5, 278, 020			17. 0
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 0
19. 00	Excluded areas		46, 600	0	46, 600			19.0
20. 00	Non-physician anesthetist Part A		U	0	U			20.0
21. 00	Non-physician anesthetist Part B		0	0	0			21.0
22. 00	Physician Part A - Administrative		0	0	0			22.0
22. 01	Physician Part A - Teaching		0	0	0			22. 0 23. 0
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			24.0
25. 00	Interns & residents (in an approved program)		0	0	0			25. 0
25. 50 25. 51	Home office wage-related Related orgainzation		0	-	0 0			25. 5 25. 5
25. 52	wage-related Home office: Physician Part A - Administrative -		0	0	О			25. 5
25. 53	wage-related Home office & Contract Physicians Part A - Teaching -		0	0	О			25. 5
	wage-related OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	159, 508		159, 508	6, 248. 00		
27.00	Administrative & General	5. 00	3, 656, 718	-315, 430	3, 341, 288	131, 720. 00	25. 37	27.0

| Peri od: | Worksheet S-3 | From 03/01/2016 | Part II | To 02/28/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0133

					11	02/28/201/	7/31/2017 3:14	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number		on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4	,	
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		6, 777	0	6, 777	0.00	0. 00	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	502, 604	0	502, 604	24, 505. 00	20. 51	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	504, 093	0	504, 093	38, 971. 00	12. 94	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	560, 547	-442, 061	118, 486	8, 059. 00	14. 70	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	442, 061	442, 061	30, 066. 00	14. 70	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	1, 108, 366	170, 464	1, 278, 830	38, 638. 00	33. 10	38.00
39.00	Central Services and Supply	14. 00	226, 693	0	226, 693	14, 221. 00	15. 94	39.00
40.00	Pharmacy	15. 00	831, 730	0	831, 730	19, 123. 00	43. 49	40.00
41.00	Medical Records & Medical	16. 00	250, 854	0	250, 854	15, 563. 00	16. 12	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Provider CCN: 15-0133

| Peri od: | Worksheet S-3 | From 03/01/2016 | Part III | To 02/28/2017 | Date/Time Prepared:

					''	0 02/20/201/	7/31/2017 3: 1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		22, 100, 264	0	22, 100, 264	876, 072. 00	25. 23	1. 00
	instructions)							
2.00	Excluded area salaries (see		33, 971	144, 966	178, 937	7, 740. 00	23. 12	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		22, 066, 293	-144, 966	21, 921, 327	868, 332. 00	25. 25	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		2, 675, 251	0	2, 675, 251	74, 256. 00	36. 03	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 278, 020	0	5, 278, 020	0.00	24. 08	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		30, 019, 564	-144, 966	29, 874, 598	942, 588. 00	31. 69	6. 00
7.00	Total overhead cost (see		7, 807, 890	-144, 966	7, 662, 924	327, 114. 00	23. 43	7. 00
	instructions)							

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0133	Peri od: Worksheet S-3 From 03/01/2016 Part IV To 02/28/2017 Date/Time Prepared: 7/31/2017 3:14 pm			

	10 02/28/201	7 Date/lime Prep 7/31/2017 3:14	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	389, 248	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	2, 963, 897	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	22, 802	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	20, 391	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	791	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	30, 475	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	145, 287	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	1, 261, 638	
	Medicare Taxes - Employers Portion Only	295, 060	
	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	70, 131	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement		1
	Total Wage Related cost (Sum of lines 1 -23)	5, 199, 720	
21.00	Part B - Other than Core Related Cost	5,177,120	- 1. 00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	124, 898	25. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0133	From 03/01/2016 To 02/28/2017	Worksheet S-3 Part V Date/Time Prepared:		

		0 02/28/201/	7/31/2017 3: 14	
	Cost Center Description	Contract Labor		
	*	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	172, 579	5, 199, 720	1.00
2.00	Hospi tal	172, 579	5, 199, 720	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (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	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

		IUNITY HOSPITAL			u of Form CMS-2		
HOSPI 7	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-0133	Peri od:	Worksheet S-10	0	
				From 03/01/2016 To 02/28/2017	Date/Time Prep 7/31/2017 3:14		
					1. 00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column	3 divided by lin	ne 202 column	n 8)	0. 114903	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				7, 549, 358	2. 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 suppler		from Medicaio	1?		4. 00	
5.00	If line 4 is "no", then enter DSH or supplemental payments	from Medicaid			0		
6. 00	Medi cai d charges				70, 186, 656		
7. 00	Medicaid cost (line 1 times line 6)				8, 064, 657	7. 00	
8. 00	Difference between net revenue and costs for Medicaid prog < zero then enter zero)	gram (line 7 minu	us sum of lir	nes 2 and 5; if	515, 299	8. 00	
	Children's Health Insurance Program (CHIP) (see instruction	ons for each line	<i>a)</i>				
9. 00	Net revenue from stand-allone CHIP		-,		8, 866	9.00	
10.00					139, 059		
11.00	9				15, 978	11. 00	
12.00	Difference between net revenue and costs for stand-alone (CHIP (line 11 mir	nus line 9; i	f < zero then	7, 112	12.00	
	enter zero)						
	Other state or local government indigent care program (see	instructions fo	or each line)				
13.00	Net revenue from state or local indigent care program (Not					13.00	
14.00	Charges for patients covered under state or local indigent	care program (1	Not included	in lines 6 or	0	14.00	
	10)	_			o	15. 00	
	15.00 State or local indigent care program cost (line 1 times line 14)						
16. 00		al indigent care	program (lir	ne 15 minus line	0	16. 00	
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)						
17 00	Private grants, donations, or endowment income restricted	to funding chari	ity care		0	17. 00	
18.00		5	,		0		
19. 00	3			(sum of lines	522, 411		
17.00	8, 12 and 16)	rocar margent (care programs	s (sum of filles	322, 411	1 7. 00	
			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
	Ta		1. 00	2. 00	3. 00		
20. 00			554, 74				
21. 00		ine 20)	63, 74				
22. 00				8, 075	8, 085		
23. 00	Cost of charity care (line 21 minus line 22)		63, 73	<u>32</u> 97, 855	161, 587	23. 00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for pa	atient days bevor	nd a Length o	of stay limit	1.00	24. 00	
00	imposed on patients covered by Medicaid or other indigent		59	y			
25. 00							
26.00	Total bad debt expense for the entire hospital complex (see instructions)						
27. 00	Medicare bad debts for the entire hospital complex (see in	nstructions)			128, 496	27. 00	
	Non-Medicare and non-reimbursable Medicare bad debt expens	se (line 26 minus	s line 27)		16, 236, 399	28. 00	
28.00	28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 16, 236, 399 28						
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad deb	ot expense (line	1 times line	28)	1, 865, 611	29. 00	
		,	1 times line	28)	1, 865, 611 2, 027, 198		

Heal th	Financial Systems	KOSCI USKO COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
				F T	From 03/01/2016 o 02/28/2017	Date/Time Pre	
						7/31/2017 3: 1	4 pm
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	0.00	2.00	4.00	col . 4)	
	CENEDAL CEDILLOS COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		1 (21 721	1 (01 701	000 110	2 441 042	1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT		1, 621, 731 3, 618, 803	1, 621, 731 3, 618, 803			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	159, 508					4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	3, 656, 718	142, 308 16, 329, 484				5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	3,030,718	10, 327, 404	19, 900, 202			
7. 00	00700 OPERATION OF PLANT	502, 604	1, 681, 334	1			
8. 00	00800 LAUNDRY & LINEN SERVICE	302,004	296, 497				
9. 00	00900 HOUSEKEEPING	504, 093	290, 497	794, 100		794, 100	
10. 00	01000 DI ETARY	560, 547	522, 174			l	
11. 00	01100 CAFETERI A	300, 347	J22, 174 N	1,002,721	853, 392	l	
13. 00	01300 NURSING ADMINISTRATION	1, 108, 366	139, 396	1, 247, 762		l	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	226, 693	2, 713, 615				1
15. 00	01500 PHARMACY	831, 730	6, 755, 876			l	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	250, 854	613, 397	864, 251			1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	230, 034	013, 377	004, 231	-1,079	002, 372	10.00
30. 00	03000 ADULTS & PEDIATRICS	3, 630, 907	2, 086, 185	5, 717, 092	-626, 621	5, 090, 471	30.00
31. 00	03100 NTENSI VE CARE UNIT	1, 043, 121	179, 453				
43. 00	04300 NURSERY	0	0	(1, 222, 0)			
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			, , , , , , , ,	100/ 710	10.00
50. 00	05000 OPERATI NG ROOM	1, 243, 438	1, 193, 154	2, 436, 592	-15, 494	2, 421, 098	50.00
51. 00	05100 RECOVERY ROOM	636, 202	134, 997	771, 199			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(
53. 00	05300 ANESTHESI OLOGY	0	876, 675	876, 675		1	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 044, 020	3, 107, 665			1	
54. 01	05401 ULTRASOUND	352, 328	177, 850				1
54. 02	05402 ONCOLOGY	0	0			l	54. 02
56.00	05600 RADI 0I SOTOPE	148, 786	189, 586	338, 372		338, 372	
57.00	05700 CT SCAN	244, 648	210, 398	455, 046	-44, 403	410, 643	57. 00
58.00	05800 MRI	201, 263	61, 215	262, 478	0	262, 478	58. 00
60.00	06000 LABORATORY	1, 423, 880	1, 848, 339	3, 272, 219	-193, 099	3, 079, 120	60.00
65.00	06500 RESPIRATORY THERAPY	398, 269	58, 625	456, 894	130, 397	587, 291	65.00
66.00	06600 PHYSI CAL THERAPY	700, 993	1, 274, 213	1, 975, 206	-2, 458	1, 972, 748	66.00
67.00	06700 OCCUPATI ONAL THERAPY	27, 459	178, 262	205, 721	-659	205, 062	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	20, 707	20, 707	0	20, 707	68. 00
69. 00	06900 ELECTROCARDI OLOGY	178, 548	17, 562	196, 110		196, 110	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(449, 686	449, 686	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(1, 892, 114	1, 892, 114	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	6, 188, 845	1	
76. 00	03950 OTHER ANCILLARY SERVICE COST	0	0	(0	0	
76. 01	03610 SLEEP LAB	82, 448	50, 606			l	
76. 03	03951 WOUND CARE	87, 098	76, 845	163, 943	-163, 943	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	1 1	437, 060	-121, 039		160, 426	l	
91. 00	09100 EMERGENCY	1, 377, 935	1, 335, 553	2, 713, 488	-50, 095	2, 663, 393	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.00	SPECIAL PURPOSE COST CENTERS	00.050.547	47 (04 470	/ 0 7/0 000		(0.100.00)	
118.00		22, 059, 516	47, 681, 473	69, 740, 989	-607, 153	69, 133, 836	1118. 00
400.00	NONREI MBURSABLE COST CENTERS	00.074	04.0/0	55.00	054	F4 400	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 971	21, 063			l	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	-3, 107	-3, 107			192. 00
	19201 WELLNESS CENTER	0	0				192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		1	l e	194. 00
	07951 MARKETI NG	0	0				194. 01
	07952 SENI OR CIRCLE	0	0		1		194. 02
200.00	07953 OTHER NONREIMBURSABLE COST CENTERS TOTAL (SUM OF LINES 118-199)	22, 093, 487	47, 699, 429	60 702 014	0	l	
200. U	I TOTAL (SUM OF LINES 110-199)	22,093,40/	41,077,429	69, 792, 916	o O	07, 172, 710	₁ 200.00

Provi der CCN: 15-0133

| Period: | Worksheet A | From 03/01/2016 | To 02/28/2017 | Date/Time Prepared: 7/31/2017 3:14 pm |

				7/31/2017 3	:14 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
_		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	_			
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 649, 342	5, 091, 185	5	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-374, 413			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 599		l .	4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	46, 715			5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	-1, 546, 789	2, 621, 659		5. 02
7.00	00700 OPERATION OF PLANT	0	,		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-19, 849			8. 00
9.00	00900 HOUSEKEEPI NG	0	794, 100		9. 00
10.00	01000 DI ETARY	0		5	10. 00
11. 00	O1100 CAFETERI A	-256, 081	597, 311		11. 00
13.00	01300 NURSING ADMINISTRATION	0	1, 415, 885	5	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	559, 383	3	14. 00
15. 00	01500 PHARMACY	0			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-29, 913	832, 659		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-1, 500, 386	3, 590, 085	5	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	1, 219, 732	2	31. 00
43.00	04300 NURSERY	0	186, 713	3	43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	2, 421, 098	3	50. 00
51.00	05100 RECOVERY ROOM	0	770, 220		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	434, 942	2	52. 00
53.00	05300 ANESTHESI OLOGY	-860, 897	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 914	2, 339, 723	3	54. 00
54.01	05401 ULTRASOUND	0	0		54. 01
54.02	05402 ONCOLOGY	-1, 050, 038	1, 611, 658	3	54. 02
56.00	05600 RADI OI SOTOPE	-60	338, 312	2	56. 00
57.00	05700 CT SCAN	-9, 404	401, 239		57. 00
58.00	05800 MRI	-19, 155	243, 323	3	58. 00
60.00	06000 LABORATORY	0	3, 079, 120		60. 00
65.00	06500 RESPI RATORY THERAPY	0	587, 291		65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 972, 748	3	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	205, 062	2	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	20, 707	7	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	196, 110		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	449, 686		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 892, 114	1	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 188, 845	5	73. 00
76.00	03950 OTHER ANCILLARY SERVICE COST	0	0		76. 00
76. 01	03610 SLEEP LAB	0	0		76. 01
76. 03	03951 WOUND CARE	0	0		76. 03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0		7	90. 00
91.00	09100 EMERGENCY	-824, 297	1, 839, 096		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	SPECIAL PURPOSE COST CENTERS				
118.00		-3, 798, 738	65, 335, 098	3	118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54, 183	3	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	93, 785		1	192. 00
	19201 WELLNESS CENTER	0			192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 00
	07951 MARKETI NG	0	604, 897	7	194. 01
	07952 SENI OR CI RCLE	0			194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0			194. 03
200.00		-3, 704, 953	66, 087, 963	3	200. 00
				•	

Provider CCN: 15-0133

					7/31	/2017 3:14 pr
	2 1 2 1	Increases	6.1	0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	3.00		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 697, 790		1
	0 — — — — —			3, 697, 790		
	B - OXYGEN					
	MEDICAL SUPPLIES CHARGED TO	71. 00	0	26, 224		1
0	PATI ENT	0.00	o	0		2
ŏ		0.00	o	0		3
Ĭ	$\overline{}$		- — 	$- \frac{3}{26,224}$		
	C - LEASE AND RENTAL		-1			
0	CAP REL COSTS-BLDG & FIXT	1.00	0	199, 993		1
0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 034, 094		2
0		0. 00	0	0		3
0		0. 00	0	0		4
0		0.00	0	0		5
0		0. 00 0. 00	0	0		7
0		0.00	0	0		8
o l		0.00	0	0		9
00		0.00	o	Ö		10
00		0.00	o	Ö		11
00		0.00	0	0		12
00		0.00	О	0		13
00		0. 00	0	0		14
00		0. 00	0	0		16
00		0.00	0	0		17
00		0. 00 0. 00	0	0		18
00		0.00	0	0		20
00		0.00	0	Ö		21
00		0.00	o	Ö		22
	$_{0}$ $ +$			1, 234, 087		
	D - OTHER CAPITAL					
	CAP REL COSTS-BLDG & FIXT	1. 00	0	74, 970		1
	CAP REL COSTS-BLDG & FIXT	1.00	0	545, 149		2
0	CAP REL COSTS-MVBLE EQUIP		0	16,770		3
ľ	E – MARKETING		U	636, 889		
	MARKETING	194. 01	144, 966	459, 931		1
	0		144, 966	459, 931		
Ī	F - CNO COST					
0	NURSING ADMINISTRATION	1300	17 <u>0, 4</u> 64	<u>o</u>		1
Į.	0		170, 464	0		
	G - CHARGABLE SUPPLIES	74 00	al	100 110		
	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	423, 462		1
	IMPL. DEV. CHARGED TO	72.00	o	1, 892, 114		2
	PATI ENTS	72.00	٩	1,072,114		-
	0			2, 315, 576		·
	H - DRUGS	<u>'</u>	'			
0	DRUGS CHARGED TO PATIENTS	7300	0	<u>6, 188, 8</u> 45		1
1	0		0	6, 188, 845		
.	I - LABOR AND DELIVERY	40.00	450 4/4	00.050		
	NURSERY	43.00	158, 461	28, 252		1 2
٦	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	36 <u>9, 131</u> 527, 592	6 <u>5, 8</u> 11 94, 063		2
ľ	J - MISC DEPARTMENTS		321, 392	74, 003		
	CLINIC	90.00	87, 098	76, 845		1
	RESPI RATORY THERAPY	65.00	82, 448	47, 949		2
	OTHER ADMINISTRATIVE AND	5. 02	1, 392, 562	2, 775, 886		3
Į.	GENERAL					
	0		1, 562, 108	2, 900, 680		
	K - RADI OLOGY	E . 05	050 005	477.050		
	RADI OLOGY-DI AGNOSTI C	54.00	352, 328	177, 850		1
)	ONCOLOGY	<u>54.</u> 02	79 <u>2,</u> 740 1, 145, 068	1, 868, 956 2, 046, 806		2
ľ	L - DIETARY		1, 140, 000	2, 040, 000		
	CAFETERI A	11. 00	442, 061	411, 331		1
1	0	— · · · · · · · · · · · · · · · · · · ·	442, 061	411, 331		'
l	M - MOB UTILITIES		=,			
	PHYSICIANS' PRIVATE OFFICES	192.00	0	<u>3, 1</u> 07		1
	$_{0}$ $ +$			3, 107		
Ľ	Grand Total: Increases		3, 992, 259	20, 015, 329		500

RECLASSI FI CATIONS

Provider CCN: 15-0133

Peri od: Worksheet A-6 From 03/01/2016 To 02/28/2017 Date/Ti me Prepared:

7/31/2017 3:14 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 5. 01 OTHER ADMINISTRATIVE AND 3, 697, 790 0 1.00 GENERAL o 3, 697, 790 B - OXYGEN 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 10, 316 0 1.00 ANESTHESI OLOGY 0 2.00 53.00 15, 778 0 2.00 3.00 LABORATORY 60.00 0 130 0 3.00 26, 224 - LEASE AND RENTAL 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 1, 366 10 1.00 0 2.00 0.00 10 2.00 3.00 OPERATION OF PLANT 7.00 0 46, 432 0 3.00 4.00 DI ETARY 10.00 0 594 0 4.00 NURSING ADMINISTRATION 0 0 5.00 13.00 2.341 5.00 01 0 CENTRAL SERVICES & SUPPLY 6.00 14.00 63.267 6.00 7.00 PHARMACY 15.00 0 126, 222 0 7.00 MEDICAL RECORDS & LIBRARY o 0 8.00 16.00 1,679 8.00 ADULTS & PEDIATRICS 0 0 30.00 4.966 9.00 9.00 INTENSIVE CARE UNIT 0 0 10.00 31.00 2.842 10 00 OPERATING ROOM 50.00 0 11.00 11.00 7, 260 0 0 12.00 RECOVERY ROOM 51.00 979 12.00 O 0 RADI OLOGY-DI AGNOSTI C 13.00 54.00 678, 530 13.00 14.00 CT SCAN 57.00 o 44, 403 14.00 16.00 LABORATORY 60.00 192, 969 0 16.00 0 PHYSICAL THERAPY 17.00 17.00 66.00 2.458 0| 18.00 OCCUPATIONAL THERAPY 67.00 0 659 18.00 19.00 SLEEP LAB 76.01 0 2,657 0 19.00 0 0 20.00 CLINIC 90.00 3, 517 20.00 o 21.00 91.00 50.095 0 **EMERGENCY** 21.00 GIFT, FLOWER, COFFEE SHOP & 22.00 190.00 851 0 22.00 CANTEEN ō 1, 234, 087 D - OTHER CAPITAL 1.00 OTHER ADMINISTRATIVE AND 1.00 5 01 0 636, 889 12 GENERAL 2.00 0.00 0 13 2.00 3.00 0.00 12 3.00 636, 889 E - MARKETING 1.00 OTHER ADMINISTRATIVE AND 5.01 144, 966 459, 931 0 1.00 GENERAL 144, 966 459, 931 - CNO COST 1.00 OTHER ADMINISTRATIVE AND 5.01 170, 464 0 0 1.00 170, 464 0 G - CHARGABLE SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 2, 307, 342 0 1.00 OPERATING ROOM 2.00 50.00 8, 234 0 2.00 2, 315, 576 H - DRUGS 1.00 PHARMACY 15.00 6, 188, 845 0 1.00 6, 188, 845 - LABOR AND DELIVERY 1.00 ADULTS & PEDIATRICS 30.00 527, 592 94, 063 0 1.00 2.00 0.00 0 2.00 527, 592 94, 063 J - MISC DEPARTMENTS OTHER ADMINISTRATIVE AND 1.00 5.01 1, 392, 562 2, 775, 886 0 1.00 GENERAL 2.00 WOUND CARE 76. 03 0 2.00 87.098 76, 845 SLEEP LAB 8<u>2</u>, 448 47.949 3.00 <u>76.</u> 01 0 3.00 2, 900, 680 1, 562, 108 - RADI OLOGY 1.00 RADI OLOGY-DI AGNOSTI C 54.00 792, 740 1, 868, 956 0 1.00 2.00 ULTRASOUND <u>54.</u>01 35<u>2, 3</u>28 177,850 0 2.00 1, 145, 068 2, 046, 806 - DI ETARY 1.00 DI ETARY 10.00 442, 061 411, 331 0 1.00 442, 061 411, 331

Health Financial Systems

KOSCIUSKO COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0133

Period:
From 03/01/2016
To 02/28/2017

Date/Time Prepared:
7/31/2017 3: 14 pm

						7/31/2017 3:	14 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	M - MOB UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	3, 107	(1. 00
	0 = = = = = =			3, 107			
500.00	Grand Total: Decreases		3, 992, 259	20, 015, 329		7	500.00

			Acqui si ti ons				
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	158, 709	0	0	0	0	1. 00
2.00	Land Improvements	1, 539, 273	0	0	0	0	2. 00
3.00	Buildings and Fixtures	55, 087, 239	130, 397	0	130, 397	0	3. 00
4.00	Building Improvements	161, 933	0	0	0	0	4. 00
5.00	Fixed Equipment	4, 147, 798	0	0	0	18, 195	5. 00
6.00	Movable Equipment	36, 088, 532	6, 313, 469	0	6, 313, 469	310, 283	6. 00
7.00	HIT designated Assets	2, 274, 322	0	0	0	1, 619	7. 00
8.00	Subtotal (sum of lines 1-7)	99, 457, 806	6, 443, 866	0	6, 443, 866	330, 097	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	99, 457, 806	6, 443, 866	0	6, 443, 866	330, 097	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6. 00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	158, 709	0				1. 00
2.00	Land Improvements	1, 539, 273	0				2. 00
3.00	Buildings and Fixtures	55, 217, 636	0				3. 00
4.00	Building Improvements	161, 933	0				4. 00
5.00	Fixed Equipment	4, 129, 603	0				5. 00
6.00	Movable Equipment	42, 091, 718	0				6. 00
7.00	HIT designated Assets	2, 272, 703	0				7. 00
8.00	Subtotal (sum of lines 1-7)	105, 571, 575	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	105, 571, 575	0				10. 00

Heal th	n Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0133	Peri od: From 03/01/2016	Worksheet A-7	pared:
SUMMARY OF CAPITAL							
	Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 621, 731	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 618, 803	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 240, 534	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 621, 731				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 618, 803				2. 00
3.00	Total (sum of lines 1-2)	I ol	5, 240, 534				3.00

0 0 0

1, 621, 731 3, 618, 803 5, 240, 534

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	KOSCIUSKO COMML	JNITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: From 03/01/2016 To 02/28/2017		pared:
		COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	DART III DECONCILIATION OF CARLTAL COCTE O	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	57, 077, 551	1	57, 077, 55	1 0. 540653	0	1.00
2.00	CAP REL COSTS-BUBB & TTXT	48, 494, 024	l .	48, 494, 02			2.00
3.00	Total (sum of lines 1-2)	105, 571, 575		105, 571, 57			3. 00
2.00		ALLOCATION OF OTHER CAPITAL SUMMARY OF 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					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 2, 359, 662		1
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 3, 078, 729		2.00
3.00	Total (sum of lines 1-2)	0		<u> </u> JMMARY OF CAPI	0 5, 438, 391	1, 232, 990	3. 00
			50	JIMIMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	10.00	11.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	1, 855, 282	74, 970	545, 14	9 57, 226	5, 091, 185	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16, 770		0 165, 661	4, 295, 254	2. 00
3. 00	Total (sum of lines 1-2)	1, 855, 282	91, 740	545, 14	9 222, 887	9, 386, 439	3. 00

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0133 Peri od: Worksheet A-8 From 03/01/2016 02/28/2017 Date/Time Prepared: 7/31/2017 3:14 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -816 OTHER ADMINISTRATIVE AND 7.00 В 5.01 7.00 stations excluded) (chapter GENERAL -18, 703 CAP REL COSTS-MVBLE EQUIP 8.00 Tel evi si on and radio servi ce 2.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 10.00 Provider-based physician A-8-2 -4, 266, 151 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 1, 393, 790 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -256, 081 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0.00 16.00 0 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents -29, 913 MEDI CAL RECORDS & LI BRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A - 8 - 365.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 66.00 24.00 Adjustment for physical A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 Utilization review 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL 737, 931 CAP REL COSTS-BLDG & FIXT 26.00 26.00 Α 1.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL -543, 753 CAP REL COSTS-MVBLE EQUIP 2.00 27.00 Α COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29. 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 OOCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 31.00 68 00 A - 8 - 3pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33.00 0 00 33 00

-1, 097 CAP REL COSTS-BLDG & FIXT

1.00

10 34.00

В

34.00 RENTAL INCOME

						7/31/2017 3: 1	4 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost deliter bescription	1.00	2.00	3.00	4. 00	5. 00	
35. 00	MISC INCOME	В		OTHER ADMINISTRATIVE AND	5, 01	0.00	35. 00
33. 00	INT SC T NCOME			GENERAL	3.01	J	33.00
36. 00	1		0	DENEIVAL	0.00	0	36. 00
37. 00	PATIENT PHONE WAGE COST	A	4 424	OTHER ADMINISTRATIVE AND	5. 02	0	37. 00
37.00	PATTENT PHONE WAGE COST	A		GENERAL	3.02	U	37.00
38. 00	PATIENT PHONE BENEFIT COSTS			EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38. 00
		A				0	
39. 00	PATIENT PHONE EXPENSE	A		OTHER ADMINISTRATIVE AND	5. 02	0	39. 00
40.00	DATI ENT DUONE DEDDEOLATION			GENERAL	0.00		40.00
40. 00	PATIENT PHONE DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	40.00
41. 00	PATIENT TV - DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	41. 00
42.00	MARKETI NG	A		OTHER ADMINISTRATIVE AND	5. 01	0	42. 00
				GENERAL			
43.00	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 01	0	43. 00
				GENERAL			
44.00	CHARI TABLE CONTRI BUTI ONS	A		OTHER ADMINISTRATIVE AND	5. 01	0	44. 00
				GENERAL			
45.00			0		0.00	0	45. 00
45. 01	MI NORI TY I NTEREST	A		OTHER ADMINISTRATIVE AND	5. 01	0	45. 01
				GENERAL			
45.02	LOBBYING EXPENSE IN	A	-6, 547	OTHER ADMINISTRATIVE AND	5. 01	0	45. 02
	ASSOCIATION DUES			GENERAL			
45.03	TRANSPORTATION COSTS	A	-1, 999	OTHER ADMINISTRATIVE AND	5. 01	0	45. 03
				GENERAL			
45.04	LEGAL FEES	A	-67, 381	OTHER ADMINISTRATIVE AND	5. 01	0	45. 04
				GENERAL			
45.05	POB DEPRECIATION	A	93, 785	PHYSICIANS' PRIVATE OFFICES	192. 00	0	45. 05
45.06			. 0		0.00	0	45. 06
45. 07			0		0.00	0	45. 07
45. 08			0		0.00	n	45. 08
45. 09	MEALS AND ENTERTAINMENT	A	_21 257	OTHER ADMINISTRATIVE AND	5. 01	0	45. 09
10.07	MENES AND ENTERTAINMENT			GENERAL	3.01		75.07
50. 00	TOTAL (sum of lines 1 thru 49)		-3, 704, 953	1 -			50. 00
30.00	(Transfer to Worksheet A,		-3, 104, 733				30.00
	column 6, line 200.)						
(1) D-	scription - all chapter referen			0110 D L 45 4			

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

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Period:
From 03/01/2016
To 02/28/2017
Date/Time Prepared:
7/31/2017 3:14 pm

Line No. Cost Center Expense I tems A Amount of All Owable Cost Annount of Ness A Column Ness A Co	011102					То	02/28/2017	Date/Time Pre 7/31/2017 3:1	
1.00		Li ne No.	Cost Center		Expense I tems		Amount of		
1.00					·	ΑI	lowable Cost	Included in	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED 1.00 2.00 2.00 2.00CAP REL COSTS-BLDG & FIXT 0.00CAP REL COSTS-BLDG & FIXT 0.00CAP REL COSTS-MVED EQUIP 0.00 2.00CAP REL COSTS-MVED EQUIP 0.00CAP REL COSTS MVED EQUIP 0.00CAP REL COSTS-MVED EQUIP 0.00CAP REL COSTS-								Wks. A, column	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00CAP REL COSTS-BLDG & FLXT OS CAPITAL OS CAPITAL 1. 1,855,282 0. 1,00 CAP REL COSTS-BLDG & FLXT OS CAPITAL COSTS - BLDG & 45,754 0. 2,00 CAP REL COSTS-MUDBLE EQUIP A. 00 0.									
HOME OFFICE COSTS:									
2.00 1. 00 CAP REL COSTS-BLDG & FIXT ASI CAPITAL COSTS - BLDG & 45, 754 0 2.00 2.00 CAP REL COSTS-MUSE EQUIP ASI CAPITAL COSTS - MOVEABL 7, 180 0 3.00 4.00 4.01 0.00 0.0			MENTS REQUIRED AS A RESULT OF	TRAI	NSACTIONS WITH RELATED O	RGAN	NIZATIONS OR	CLAI MED	
3.00	1.00			DI RE	ECT ALLOCATION - CAPITAL-		1, 855, 282	0	
4. 00	2.00			PASI	CAPITAL COSTS - BLDG &		45, 754	0	2.00
4. 01	3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	PASI	CAPITAL COSTS - MOVEABL	.	7, 180	0	3.00
4. 02				PASI	OPERATING COSTS		680, 454	0	
4. 03 4. 04 4. 05 4. 06 4. 06 5. 01 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 4. 09 5. 02 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 5. 01 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 01 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 01 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 01 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 02 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 04 6. 07 6. 02 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 05 6. 04 6. 07 6. 02 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 06 6. 04 6. 07 6. 02 OTHER ADMIN ISTRATIVE AND GEN MANAGEMENT FEES 6. 06 6. 04 6. 07 6. 02 OTHER ADMIN ISTRATIVE AND GEN AUDIT FEES 6. 06 6. 07 6. 08 6. 08 6. 09 6.							0	0	4. 01
4. 04 4. 05 4. 06 CAP REL COSTS-BLDG & FIXT 2. 00 CAP REL COSTS-MVBLE EQUIP 4. 05 5. 01 OTHER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 01 OTHER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 02 OTHER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 04 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE CALCORATIONS (PER COSTS (SEE EXHIB 5. 06 OF ALTER ADMIN ISTRATIVE AND GEN MALPRACTICE		0.00					0	0	4. 02
4. 05 4. 06 4. 06 4. 06 5. 01 OTHER ADMINISTRATIVE AND GEN MAND GEN MAND GEN CONTACT CE COSTS (SEE EXHI B 15, 306 0 4. 06 4. 08 5. 02) OTHER ADMINISTRATIVE AND GEN MAND GEN CIG LEASED EQUIPMENT (SEE EXHI B 15, 306 0 4. 08 4. 09 4. 09 5. 01) OTHER ADMINISTRATIVE AND GEN CIG LEASED EQUIPMENT (SEE EXHI B 15, 306 0 4. 09 4. 09 5. 01) OTHER ADMINISTRATIVE AND GEN CIG LEASED EQUIPMENT (SEE EXHI B 15, 306 0 4. 08 4. 09 4. 09 5. 01) OTHER ADMINISTRATIVE AND GEN CIG LEASED EQUIPMENT (SEE EXHI B 15, 306 0 4. 09 4. 09 4. 10 6. 01) OTHER ADMINISTRATIVE AND GEN CIG LEASED EQUIPMENT (SEE EXHI B 15, 306 0 4. 09 4. 09 4. 11 6. 0. 00 0 6. 00 0 0 0 4. 15 4. 12 6. 00 0 0 0 0 4. 15 4. 12 6. 00 0 0 0 0 4. 15 4. 12 6. 00 0 0 0 0 0 4. 15 4. 12 6. 00 0 0 0 0 0 0 4. 15 4. 12 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0.00					0	0	
4. 06	4.04			NEW	CAPITAL - BUILDING & FIX		11, 472	0	4. 04
4. 07 4. 08 5. 01 OTHER ADMINISTRATIVE AND GEN MALPRACTICE COSTS (SEE EXHIB 95, 306 94.07 5. 02 OTHER ADMINISTRATIVE AND GEN CIG LEASED EQUIPMENT (SEE EX 95, 462 04.08 5. 02 OTHER ADMINISTRATIVE AND GEN MANAGEMENT FEES 0678, 227 4.09 4. 10 5. 01 OTHER ADMINISTRATIVE AND GEN 4.11 5. 01 OTHER ADMINISTRATIVE AND GEN ADDITHER SET 0.0 65, 498 4.11 4. 11 5. 01 OTHER ADMINISTRATIVE AND GEN ADDITHER SET 0.0 65, 498 4.11 4. 12 5. 01 OTHER ADMINISTRATIVE AND GEN ADDITHER SET 0.0 65, 498 4.11 4. 13 6. 00	4.05	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW	CAPITAL - MOVABLE EQUIPM		158, 481	0	4. 05
4. 08	4.06	5. 01	OTHER ADMINISTRATIVE AND GEN	NON-	CAPITAL HOME OFFICE COST		1, 907, 623	0	4.06
4. 10	4.07						155, 306	0	4. 07
4. 10 4. 11 5. 01 OTHER ADMINISTRATIVE AND GEN AUDIT FEES 0 65, 498 4. 11 4. 12 4. 13 0. 00 4. 14 4. 15 4. 14 0. 00 4. 16 4. 17 4. 18 0. 00 4. 18 4. 19 4. 19 4. 19 4. 19 4. 19 4. 19 4. 19 4. 19 5. 01 OTHER ADMINISTRATIVE AND GEN AUDIT FEES 0 65, 498 4. 11 4. 12 4. 13 0. 00 0 0 1, 515, 251 4. 12 4. 13 0. 00 0 0 0 4. 14 4. 15 0. 00 0 0 0 4. 16 4. 17 4. 18 1. 5. 01 OTHER ADMINISTRATIVE AND GEN AUDIT FEES 0 0 0 0 0 4. 16 4. 17 4. 18 1. 5. 01 OTHER ADMINISTRATIVE AND GEN AUDIT FEES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.08	5. 02	OTHER ADMINISTRATIVE AND GEN	CIG	LEASED EQUIPMENT (SEE EX		95, 462	0	4. 08
4. 11	4.09	5. 02	OTHER ADMINISTRATIVE AND GEN	MANA	GEMENT FEES		0	678, 227	4. 09
4. 12	4. 10						0		
4. 13 4. 14 4. 15 4. 16 4. 17 4. 18 4. 19 4. 20 4. 20 4. 21 4. 22 5. 02 OTHER ADMINISTRATIVE AND GEN AL22 4. 23 5. 02 OTHER ADMINISTRATIVE AND GEN AL22 4. 23 5. 02 OTHER ADMINISTRATIVE AND GEN AL22 5. 02 OTHER ADMINISTRATIVE AND GEN BESS FEES 4. 23 5. 02 OTHER ADMINISTRATIVE AND GEN BESS FEES 5. 02 OTHER ADMINISTRATIVE AND GEN BESS FEES 6. 0 719, 136 7							0	65, 498	4. 11
4. 14			La contraction of the contractio	CORP	PORATE OVERHEAD ALLOCATIO	1	0	1, 515, 251	4. 12
4. 15	4. 13		l .				0	0	4. 13
4. 16 4. 17 4. 18 4. 19 4. 20 4. 21 4. 22 5. 02 OTHER ADMINISTRATIVE AND GEN 4. 23 4. 24 4. 25 4. 25 4. 26 4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4. 14		l .				0	0	4. 14
4. 17 4. 18 4. 19 4. 20 4. 21 4. 22 5. 02 OTHER ADMINISTRATIVE AND GEN 4. 23 4. 24 4. 25 4. 25 4. 26 4. 26 4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4. 15		l .				0	0	4. 15
4. 18 4. 19 4. 20 4. 21 4. 22 4. 22 5. 02 6 OTHER ADMINISTRATIVE AND GEN 4. 24 4. 25 4. 25 4. 26 4. 26 4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			ł .				0	0	
4. 19 4. 20 4. 21 4. 21 5. 02 OTHER ADMINISTRATIVE AND GEN 4. 22 5. 02 OTHER ADMINISTRATIVE AND GEN 5. 02 OTHER ADMINISTRATIVE AND GEN 6. 02 OTHER ADMINISTRATIVE AND GEN 719, 136 4. 21 8. 02 OTHER ADMINISTRATIVE AND GEN 8. 02 OTHER ADMINISTRATIVE AND GEN 8. 04, 600 9. 4. 19 9ASI COLLECTION FEES 9. 0 9. 4, 307 9. 4. 22 9. 4. 24 9. 5. 01 OTHER ADMINISTRATIVE AND GEN 9ASI LIEN UNIT COLLECTION FE 9. 0 9. 4. 19 9. 4. 20 9. 4. 21 9. 4. 2			l .				0	۳۱	
4. 20	4. 18		l l	PPSI	FEES		0	31, 200	4. 18
4. 21			l .				0	- 1	
4. 22							0	- 1	
4. 23							0		
4. 24 4. 25 4. 25 4. 26 4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			l l	1			0		
4. 25 4. 26 4. 27 5. 00 CAP REL COSTS-MVBLE EQUIP 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.							0		
4. 26 4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12. 4. 26 LAUNDRY & LINEN SERVICE LAUNDRY OPERATING LAUNDRY OPERATING LAUNDRY OPERATING LAUNDRY OPERATING STORAGE COLUMN 1							0		
4. 27 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12. 8. 00 LAUNDRY & LINEN SERVICE LAUNDRY OPERATING 276, 648 296, 497 4. 27 5. 00 5, 223, 932 3, 830, 142 5. 00							0	173, 983	
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.								- 1	
Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			LAUNDRY & LINEN SERVICE	LAUN	IDRY OPERATING		276, 648	296, 497	4. 27
Worksheet A-8, column 2, Line 12.	5.00						5, 223, 932	3, 830, 142	5.00
li ne 12.									
		-							

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

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

i ei ilibui	Sement under title Aviii.		
6.00	В	0.00 COMMUNITY HEALTH SYSTEMS 100.00	6. 00
7.00	С	0.00 H0SPI TAL LAUNDR 20.00	7.00
8.00	С	0. 00 PASI 100. 00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Heal th F	Financial Systems	KOSCIUSKO COMMU	JNITY HOSPITAL		In Lieu of Form CMS-2552-10		
		RELATED ORGANIZATIONS AND HOM	E Provi der (CCN: 15-0133	Peri od:	Worksheet A-8	3-1
OFFICE (COSTS				From 03/01/2016 To 02/28/2017		
				Related Orga	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	1	Name	Percentage of Ownership	

3.00

4. 00

5. 00

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

1. 00

- 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.

2.00

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.

OTTTOL	00313				To 02/28/2017	Date/Time Pre 7/31/2017 3:1	epared:
	Net	Wkst. A-7 Ref.				, , , , , , , , , , , , , , , , , , , ,	
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:					
1.00	1, 855, 282	11					1. 00
2.00	45, 754	14					2. 00
3.00	7, 180	14					3. 00
4.00	680, 454	0					4. 00
4.01	0	0					4. 01
4.02	0	0					4. 02
4.03	0	0					4. 03
4.04	11, 472	14					4. 04
4.05	158, 481	14					4. 05
4.06	1, 907, 623	0					4. 06
4.07	155, 306	0					4. 07
4.08	95, 462	0					4. 08
4.09	-678, 227	0					4. 09
4. 10	-9, 500	0					4. 10
4. 11	-65, 498	0					4. 11
4. 12	-1, 515, 251	0					4. 12
4. 13	0	O					4. 13
4.14	0	o					4. 14
4. 15	0	o					4. 15
4. 16	0	o					4. 16
4. 17	0	O					4. 17
4. 18	-31, 200	0					4. 18
4. 19	0	o					4. 19
4. 20	0	0					4. 20
4. 21	-719, 136	0					4. 21
4. 22	-4, 307	0					4. 22
4. 23	-49, 600						4. 23
4.24	-286, 943	0					4. 24
4. 25	-173, 983	0					4. 25
4. 26	30, 270	9					4. 26
4. 27	-19, 849	0					4. 27
5.00	1, 393, 790						5. 00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED 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.

Total Comment and the Attitude							
6.00	HOSPITAL MANAGEMENT		6. 00				
7.00	LAUNDRY SERVICES		7. 00				
8.00	DEBT COLLECTION		8. 00				
9. 00 10. 00			9. 00				
10.00			10.00				
100.00			100.00				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 03/01/2016 Date/Time Prepared: 7/21/2017 2:14 pm Provider CCN: 15-0133

					7	Fo 02/28/2017	7 Date/Time Pre 7/31/2017 3:1	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	T DIII
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	1, 500, 386	1, 500, 386	0	0	0	1. 00
2.00	91.00	EMERGENCY	824, 297	824, 297	0	0	0	2. 00
3.00	5. 01	OTHER ADMINISTRATIVE AND	0	0	0	0	0	3. 00
		GENERAL						
4.00	53. 00	ANESTHESI OLOGY	860, 897	860, 897	0	0	0	4. 00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 914	1, 914	0	0	0	5. 00
6.00	60.00	LABORATORY	0	0	0	0	0	6. 00
7.00	90.00	CLI NI C	0	0	0	0	0	7. 00
8. 00	54. 02	ONCOLOGY	1, 050, 038	1, 050, 038	0	0	0	8. 00
9.00	57. 00	CT SCAN	9, 404	9, 404	0	0	0	9. 00
10.00	58. 00	MRI	19, 155	19, 155	0	0	0	10. 00
11. 00	56.00	RADI OI SOTOPE	60	60	0	0	0	11. 00
200.00			4, 266, 151	4, 266, 151	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	1. 00
2.00	91. 00	91. OO EMERGENCY		0	0	0	0	2. 00
3.00	5. 01	OTHER ADMINISTRATIVE AND	0	0	0	0	0	3. 00
		GENERAL						
4.00		ANESTHESI OLOGY	0	· -	_	0	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5. 00
6. 00		LABORATORY	0	0	0	0	0	6. 00
7. 00		CLI NI C	0	0	0	0	0	7. 00
8. 00		ONCOLOGY	0	0	0	0	0	8. 00
9. 00		CT SCAN	0	0	0	0	0	9. 00
10. 00	58. 00		0	0	0	0	0	10. 00
11. 00	56. 00	RADI OI SOTOPE	0	0	0	0	0	11. 00
200.00			0	0	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADULTS & PEDIATRICS	15.00					1. 00
2.00		EMERGENCY				,	•	2.00
3.00		OTHER ADMINISTRATIVE AND			_	024, 247	•	3.00
3.00		GENERAL	0		0	١		3.00
4.00	53. 00 ANESTHESI OLOGY		0	0	0	860, 897		4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	· -	_	1, 914		5. 00
6. 00	60. OOLABORATORY				0	1, 714	1	6. 00
7. 00		CLI NI C						7. 00
8. 00		ONCOLOGY			0	l ~		8. 00
9. 00		CT SCAN		·	_	9, 404	•	9. 00
10. 00	58.00					19, 155		10.00
11. 00		RADI OI SOTOPE				19, 155		11.00
200.00	30.00	INDI OF SOTOLE			0	l	•	200.00
200.00	ı l		ı	ı	ı	4, 200, 151	I	200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0133 Peri od: Worksheet B From 03/01/2016 Part I Date/Time Prepared: 02/28/2017 7/31/2017 3:14 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 5, 091, 185 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 091, 185 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 295, 254 4, 295, 254 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 996, 641 12, 563 10, 599 4, 019, 803 4.00 00540 OTHER ADMINISTRATIVE AND GENERAL 198. 081 5 01 10, 754, 429 234, 786 357, 139 11 544 435 5 01 5.02 00560 OTHER ADMINISTRATIVE AND GENERAL 2, 621, 659 379, 125 319, 854 255, 212 3, 575, 850 5.02 2, 134, 399 7.00 00700 OPERATION OF PLANT 374, 461 315, 919 92, 111 2, 916, 890 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 276, 648 7, 795 6,576 291, 019 8.00 00900 HOUSEKEEPI NG 92, 384 916, 808 9 00 794, 100 13.876 9 00 16, 448 10.00 01000 DI ETARY 228, 735 45, 185 38, 121 21, 715 333, 756 10.00 01100 CAFETERI A 597, 311 32, 027 81, 016 748, 316 11.00 37, 962 11.00 01300 NURSING ADMINISTRATION 8, 297 234, 369 1, 668, 386 13.00 13.00 1.415.885 9, 835 01400 CENTRAL SERVICES & SUPPLY 22, 031 41, 546 14.00 559, 383 26, 113 649, 073 14 00 15.00 01500 PHARMACY 1, 272, 539 25, 672 21,658 152, 429 1, 472, 298 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 832, 659 35, 987 30, 361 45, 974 944, 981 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 590, 085 546, 406 460 984 568 744 5, 166, 219 30.00 03100 INTENSIVE CARE UNIT 1, 219, 732 122, 135 103, 041 191, 171 1, 636, 079 31.00 31.00 43.00 04300 NURSERY 186, 713 11, 693 9,865 29, 041 237, 312 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 421, 098 227, 420 191, 866 227, 882 3, 068, 266 50.00 05100 RECOVERY ROOM 770, 220 10, 718 9,043 116, 595 906, 576 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 434, 942 44, 718 37, 727 67, 650 585, 037 52.00 05300 ANESTHESI OLOGY 53 00 C 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 339, 723 169, 386 142, 905 293, 890 2, 945, 904 54.00 05401 ULTRASOUND 54.01 54.01 54.02 05402 ONCOLOGY 1, 611, 658 145, 637 122, 869 145, 284 2, 025, 448 54.02 56.00 05600 RADI OI SOTOPE 338, 312 6, 639 5, 601 27, 268 377, 820 56.00 05700 CT SCAN 27, 698 44, 836 57.00 401, 239 32,830 506, 603 57.00 58.00 05800 MRI 243, 323 43, 548 36, 740 36, 885 360, 496 58.00 06000 LABORATORY 3, 079, 120 79, 185 66.805 260, 952 60.00 3, 486, 062 60 00 65.00 06500 RESPIRATORY THERAPY 587, 291 39, 274 33, 134 88, 100 747, 799 65.00 06600 PHYSI CAL THERAPY 128, 470 66, 00 1, 972, 748 124, 409 104, 959 2, 330, 586 66.00 06700 OCCUPATIONAL THERAPY 205, 062 67.00 5.032 210.094 67.00 06800 SPEECH PATHOLOGY 20, 707 1, 299 1.096 23, 102 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 196, 110 650 548 32, 722 230, 030 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 449, 686 449, 686 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 892, 114 0 72 00 Ω 0 1 892 114 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 188, 845 C 0 0 6, 188, 845 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST 0 0 0 0 76.00 76. 01 03610 SLEEP LAB 0 C 0 0 0 76.01 03951 WOUND CARE 0 76.03 76.03 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 476, 447 49, 472 41, 738 96, 061 663, 718 90.00 09000 CLI NI C 91.00 09100 EMERGENCY 1,839,096 174, 089 146.873 252, 531 2, 412, 589 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 65, 335, 098 61, 512, 197 118. 00 118.00 3, 035, 440 2, 560, 892 3, 987, 009 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 75, 140 190. 00 54.183 7.990 6.741 6.226 93, 785 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,700,395 1, 434, 566 3, 228, 746 192. 00 192. 01 19201 WELLNESS CENTER 0 153, 211 129, 259 0 282, 470 192. 01 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194 00 194. 01 07951 MARKETI NG 604, 897 22, 919 26, 568 681, 550 194. 01 27, 166 194. 02 07952 SENI OR CIRCLE 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 166, 983 307, 860 194. 03 140.877 0 0 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 66, 087, 963 5, 091, 185 4, 295, 254 4, 019, 803 66, 087, 963 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0133

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 03/01/2016 | Part I | To 02/28/2017 | Date/Time Prepared: | 7/31/2017 3:14 pm

						7/31/2017 3:1	4 pm
	Cost Center Description	OTHER	Subtotal	OTHER	OPERATION OF	LAUNDRY &	
		ADMI NI STRATI VE		ADMI NI STRATI VE	PLANT	LINEN SERVICE	
		AND GENERAL		AND GENERAL			
		5. 01	5A. 01	5. 02	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 OTHER ADMINISTRATIVE AND GENERAL	11, 544, 435					5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	756, 847	4, 332, 697				5. 02
7.00	00700 OPERATION OF PLANT	617, 374	3, 534, 264		3, 798, 995		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	61, 596	352, 615		7, 240	386, 267	8. 00
9.00	00900 HOUSEKEEPI NG	194, 047	1, 110, 855		15, 276	0	9. 00
10. 00	01000 DI ETARY	70, 641	404, 397		41, 968	0	10. 00
11. 00	01100 CAFETERI A	158, 385	906, 701			0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	353, 122	2, 021, 508			0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	137, 380	786, 453			13, 169	14. 00
15. 00	01500 PHARMACY	311, 619	1, 783, 917		23, 844	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	200, 010	1, 144, 991	85, 764	33, 425	0	16. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	1, 093, 456	6, 259, 675		507, 498	85, 602	30. 00
31. 00	03100 INTENSIVE CARE UNIT	346, 284	1, 982, 363		113, 438		31. 00
43.00	04300 NURSERY	50, 228	287, 540	21, 538	10, 860	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	649, 414	3, 717, 680		211, 226	83, 955	50.00
51. 00	05100 RECOVERY ROOM	191, 881	1, 098, 457		9, 955	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	123, 826	708, 863	53, 097	41, 533	39, 508	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	623, 515	3, 569, 419	267, 364	157, 325	42, 072	54. 00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
54. 02	05402 ONCOLOGY	428, 696	2, 454, 144		135, 267	0	54. 02
56. 00	05600 RADI OI SOTOPE	79, 967	457, 787		6, 166	0	56. 00
57. 00	05700 CT SCAN	107, 225	613, 828			0	57. 00
58. 00	05800 MRI	76, 301	436, 797			0	58. 00
60.00	06000 LABORATORY	737, 842	4, 223, 904		73, 546	0	60.00
65.00	06500 RESPI RATORY THERAPY	158, 275	906, 074		36, 477	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	493, 280	2, 823, 866	211, 519	115, 550	25, 914	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	44, 467	254, 561		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 890	27, 992		1, 207	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	48, 687	278, 717	20, 877	603	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95, 178	544, 864	40, 812	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	400, 475	2, 292, 589	171, 724	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 309, 928	7, 498, 773	561, 701	0	0	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76. 00
76. 01	03610 SLEEP LAB	0	0	0	0	0	76. 01
76. 03	03951 WOUND CARE	0	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	140, 479	804, 197			6, 585	90. 00
91. 00	09100 EMERGENCY	510, 637	2, 923, 226	218, 961	161, 693	46, 093	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0)			92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		10, 575, 952	60, 543, 714	4, 210, 444	1, 889, 633	365, 944	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 904	91, 044		7, 421		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	683, 380	3, 912, 126		1, 579, 316		192. 00
	1 19201 WELLNESS CENTER	59, 786	342, 256	25, 636	142, 302	20, 323	
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
	1 07951 MARKETI NG	144, 253	825, 803	61, 856	25, 231		194. 01
	2 07952 SENI OR CI RCLE	0	0	0	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	65, 160	373, 020	27, 941	155, 092	0	194. 03
200.00			0)			200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	11, 544, 435	66, 087, 963	4, 332, 697	3, 798, 995	386, 267	202. 00

Provider CCN: 15-0133

| Peri od: | Worksheet B | From 03/01/2016 | Part | | To 02/28/2017 | Date/Time Prepared:

				1	0 02/28/2017	Date/Time Pre 7/31/2017 3:1	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	·				ADMI NI STRATI ON	SERVICES &	
		0.00	10.00	11 00	12.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00540 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	1, 209, 338					9. 00
10. 00	01000 DI ETARY	14, 044	490, 700				10.00
11. 00	01100 CAFETERIA	11, 799	0	1, 021, 675			11.00
13.00	01300 NURSING ADMINISTRATION	3, 057	0	62, 035	l	040 707	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 116	0	22, 837	0	913, 737	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 979	0 0	30, 684	0	28, 450	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11, 185	U _I	24, 974	<u> </u>	1, 221	16. 00
30. 00	03000 ADULTS & PEDIATRICS	169, 824	262, 358	173, 051	525, 371	48, 029	30.00
31. 00	03100 NTENSI VE CARE UNI T	37, 960	47, 869	57, 327	203, 630	16, 108	1
43. 00	04300 NURSERY	3, 634	0	14, 223	61, 197	0	43. 00
	ANCILLARY SERVICE COST CENTERS		'	·			
50.00	05000 OPERATI NG ROOM	70, 682	7, 637	64, 673	242, 734	185, 155	50. 00
51. 00	05100 RECOVERY ROOM	3, 331	0	32, 854		11, 649	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 898	53, 169	28, 413	122, 223	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	52, 645	0	103, 136	313, 044	15, 390	1
54. 01	05401 ULTRASOUND	45 264	0	20 221	154 750	0 470	54. 01
54. 02 56. 00	05402 ONCOLOGY	45, 264	0	39, 331	154, 752	8, 478 2, 913	54. 02 56. 00
57. 00	05700 CT SCAN	2, 063 10, 204	ol Ol	6, 678 14, 290	0	11, 279	•
58. 00	05800 MRI	13, 535	o	10, 350	0	1, 191	58. 00
60.00	06000 LABORATORY	24, 611	0	109, 146	-	89, 632	•
65. 00	06500 RESPI RATORY THERAPY	12, 206	ő	30, 350		6, 670	65. 00
66. 00	06600 PHYSI CAL THERAPY	38, 666	o	57, 494	0	6, 442	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	3, 472	O	1, 121	67.00
68. 00	06800 SPEECH PATHOLOGY	404	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	202	O	14, 357	34, 855	386	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	62, 373	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	349, 536	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76. 00
76. 01	03610 SLEEP LAB	0	0	0	0	0	76. 01
76. 03	03951 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 03
90. 00	09000 CLINIC	15, 376	ol	35, 492	102, 322	22, 534	90.00
91. 00	09100 EMERGENCY	54, 107	o	74, 088		40, 495	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	01,107	Š.	7 1, 000	200, 707	10, 170	92.00
	SPECIAL PURPOSE COST CENTERS				l l		
118.00		624, 792	371, 033	1, 009, 255	2, 247, 153	909, 052	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3, 105	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	528, 485	0	0	0		192. 00
	19201 WELLNESS CENTER	47, 618	73, 274	0	0		192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0 443	47 202	0 215	0		194. 00
	07951 MARKETI NG	8, 443	46, 393	9, 315	0		194. 01
	207952 SENIOR CIRCLE 307953 OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194. 02 194. 03
200.00		"	٩	Ü		Ü	200. 00
200.00	, ,		n	0		Λ	201.00
202.00		1, 209, 338	490, 700	1, 021, 675	2, 247, 153		
_32.00	1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	., 20,, 000		., 52., 570	_, _, _, .00	,,	,

Heal th	Financial Systems	KOSCIUSKO COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 03/01/2016 To 02/28/2017		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15. 00	16. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 008, 497 0	1, 301, 560				1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	114, 891	8, 615, 17			1
31. 00	03100 I NTENSI VE CARE UNIT	0	9, 636				1
43. 00	04300 NURSERY	0	3, 161	402, 15	3 0	402, 153	43. 00
	ANCI LLARY SERVI CE COST CENTERS				.1		l
50.00	05000 OPERATI NG ROOM	0	154, 253				
51. 00	05100 RECOVERY ROOM	0	13, 570	1, 376, 28		1, 376, 289	1
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	7, 362	1, 068, 06	6 0 0 0	1, 068, 066 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		41, 345	4, 561, 74		4, 561, 740	1
54. 01	05401 ULTRASOUND		41, 545	4, 301, 74	0 0	4, 301, 740	1
54. 02	05402 ONCOLOGY		32, 860	3, 053, 92		3, 053, 921	1
56. 00	05600 RADI OI SOTOPE		18, 178			528, 075	1
57. 00	05700 CT SCAN	l ol	115, 478	841, 54		841, 549	1
58. 00	05800 MRI	o	32, 295	567, 33		567, 333	1
60.00	06000 LABORATORY	0	141, 929	4, 979, 15		4, 979, 155	
65.00	06500 RESPI RATORY THERAPY	o	32, 437	1, 185, 92	5 0	1, 185, 925	65. 00
66.00	06600 PHYSI CAL THERAPY	o	18, 647	3, 298, 09	8 0	3, 298, 098	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 743	280, 96	5 0	280, 965	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	390	32, 09		32, 090	
69. 00	06900 ELECTROCARDI OLOGY	0	17, 873			367, 870	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	39, 447	687, 49		687, 496	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2 000 407	40, 300	2, 854, 14		2, 854, 149	•
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST	2, 008, 497	376, 149	10, 445, 12	0 0	10, 445, 120 0	1
	03610 SLEEP LAB	0	0		0 0		1
	03951 WOUND CARE		0		0 0		
70.03	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		0 0		70.03
90.00	09000 CLI NI C	0	12, 675	1, 105, 36	9 0	1, 105, 369	90.00
91.00	09100 EMERGENCY	O	75, 941	3, 863, 59			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	,	2, 008, 497	1, 301, 560	57, 770, 45	8 0	57, 770, 458	118. 00
	NONREI MBURSABLE COST CENTERS	1 _1					4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	111, 11		· ·	
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 WELLNESS CENTER	0	0	6, 019, 92		6, 019, 927 651, 409	1
	07950 OTHER NONREIMBURSABLE COST CENTERS		0	651, 40	0 0		194. 00
	07951 MARKETI NG		0	979, 00		979, 004	
	07952 SENI OR CI RCLE		n	,,,,,	ol ol	· ·	194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS		Ö	556, 05	3 0	556, 053	194. 03
200.00					o o	0	200. 00
201.00	Negative Cost Centers	0	0		0 0	0	201. 00
202.00	TOTAL (sum lines 118-201)	2, 008, 497	1, 301, 560	66, 087, 96	3 0	66, 087, 963	202. 00

| Peri od: | Worksheet B | From 03/01/2016 | Part II | To 02/28/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0133

				То	02/28/2017	Date/Time Pre 7/31/2017 3:1	
			CAPI TAL REI	LATED COSTS		773172017 3. 1	4 piii
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
GEN	ERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
	00 CAP REL COSTS-BLDG & FIXT						1. 00
	OO CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 004	OO EMPLOYEE BENEFITS DEPARTMENT	0	12, 563	10, 599	23, 162	23, 162	4. 00
	040 OTHER ADMINISTRATIVE AND GENERAL	0	234, 786	198, 081	432, 867	2, 058	5. 01
	660 OTHER ADMINISTRATIVE AND GENERAL	0	379, 125		698, 979	1, 471	5. 02
	OO OPERATION OF PLANT	0	374, 461		690, 380	531	7. 00
	300 LAUNDRY & LINEN SERVICE	0	7, 795		14, 371	0	8. 00
	HOUSEKEEPI NG	0	16, 448		30, 324	532	9.00
	00 DI ETARY 00 CAFETERI A	0	45, 185 37, 962		83, 306 69, 989	125 467	10. 00 11. 00
	OO NURSING ADMINISTRATION	0	9, 835		18, 132	1, 350	13. 00
	OO CENTRAL SERVICES & SUPPLY	0	26, 113		48, 144	239	14. 00
	OO PHARMACY	0	25, 672		47, 330	878	15. 00
16. 00 016	MEDICAL RECORDS & LIBRARY	0	35, 987		66, 348	265	16. 00
I NP	ATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	0	0.07.00		1, 007, 390	3, 276	30. 00
	OO INTENSIVE CARE UNIT	0			225, 176	1, 102	31. 00
	NURSERY	0	11, 693	9, 865	21, 558	167	43. 00
	ILLARY SERVICE COST CENTERS OOO OPERATING ROOM	0	227, 420	191, 866	419, 286	1, 313	50.00
	OO RECOVERY ROOM	0	10, 718		19, 761	672	51.00
	OO DELIVERY ROOM & LABOR ROOM	0	44, 718		82, 445	390	52.00
	OO ANESTHESI OLOGY	Ö	0		0	0	53. 00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	0	169, 386	142, 905	312, 291	1, 693	54.00
54. 01 054	01 ULTRASOUND	0	0	0	0	0	54. 01
	02 ONCOLOGY	0	145, 637		268, 506	837	54. 02
	000 RADI OI SOTOPE	0	6, 639		12, 240	157	56. 00
	OO CT SCAN	0	32, 830		60, 528	258	ı
	800 MRI 800 LABORATORY	0	43, 548		80, 288 145, 990	213	58. 00 60. 00
	00 RESPIRATORY THERAPY	0	79, 185 39, 274		72, 408	1, 504 508	65. 00
	000 PHYSI CAL THERAPY	0	124, 409		229, 368	740	66.00
	OO OCCUPATIONAL THERAPY	0	0		0	29	67. 00
	300 SPEECH PATHOLOGY	0	1, 299		2, 395	0	68. 00
69. 00 069	OOO ELECTROCARDI OLOGY	0	650	548	1, 198	189	69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	OO IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	050 OTHER ANCILLARY SERVICE COST 010 SLEEP LAB	0	0	0	0	0	76. 00 76. 01
	151 WOUND CARE	0		- 1	0	0	76. 01
	PATIENT SERVICE COST CENTERS			9	<u> </u>	0	70.03
	000 CLINIC	0	49, 472	41, 738	91, 210	554	90. 00
	OO EMERGENCY	0			320, 962		91. 00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	CLAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	3, 035, 440	2, 560, 892	5, 596, 332	22, 973	118. 00
	REI MBURSABLE COST CENTERS		7 000		44.704	2.4	1400 00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0	7, 990 1, 700, 395		14, 731 3, 134, 961		190. 00 192. 00
	201 WELLNESS CENTER		1, 700, 395		3, 134, 961 282, 470		192. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	155, 211		282, 470		194. 00
	951 MARKETI NG	0	27, 166		50, 085		194. 01
194. 02 079	52 SENIOR CIRCLE	0	0	0	0		194. 02
	053 OTHER NONREIMBURSABLE COST CENTERS	0	166, 983	140, 877	307, 860		194. 03
200.00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers		0	_	0		201. 00
202. 00	TOTAL (sum lines 118-201)	0	5, 091, 185	4, 295, 254	9, 386, 439	23, 162	J202. 00

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0133 Peri od: Worksheet B From 03/01/2016 Part II 02/28/2017 Date/Time Prepared: 7/31/2017 3:14 pm Cost Center Description OTHER OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE ADMI NI STRATI VE LINEN SERVICE **PLANT** AND GENERAL AND GENERAL 7.00 8. 00 9. 00 5.01 5.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 OTHER ADMINISTRATIVE AND GENERAL 434, 925 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 28, 514 728, 964 5.02 5.02 7.00 00700 OPERATION OF PLANT 23, 259 44, 539 758, 709 7.00 00800 LAUNDRY & LINEN SERVICE 22, 582 8.00 2.321 4.444 1.446 8 00 9.00 00900 HOUSEKEEPI NG 7, 311 13, 999 3,051 55, 217 9.00 10.00 01000 DI ETARY 2,661 5, 096 8, 382 0 641 10.00 01100 CAFETERI A 5.967 11, 426 7.042 539 11.00 11.00 0 01300 NURSING ADMINISTRATION 13, 304 13.00 25, 475 1,824 0 140 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 176 9, 911 4,844 371 14.00 15.00 01500 PHARMACY 11, 740 22, 481 4, 762 364 15.00 01600 MEDICAL RECORDS & LIBRARY 7,535 16.00 14, 429 6,675 511 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 41, 195 101, 354 5,004 30.00 78, 884 7, 754 31.00 03100 INTENSIVE CARE UNIT 13,046 24, 982 22, 655 1,733 31.00 1.347 04300 NURSERY 1,892 43.00 3, 624 2, 169 166 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 46, 850 3, 227 50.00 24, 466 42, 185 4, 908 50.00 05100 RECOVERY ROOM 7, 229 51.00 13, 843 1. 988 152 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 4,665 8, 933 8, 295 2, 310 635 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 23, 491 44, 982 31, 420 2, 460 2, 404 54.00 54 01 05401 ULTRASOUND Ω 54 01 0 54.02 05402 ONCOLOGY 16, 151 30, 927 27,015 0 2,067 54.02 56.00 05600 RADI OI SOTOPE 3,013 5, 769 1, 231 0 94 56.00 57.00 05700 CT SCAN 4,040 7, 735 6,090 0 466 57.00 05800 MRI 0 58.00 2,875 5, 505 8,078 618 58.00 60.00 06000 LABORATORY 27, 798 53, 230 14,688 0 1, 124 60.00 06500 RESPIRATORY THERAPY 65.00 5, 963 11, 418 7, 285 0 557 65.00 66 00 06600 PHYSI CAL THERAPY 18 584 35 586 23.077 1, 515 1, 765 66 00 06700 OCCUPATIONAL THERAPY 67.00 1,675 3, 208 0 0 0 67.00 06800 SPEECH PATHOLOGY 184 353 241 0 18 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69.00 1,834 3, 512 120 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 586 6, 866 Ω 71 00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15,088 28, 891 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 49.345 94, 526 0 76.00 03950 OTHER ANCILLARY SERVICE COST 0 Λ 0 0 0 76.00 03610 SLEEP LAB 0 0 76.01 0 Ω 0 76.01 03951 WOUND CARE 0 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 292 9, 177 702 90.00 10. 134 385 91.00 09100 EMERGENCY 19, 238 36,838 32, 292 2.695 2, 470 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 398, 438 708, 396 377, 386 21, 394 28, 527 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 482 0 190. 00 599 1, 147 192.00 19200 PHYSICIANS' PRIVATE OFFICES 25, 746 315, 408 0 24, 130 192. 00 2, 174 192. 01 192. 01 19201 WELLNESS CENTER 2, 252 4, 313 28, 420 1, 188 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00

5, 435

2.455

434.925

10, 407

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728, 964

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386 194. 01

0 194. 02

0 194. 03

0 201.00

55, 217 202. 00

200.00

194. 01 07951 MARKETI NG

200.00

201.00

202.00

194. 02 07952 SENI OR CIRCLE

194.03 07953 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0133

| Peri od: | Worksheet B | From 03/01/2016 | Part II | Date/Time Prepared: | 7/31/2017 3:14 pm

					02/20/2017	7/31/2017 3: 1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	μ			ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		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						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY	100, 211					10.00
11. 00	01100 CAFETERI A	100, 211	95. 430				11. 00
13. 00	01300 NURSING ADMINISTRATION		5, 794				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				71 500		14. 00
			2, 133	1	71, 588	02 (50	1
15. 00	01500 PHARMACY	1	2, 866		2, 229	92, 650	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 333	0	96	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F2 F70	1/ 1/2	1 1 10/	2.7/2	0	20.00
30.00	03000 ADULTS & PEDI ATRI CS	53, 579	16, 163	1	3, 763	0	
31. 00	03100 INTENSIVE CARE UNIT	9, 776	5, 355		1, 262	0	
43. 00	04300 NURSERY	0	1, 329	1, 798	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS			1			4
50. 00	05000 OPERATING ROOM	1, 560	6, 041		14, 507	0	
51. 00	05100 RECOVERY ROOM	0	3, 069		913	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	10, 858	2, 654	3, 591	0	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 633	9, 197	1, 206	0	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
54. 02	05402 ONCOLOGY	0	3, 674	4, 546	664	0	54. 02
56.00	05600 RADI OI SOTOPE	0	624	0	228	0	56. 00
57.00	05700 CT SCAN	0	1, 335	0	884	0	57.00
58.00	05800 MRI	O	967	0	93	0	58. 00
60.00	06000 LABORATORY	o	10, 195	o	7, 023	0	60.00
65.00	06500 RESPIRATORY THERAPY	o	2, 835	2, 757	523	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	O	5, 370	1	505	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	l ol	324	1	88	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	o	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 341	1, 024	30	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	4, 887	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0		27, 382	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0	92, 650	1
76. 00	03950 OTHER ANCILLARY SERVICE COST		0		o o	72, 000	1
76. 01	03610 SLEEP LAB		0		o	0	1
76. 03	03951 WOUND CARE		0		0	0	1
70.03	OUTPATIENT SERVICE COST CENTERS	٩		<u>'</u>	9		70.03
90. 00	09000 CLINIC	O	3, 315	3, 006	1, 765	0	90.00
91. 00	09100 EMERGENCY		6, 920		3, 173	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0, 920	7, 702	3, 173	U	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
110 00		75 773	04.270	// 010	71 221	02.450	110 00
118. 00		75, 773	94, 270	66, 019	71, 221	92, 650	118. 00
100.00	NONREI MBURSABLE COST CENTERS		200	J ol	24.2		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	290	1	213		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	14.0(4	0		0		192. 00
	19201 WELLNESS CENTER	14, 964	0		O O		192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
	07951 MARKETI NG	9, 474	870	0	154		194. 01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200.00	,						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	100, 211	95, 430	66, 019	71, 588	92, 650	202. 00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0133 P	eri od:	Worksheet B
			F	rom 03/01/2016 0 02/28/2017	Part II
			1	02/28/201/	Date/Time Prepared: 7/31/2017 3:14 pm
Cost Center Description	MEDI CAL	Subtotal	Intern &	Total	773172017 3. 11 pin
·	RECORDS &		Residents Cost		
	LI BRARY		& Post		
			Stepdown		
	1/ 00	04.00	Adjustments	07.00	
CENEDAL CEDVICE COCT CENTEDS	16. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FIXT		1			1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01 00540 OTHER ADMINISTRATIVE AND GENERAL					5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL					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 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	98, 192				16.00
I NPATIENT ROUTINE SERVICE COST CENTERS	70, 172				10.00
30. 00 03000 ADULTS & PEDIATRICS	8, 653	1, 342, 451	0	1, 342, 451	30.00
31.00 03100 INTENSIVE CARE UNIT	726	313, 142	Ö		l
43. 00 04300 NURSERY	238	32, 941	0	32, 941	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	11, 618	583, 092	0	583, 092	
51. 00 05100 RECOVERY ROOM	1, 022	52, 298	0	52, 298	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	555	125, 331	0	125, 331	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	441 001	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	3, 114	441, 891	0	441, 891	54. 00 54. 01
54. 01 05401 0E1RASOUND 54. 02 05402 0NCOLOGY	2, 475	356, 862	0	356, 862	
56. 00 05600 RADI OI SOTOPE	1, 369	24, 725	Ö	24, 725	56. 00
57. 00 05700 CT SCAN	8, 698	90, 034	Ö	90, 034	
58. 00 05800 MRI	2, 432	101, 069	Ö	101, 069	
60. 00 06000 LABORATORY	10, 690	272, 242	0	272, 242	
65. 00 06500 RESPI RATORY THERAPY	2, 443	106, 697	0	106, 697	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 404	317, 914	0	317, 914	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	207	5, 531	0	5, 531	67. 00
68. 00 06800 SPEECH PATHOLOGY	29	3, 220	0	3, 220	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 346	10, 603	0	10, 603	69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	2, 971	18, 310	0	18, 310	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	3, 035 28, 492	74, 396 265, 013		74, 396 265, 013	72. 00 73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST	20, 472	203, 013	Ö	203, 013	76.00
76. 01 03610 SLEEP LAB		o	o o	0	
76. 03 03951 WOUND CARE	o	Ö	Ō	O	76. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	955	126, 495	0	126, 495	90.00
91. 00 09100 EMERGENCY	5, 720	439, 665	0	439, 665	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92. 00
SPECIAL PURPOSE COST CENTERS	00.400	5 400 000	_	5 400 000	110.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	98, 192	5, 103, 922	0	5, 103, 922	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		18, 498	0	18, 498	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	3, 500, 245		3, 500, 245	
192. 01 19201 WELLNESS CENTER		335, 781	0	335, 781	192. 01
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	194. 00
194. 01 07951 MARKETI NG		82, 003		82, 003	194. 01
194. 02 07952 SENI OR CIRCLE		o	0	0	194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	345, 990	0	345, 990	194. 03
200.00 Cross Foot Adjustments		o	0	o	200. 00
201.00 Negative Cost Centers	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	98, 192	9, 386, 439	0	9, 386, 439	202. 00

			KOSCI USKO COMMU				u of Form CMS-	
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 03/01/2016	Worksheet B-1	
						o 02/28/2017	Date/Time Pre	pared.
						0 02, 20, 201,	7/31/2017 3:1	4 pm
			CAPI TAL REI	LATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	OTHER	
			(SQUARE FEET)	(SQUARE FEET)	BENEFITS		ADMI NI STRATI VE	
					DEPARTMENT		AND GENERAL	
					(GROSS		(ACCUM. COST)	
			1.00		SALARI ES)	54.04		
	OFNED	AL CERVILOE COCT CENTERS	1.00	2.00	4. 00	5A. 01	5. 01	
1 00		AL SERVICE COST CENTERS	201 070		ı			1 00
1.00		CAP REL COSTS BLDG & FIXT	391, 879					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP	0/7	391, 879	1			2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	967 18. 072				E4 E40 E00	4. 00
5. 01	1	OTHER ADMINISTRATIVE AND GENERAL					54, 543, 528	
5. 02		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	29, 182	1			3, 575, 850	1
7. 00 8. 00		LAUNDRY & LINEN SERVICE	28, 823 600	1			2, 916, 890 291, 019	1
9.00		HOUSEKEEPING	1, 266	l .			916, 808	1
10. 00		DIETARY	3, 478	1		1	333, 756	1
11. 00	1	CAFETERI A	2, 922	1			748, 316	1
13. 00		NURSI NG ADMI NI STRATI ON	757	l ·			1, 668, 386	1
14. 00		CENTRAL SERVICES & SUPPLY	2, 010	l .			649, 073	1
15. 00		PHARMACY	1, 976	l .			1, 472, 298	
	1	MEDICAL RECORDS & LIBRARY	2,770				944, 981	1
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	2,770	2,770	250, 054	٠	744, 701	10.00
30. 00		ADULTS & PEDIATRICS	42, 058	42, 058	3, 103, 315	5 0	5, 166, 219	30.00
31. 00		INTENSIVE CARE UNIT	9, 401		1, 043, 121		1, 636, 079	•
43. 00	1	NURSERY	900				237, 312	
10.00		LARY SERVICE COST CENTERS	700	700	100, 101	<u> </u>	207,012	10.00
50. 00		OPERATING ROOM	17, 505	17, 505	1, 243, 438	8 0	3, 068, 266	50.00
51. 00	1	RECOVERY ROOM	825				906, 576	1
52. 00		DELIVERY ROOM & LABOR ROOM	3, 442	l .	369, 131		585, 037	•
53. 00		ANESTHESI OLOGY	0	0	(o	0	1
54.00		RADI OLOGY-DI AGNOSTI C	13, 038	13, 038	1, 603, 608		2, 945, 904	
54. 01	1	ULTRASOUND	0	0	(o	0	1
54. 02	1	ONCOLOGY	11, 210	11, 210	792, 740		2, 025, 448	1
56.00	1	RADI OI SOTOPE	511		148, 786		377, 820	1
57.00	1	CT SCAN	2, 527				506, 603	
58. 00	05800		3, 352				360, 496	
60.00	1	LABORATORY	6, 095				3, 486, 062	1
65.00	06500	RESPI RATORY THERAPY	3, 023	1			747, 799	1
66.00		PHYSI CAL THERAPY	9, 576				2, 330, 586	1
67.00	06700	OCCUPATI ONAL THERAPY	0	0	27, 459	o	210, 094	67. 00
68.00	06800	SPEECH PATHOLOGY	100	100		o	23, 102	68. 00
69.00	06900	ELECTROCARDI OLOGY	50	50	178, 548	o o	230, 030	69.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			449, 686	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		o	1, 892, 114	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	C	0	6, 188, 845	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	(o	0	76.00
76. 01	03610	SLEEP LAB	0	0	(o	0	76. 01
76. 03	03951	WOUND CARE	0	0	(o	0	76. 03
		TIENT SERVICE COST CENTERS						
90.00	09000	CLI NI C	3, 808	3, 808	524, 158	0	663, 718	90.00
		EMERGENCY	13, 400	13, 400	1, 377, 935	0	2, 412, 589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECI.	AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	233, 644	233, 644	21, 755, 042	-11, 544, 435	49, 967, 762	118. 00
		MBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	33, 971	0	75, 140	190. 00
		PHYSICIANS' PRIVATE OFFICES	130, 883	130, 883	C	0	3, 228, 746	192. 00
		WELLNESS CENTER	11, 793	11, 793	(0	282, 470	192. 01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 00
		MARKETI NG	2, 091	2, 091	144, 966	0	681, 550	194. 01
		SENI OR CIRCLE	0	0	(0		194. 02
		OTHER NONREIMBURSABLE COST CENTERS	12, 853	12, 853	(0	307, 860	194. 03
200.00		Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers						201. 00
202.00	1	Cost to be allocated (per Wkst. B,	5, 091, 185	4, 295, 254	4, 019, 803	3	11, 544, 435	202.00
000 -		Part I)	40.5=:=:	40.5:-:		,		000
203.00	1	Unit cost multiplier (Wkst. B, Part I)	12. 991727	10. 960664			0. 211655	•
204.00	'	Cost to be allocated (per Wkst. B,			23, 162	<u>'</u>	434, 925	204. 00
205 62		Part II)			0.00405		0 00707:	205 20
205. 00	'	Unit cost multiplier (Wkst. B, Part			0. 00105 <i>6</i>		0. 007974	205.00
		[11]	l	I	I			I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS KOSCI USKO COMMUNI TY HOSPI TAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0133 | Peri od: | From 03/01/2016 | To 02/28/2017 | Date/Ti me Prepared:

				T	0 02/28/2017	Date/Time Pre 7/31/2017 3:1	
	Cost Center Description	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	4 piii
	·		ADMI NI STRATI VE		LINEN SERVICE	(SQUARE FEET)	
			AND GENERAL	(SQUARE FEET)	(POUNDS OF		
		5A. 02	(ACCUM. COST) 5.02	7.00	LAUNDRY) 8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0/11/02	0.02	7.00	0.00	7, 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL			•			4. 00 5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	-4, 332, 697	57, 843, 140				5. 02
7. 00	00700 OPERATION OF PLANT	0	3, 534, 264				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	352, 615	600	486, 456		8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 110, 855	1		299, 501	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	404, 397 906, 701	1	0	3, 478 2, 922	1
13. 00	01300 NURSING ADMINISTRATION		2, 021, 508	1	0	757	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	786, 453	1	16, 585	l .	1
15.00	01500 PHARMACY	0	1, 783, 917		0	1, 976	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 144, 991	2, 770	0	2, 770	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T 0	/ 2FD /7F	12.050	107 005	42.050	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				107, 805 29, 024		1
43. 00	04300 NURSERY	0		1		l	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	_, ,			17, 505	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELI VERY ROOM & LABOR ROOM	0	1, 098, 457 708, 863	1	0 49, 756		1
53. 00	05300 ANESTHESI OLOGY		700, 803	3, 442	49, 750	3, 442	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	3, 569, 419	13, 038	52, 984	13, 038	
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
54. 02	05402 ONCOLOGY	0	2, 454, 144			11, 210	1
56. 00 57. 00	05600	0	457, 787 613, 828	1	0	511 2, 527	1
58. 00	05800 MRI		436, 797	l	0		1
60.00	06000 LABORATORY	0	4, 223, 904	l	_	-,	1
65.00	06500 RESPI RATORY THERAPY	0	906, 074	3, 023	0	3, 023	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 823, 866	1	32, 635	l	1
67. 00	06700 OCCUPATIONAL THERAPY	0	254, 561	1			
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		27, 992 278, 717	1		100 50	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	544, 864	1		l	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 292, 589	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	7, 498, 773	1	0	0	
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST 03610 SLEEP LAB	0	0	_	0	0	
76. 01	03951 WOUND CARE						1
70.00	OUTPATIENT SERVICE COST CENTERS						70.00
90.00	09000 CLI NI C	0		1	,		
91.00	09100 EMERGENCY	0	2, 923, 226	13, 400	58, 049	13, 400	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
118.00		-4, 332, 697	56, 211, 017	156, 600	460, 862	154, 734	118. 00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	91, 044	1		l	190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 WELLNESS CENTER	-3, 912, 126	342, 256	130, 883 11, 793		130, 883	192. 00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS		342, 230	11, 773	23, 374		194. 00
194.01	07951 MARKETI NG	0	825, 803	2, 091	0	l	194. 01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	373, 020	12, 853	0	0	194. 03
200. 00 201. 00	, ,						200. 00 201. 00
202.00	1 1 0		4, 332, 697	3, 798, 995	386, 267	1, 209, 338	1
	Part I)						
203.00			0. 074904	1		l .	1
204.00	Cost to be allocated (per Wkst. B, Part II)		728, 964	758, 709	22, 582	55, 217	204. 00
205.00	1 1 1		0. 012602	2. 409862	0. 046421	0. 184363	205. 00

Heal th	Financial Systems	KOSCI USKO COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	NLLOCATION - STATISTICAL BASIS		Provi der Co	F	eriod: rom 03/01/2016 o 02/28/2017	Worksheet B-1 Date/Time Pre 7/31/2017 3:1	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON (NURSI NG SA LARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	T pill
	I	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	87, 768	30, 600				1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o	1, 858				13. 00
14. 00 15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	684 919 748	0	5, 136, 666 159, 932	6, 188, 845 0	1
	INPATIENT ROUTINE SERVICE COST CENTERS				·		
30. 00	03000 ADULTS & PEDIATRICS	46, 926	5, 183			0	
31. 00 43. 00	03100 NTENSI VE CARE UNIT 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 562	1, 717 426			0	
50.00	05000 OPERATI NG ROOM	1, 366	1, 937	1, 243, 438	1, 040, 869	0	50.00
51. 00	05100 RECOVERY ROOM	0	984			0	
52.00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	9, 510	851	626, 104	0	0	
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C		3, 089	1, 603, 608	86, 518	0	
54. 01	05401 ULTRASOUND		3,007	1, 003, 000	00, 310	0	54. 01
54. 02	05402 ONCOLOGY	o	1, 178	792, 740	47, 661	0	1
56.00	05600 RADI OI SOTOPE	0	200		16, 375	0	56. 00
57. 00	05700 CT SCAN	0	428		63, 408	0	
58. 00	05800 MRI	0	310	1	6, 698	0	
60.00	06000 LABORATORY	0	3, 269		503, 877	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	909			0	
67.00	06700 OCCUPATIONAL THERAPY		1, 722 104		36, 216 6, 300	0	
68. 00	06800 SPEECH PATHOLOGY		0		0, 300	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	430	178, 548	2, 170	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	350, 635	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 964, 941	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	6, 188, 845	
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST 03610 SLEEP LAB		0		0	0	
	03951 WOUND CARE		0		0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,1	<u> </u>		70.00
90.00	09000 CLI NI C	0	1, 063	524, 158	126, 675	0	90. 00
91. 00		0	2, 219	1, 377, 935	227, 649	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	66, 364	30, 228	11, 511, 374	5, 110, 326	6, 188, 845	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	93	0	15, 303	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1		0	192. 00
	19201 WELLNESS CENTER	13, 106	0	1		0	192. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	-		194. 00
	07951 MARKETI NG 07952 SENI OR CI RCLE	8, 298	279		11, 037		194. 01 194. 02
	07952 SENTOR CTRCLE		0		0		194. 02
200.00			· ·				200. 00
201.00	Negative Cost Centers						201. 00
202.00		490, 700	1, 021, 675	2, 247, 153	913, 737	2, 008, 497	202. 00
202 65	Part I)	F F0007:	22 2222	0 405010	0 477005	0.004505	202 22
203. 00 204. 00		5. 590876 100, 211	33. 388072 95, 430	1		0. 324535	203. 00
204. UL	Part II)	100, 211	70, 430	, 30,019	71,008	72,000	204.00
205.00	Unit cost multiplier (Wkst. B, Part	1. 141771	3. 118627	0. 005735	0. 013937	0. 014970	205. 00
	11)	ı I		I	ı		I

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0133 Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0133 From 03/01/2016 02/28/2017 Date/Time Prepared: 7/31/2017 3:14 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES) 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 OTHER ADMINISTRATIVE AND GENERAL 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 502, 776, 811 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 44, 376, 402 30. 00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 721, 898 31.00 43.00 04300 NURSERY 1, 220, 749 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50 00 59 580 121 50 00 05100 RECOVERY ROOM 51.00 5, 241, 580 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 843, 710 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 969, 502 54 00 54.01 05401 ULTRASOUND 54.01 05402 ONCOLOGY 12, 691, 991 54.02 54.02 56.00 05600 RADI OI SOTOPE 7, 021, 252 56, 00 57.00 05700 CT SCAN 44, 603, 413 57.00 58.00 05800 MRI 12, 474, 059 58.00 06000 LABORATORY 54, 819, 884 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 12, 528, 768 65.00 06600 PHYSI CAL THERAPY 7, 202, 524 66.00 66 00 06700 OCCUPATIONAL THERAPY 1,059,409 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 150, 740 68.00 06900 ELECTROCARDI OLOGY 6, 903, 251 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 15, 236, 402 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 565, 732 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 145, 337, 457 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST 76.00 0 76. 01 03610 SLEEP LAB 0 76.01 03951 WOUND CARE 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 895, 688 90.00 91.00 09100 EMERGENCY 29, 332, 279 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 502, 776, 811 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 192. 01 19201 WELLNESS CENTER 0 192. 01 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.00 194. 01 07951 MARKETI NG 194. 01 194. 02 07952 SENI OR CIRCLE 0 194.02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 194. 03 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 301, 560 202.00 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 0.002589 203 00 204.00 204. 00 Cost to be allocated (per Wkst. B, 98, 192 Part II) 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000195 II)

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0133	Peri od:	Worksheet C	
		From 03/01/2016 I		
		To 02/20/2017	Data /Tima Dranarad.	

					o 02/28/2017	Date/Time Pre 7/31/2017 3:1	
			Title	XVIII	Hospi tal	PPS	
					Costs		
Cost Center Desc	cription	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)		0.00		5.00	
LAIDATI ENT. DOUTLAG CED	U OF OOCT OFNITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERV		0 (15 174		0 /15 174		0 (15 174	1 20 00
30.00 03000 ADULTS & PEDIATE 31.00 03100 INTENSIVE CARE U		8, 615, 174		8, 615, 174		8, 615, 174	1
	JNI I	2, 639, 864		2, 639, 864		2, 639, 864	1
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST	T CENTEDS	402, 153		402, 153	i U	402, 153	43. 00
50. 00 05000 OPERATING ROOM	I CENTERS	5, 016, 464		5, 016, 464	0	5, 016, 464	50.00
51. 00 05100 RECOVERY ROOM		1, 376, 289		1, 376, 289		1, 376, 289	1
52. 00 05200 DELI VERY ROOM &	LAROR ROOM	1, 068, 066		1, 068, 066		1, 068, 066	1
53. 00 05200 DELIVERY ROOM &	LABOR ROOM	1,000,000		1,000,000	0	1, 008, 000	53.00
54. 00 05400 RADI OLOGY - DI AGNO	NSTI C	4, 561, 740		4, 561, 740		4, 561, 740	
54. 01 05401 ULTRASOUND	5116	4, 301, 740		4, 301, 740		4, 301, 740	54. 01
54. 02 05402 0NCOLOGY		3, 053, 921		3, 053, 921	0	3, 053, 921	54. 02
56. 00 05600 RADI OI SOTOPE		528, 075		528, 075	0	528, 075	56.00
57. 00 05700 CT SCAN		841, 549		841, 549		841, 549	1
58. 00 05800 MRI		567, 333		567, 333		567, 333	
60. 00 06000 LABORATORY		4, 979, 155		4, 979, 155		4, 979, 155	1
65. 00 06500 RESPIRATORY THEF	RAPY	1, 185, 925	0			1, 185, 925	1
66. 00 06600 PHYSI CAL THERAPY	<i>(</i>	3, 298, 098		3, 298, 098		3, 298, 098	
67. 00 06700 OCCUPATI ONAL THE	RAPY	280, 965		280, 965		280, 965	67. 00
68. 00 06800 SPEECH PATHOLOGY	(32, 090	0	32, 090	0	32, 090	68. 00
69. 00 06900 ELECTROCARDI OLOG	SY	367, 870		367, 870	0	367, 870	69. 00
71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	687, 496		687, 496	0	687, 496	71. 00
72.00 07200 I MPL. DEV. CHARG	GED TO PATIENTS	2, 854, 149		2, 854, 149	0	2, 854, 149	72. 00
73.00 07300 DRUGS CHARGED TO		10, 445, 120		10, 445, 120	0	10, 445, 120	73. 00
76. 00 03950 OTHER ANCILLARY	SERVICE COST	0		C	0	0	76. 00
76. 01 03610 SLEEP LAB		0		C	0	0	76. 01
76. 03 03951 WOUND CARE		0		C	0	0	76. 03
OUTPATIENT SERVICE COS	ST CENTERS	,					
90. 00 09000 CLI NI C		1, 105, 369		1, 105, 369		1, 105, 369	
91. 00 09100 EMERGENCY		3, 863, 593		3, 863, 593		3, 863, 593	1
92. 00 09200 OBSERVATION BEDS		1, 698, 860		1, 698, 860		1, 698, 860	
200.00 Subtotal (see in		59, 469, 318		,,		59, 469, 318	1
201.00 Less Observation		1, 698, 860		1, 698, 860		1, 698, 860	
202.00 Total (see instr	ructions)	57, 770, 458	0	57, 770, 458	0	57, 770, 458	J202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Peri od: Worksheet C	_	
		From 03/01/2016 Part I		

					o 02/28/2017	Date/Time Prep 7/31/2017 3:1/	
			Title	XVIII	Hospi tal	PPS	трііі
			Charges	7	1.00p. tu.		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	37, 791, 618		37, 791, 618			30.00
	03100 I NTENSI VE CARE UNI T	3, 721, 898		3, 721, 898			31. 00
43.00	04300 NURSERY	1, 220, 749		1, 220, 749			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	20, 135, 498	39, 444, 623			0.000000	
	05100 RECOVERY ROOM	1, 747, 323	3, 494, 257	5, 241, 580		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 571, 121	272, 589	2, 843, 710		0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0.00000	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 752, 730	14, 216, 772	15, 969, 502	0. 285653	0.000000	54.00
54. 01	05401 ULTRASOUND	0	0	C	0.000000	0.000000	54. 01
54.02	05402 ONCOLOGY	59, 637	12, 632, 354	12, 691, 991	0. 240618	0.000000	54.02
56.00	05600 RADI OI SOTOPE	610, 777	6, 410, 475	7, 021, 252	0. 075211	0.000000	56.00
57.00	05700 CT SCAN	7, 589, 766	37, 013, 647	44, 603, 413	0. 018867	0.000000	57.00
58.00	05800 MRI	1, 053, 062	11, 420, 997	12, 474, 059	0. 045481	0.000000	58. 00
60.00	06000 LABORATORY	14, 838, 289	39, 981, 595	54, 819, 884	0. 090828	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	8, 652, 718	3, 876, 050	12, 528, 768	0. 094656	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	1, 202, 304	6, 000, 220	7, 202, 524	0. 457909	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	102, 212	957, 197	1, 059, 409	0. 265209	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	75, 390	75, 350	150, 740	0. 212883	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 827, 437	5, 075, 814	6, 903, 251	0. 053289	0. 000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 509, 808	8, 726, 594	15, 236, 402	0. 045122	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 094, 724	5, 471, 008	15, 565, 732	0. 183361	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	48, 247, 025	97, 090, 432	145, 337, 457	0. 071868	0.000000	73.00
	03950 OTHER ANCILLARY SERVICE COST	0	0		0.000000	0.000000	76. 00
76. 01	03610 SLEEP LAB	0	0		0.000000	0. 000000	76. 01
76. 03	03951 WOUND CARE	0	0		0. 000000	0. 000000	76. 03
	OUTPATIENT SERVICE COST CENTERS	' '			•		
90.00	09000 CLI NI C	583, 917	4, 311, 771	4, 895, 688	0. 225784	0.000000	90. 00
91.00	09100 EMERGENCY	6, 132, 000	23, 200, 279		0. 131718	0. 000000	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 771, 674	4, 813, 110			0. 000000	
200.00		178, 291, 677	324, 485, 134				200. 00
201. 00			.,,				201. 00
202. 00	1 1	178, 291, 677	324, 485, 134	502, 776, 811			202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm	

				7/31/2017 3: 14	pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	30. 00
31.00 03100 INTENSIVE CARE UNIT				3	31. 00
43. 00 04300 NURSERY				4	43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 084197			5	50. 00
51.00 05100 RECOVERY ROOM	0. 262571			5	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 375589			5	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			5	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 285653			5	54. 00
54. 01 05401 ULTRASOUND	0. 000000			5	54. 01
54. 02 05402 ONCOLOGY	0. 240618			5	54. 02
56. 00 05600 RADI 0I SOTOPE	0. 075211			5	56. 00
57. 00 05700 CT SCAN	0. 018867			5	57. 00
58. 00 05800 MRI	0. 045481			5	58. 00
60. 00 06000 LABORATORY	0. 090828			1 6	60. 00
65. 00 06500 RESPIRATORY THERAPY	0. 094656				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 457909				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 265209				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 212883				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 053289				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045122				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 183361			•	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 071868				73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST	0. 000000			1 7	76. 00
76. 01 03610 SLEEP LAB	0. 000000			•	76. 01
76. 03 03951 WOUND CARE	0. 000000			1 7	76. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 225784			9	90. 00
91. 00 09100 EMERGENCY	0. 131718			g	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 257998				92. 00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds					01. 00
202.00 Total (see instructions)				l l	02. 00
	1			ļ	

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Peri od: From 03/01/2016		

					o 02/28/2017	Date/Time Pre 7/31/2017 3:1	
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS	1			_		
	3000 ADULTS & PEDIATRICS	8, 615, 174		8, 615, 174		8, 615, 174	30.00
	3100 INTENSIVE CARE UNIT	2, 639, 864		2, 639, 864		2, 639, 864	1
	300 NURSERY	402, 153		402, 153	0	402, 153	43. 00
	ICI LLARY SERVI CE COST CENTERS					= 047 474	
	OOOO OPERATING ROOM	5, 016, 464		5, 016, 464		5, 016, 464	1
	5100 RECOVERY ROOM	1, 376, 289		1, 376, 289		1, 376, 289	1
	5200 DELIVERY ROOM & LABOR ROOM	1, 068, 066		1, 068, 066	0	1, 068, 066	
	3300 ANESTHESI OLOGY	0		4 5/4 740	0	0	53.00
	6400 RADI OLOGY-DI AGNOSTI C	4, 561, 740		4, 561, 740	0	4, 561, 740	
	401 ULTRASOUND	0 050 004		0 050 004	0	0	54. 01
	5402 ONCOLOGY	3, 053, 921		3, 053, 921		3, 053, 921	54. 02
	6600 RADI OI SOTOPE	528, 075		528, 075		528, 075	56.00
	5700 CT SCAN	841, 549		841, 549		841, 549	1
	8800 MRI	567, 333		567, 333		567, 333	
	0000 LABORATORY	4, 979, 155		4, 979, 155		4, 979, 155	1
	5500 RESPI RATORY THERAPY	1, 185, 925		.,		1, 185, 925	
	6600 PHYSI CAL THERAPY	3, 298, 098		3, 298, 098		3, 298, 098	1
	5700 OCCUPATI ONAL THERAPY	280, 965		280, 965		280, 965	l
	800 SPEECH PATHOLOGY	32, 090		32, 090		32, 090	l
	900 ELECTROCARDI OLOGY	367, 870		367, 870		367, 870	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	687, 496		687, 496		687, 496	
	200 IMPL. DEV. CHARGED TO PATIENTS	2, 854, 149		2, 854, 149		2, 854, 149	
	300 DRUGS CHARGED TO PATIENTS	10, 445, 120		10, 445, 120	0	10, 445, 120	
	950 OTHER ANCILLARY SERVICE COST	0		C	0	0	76. 00
	3610 SLEEP LAB	0		C	0	0	76. 01
	9951 WOUND CARE	0		C	0	0	76. 03
	TPATIENT SERVICE COST CENTERS	1					
	2000 CLINIC	1, 105, 369		1, 105, 369		.,	
	2100 EMERGENCY	3, 863, 593		3, 863, 593		3, 863, 593	
	0200 OBSERVATION BEDS (NON-DISTINCT PART	1, 698, 860		1, 698, 860		1, 698, 860	1
200.00	Subtotal (see instructions)	59, 469, 318		59, 469, 318		59, 469, 318	
201.00	Less Observation Beds	1, 698, 860		1, 698, 860		1, 698, 860	
202. 00	Total (see instructions)	57, 770, 458	0	57, 770, 458	0	57, 770, 458	202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-1	0
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Peri od: Worksheet C	_
		From 03/01/2016 Part I	

					o 02/28/2017	Date/Time Pre 7/31/2017 3:1	
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	37, 791, 618		37, 791, 618			30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 721, 898		3, 721, 898	s		31. 00
43.00	04300 NURSERY	1, 220, 749		1, 220, 749			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20, 135, 498	39, 444, 623	59, 580, 121	0. 084197	0. 000000	50.00
51.00	05100 RECOVERY ROOM	1, 747, 323	3, 494, 257	5, 241, 580	0. 262571	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 571, 121	272, 589	2, 843, 710	0. 375589	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0. 000000	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 752, 730	14, 216, 772	15, 969, 502	0. 285653	0.000000	54. 00
54. 01	05401 ULTRASOUND	0	0	0	0. 000000	0.000000	54. 01
54.02	05402 ONCOLOGY	59, 637	12, 632, 354			0.000000	54. 02
56.00	05600 RADI OI SOTOPE	610, 777	6, 410, 475	7, 021, 252	0. 075211	0.000000	56. 00
57.00	05700 CT SCAN	7, 589, 766	37, 013, 647	44, 603, 413	0. 018867	0.000000	
58. 00	05800 MRI	1, 053, 062	11, 420, 997	12, 474, 059	0. 045481	0.000000	
60.00	06000 LABORATORY	14, 838, 289	39, 981, 595			0.000000	
65.00	06500 RESPI RATORY THERAPY	8, 652, 718	3, 876, 050			0.000000	
66. 00	06600 PHYSI CAL THERAPY	1, 202, 304	6, 000, 220	7, 202, 524	0. 457909	0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	102, 212	957, 197	1, 059, 409		0.000000	
68. 00	06800 SPEECH PATHOLOGY	75, 390	75, 350			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 827, 437	5, 075, 814	6, 903, 251		0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 509, 808	8, 726, 594	15, 236, 402	0. 045122	0.000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 094, 724	5, 471, 008			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	48, 247, 025	97, 090, 432	145, 337, 457	0. 071868	0.000000	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST	0	0	0	0. 000000	0.000000	
76. 01	03610 SLEEP LAB	0	0	0	0. 000000	0.000000	76. 01
76. 03	03951 WOUND CARE	0	0	0	0. 000000	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	583, 917	4, 311, 771			0.000000	90.00
91.00	09100 EMERGENCY	6, 132, 000	23, 200, 279	29, 332, 279		0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 771, 674	4, 813, 110			0.000000	
200.00		178, 291, 677	324, 485, 134	502, 776, 811			200. 00
201.00							201. 00
202.00	Total (see instructions)	178, 291, 677	324, 485, 134	502, 776, 811			202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX Hospital PPS Inpatient Ratio 11.00					02, 20, 201,	7/31/2017 3: 14 pm
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30000 ADULTS & PEDI ATRIC CS 31.00 3				Title XIX	Hospi tal	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 31.00 31.00 03300 INTENSI VE CARE UNI T 31.00 43.00 AURSERY OM 50.00 55.00 55.00 65.00 RECOVERY ROOM 51.00 52.00 DELI VERY ROOM & LABOR ROOM 52.00 DELI VERY ROOM & LABOR ROOM 53.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.285653 55.00 54.01 05401 ULTRASOUND 0.000000 54.01 05401 ULTRASOUND 0.000000 54.01 05401 ULTRASOUND 0.000000 54.01 05401 ULTRASOUND 0.000000 54.02 05600 RADI OLOGY-DI AGNOSTI C 0.285653 55.00 05402 ONCOLOGY 0.240618 54.00 05402 ONCOLOGY 0.240618 55.00 05402 ONCOLOGY 0.240618 55.00 05500 RADI OLOGY 0.05211 56.00 05700 CT SCAN 0.018867 57.00 05700 CT SCAN 0.018867 57.00 05700 CT SCAN 0.045481 58.00 06900 RESPI RATORY THERAPY 0.045481 58.00 06900 RESPI RATORY THERAPY 0.090828 60.00 06500 RESPI RATORY THERAPY 0.090828 60.00 06500 RESPI RATORY THERAPY 0.045481 66.00 06900 SPECH PATHOLOGY 0.245209 66.00 06900 SPECH PATHOLOGY 0.265209 66.00 06900 SPECH PATHOLOGY 0.25289 69.00 06900 SPECH PATHOLOGY 0.053289 69.00 06900 SPECH PATHOLOGY 0.053289 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.045122 71.00 07300 DRUGS CHARGED TO PATI ENTS 0.183361 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.071868 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.071868 07300 07300 DRUGS CHARGED TO PATI ENTS 0.071868 073000 07300 07300 07300 07300 07300 07300 0730		Cost Center Description	PPS Inpatient		<u> </u>	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 43.00 1NTENSI VE CARE UNI T 31.00 43.00 NURSERY 43.00 43.00 NURSERY 43.00 ANCI LLARY SERVICE COST CENTERS 43.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 0.262571 51.00 51.00 65.000 0PERATI NG ROOM 0.262571 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.375589 52.00 65.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 65.00		·	Ratio			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSI VE CARE UNIT 31. 00 31.			11. 00			
31. 00		INPATIENT ROUTINE SERVICE COST CENTERS				
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 084197 51. 00 05100 RECOVERY ROOM 0. 262571 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 375589 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 285653 54. 00 54. 01 05401 ULTRASOUND 0. 000000 54. 01 54. 02 05402 ONCOLOGY 0. 240618 54. 02 56. 00 05500 RADI OLOGY-DI AGNOSTI C 0. 075211 56. 00 05700 CT SCAN 0. 075211 56. 00 05700 CT SCAN 0. 018867 57. 00 05800 MRI 0. 045481 58. 00 06500 RSPI RATORY THERAPY 0. 045481 58. 00 06500 RSPI RATORY THERAPY 0. 099828 60. 00 06500 RSPI RATORY THERAPY 0. 094656 65. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 68. 00 06900 ELECTROCARDI OLOGY 0. 212883 69. 00 06900 ELECTROCARDI OLOGY 0. 212883 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVICE COST 0. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 0000000 76. 00000000000000000000000000000000000	30.00	03000 ADULTS & PEDIATRICS				30.00
ANCI LLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT				31.00
50. 00 05000 OPERATI NG ROOM 0.084197 50.00 51. 00 05100 RECOVERY ROOM RECOVERY ROOM Color New York Provided Color	43.00	04300 NURSERY				43. 00
51. 00 05100 RECOVERY ROOM 0. 262571 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 375589 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 285653 54. 00 54. 01 05401 ULTRASOUND 0. 000000 54. 01 54. 02 05402 ONCOLOGY 0. 240618 54. 02 56. 00 05600 RADI OI SOTOPE 0. 075211 56. 00 57. 00 05700 CT SCAN 0. 045481 58. 00 60. 00 06800 MRI 0. 045481 58. 00 60. 00 06500 RESPI RATORY THERAPY 0. 090828 60. 00 65. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 71. 00 07300						
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 375589 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 285653 54. 01 54. 01 05401 ULTRASOUND 0. 000000 54. 01 54. 02 05402 ONCOLOGY 0. 240618 54. 02 56. 00 05600 RADI OI SOTOPE 0. 075211 56. 00 57. 00 05700 CT SCAN 0. 018867 57. 00 58. 00 05800 MRI 0. 045481 58. 00 60. 00 06000 LABORATORY 0. 090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 045122 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 071868 72. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 73. 00	50.00	05000 OPERATING ROOM	0. 084197			50.00
53. 00 05300 05400 RADI OLOGY - DI AGNOSTI C 0.000000 0.285653 54.00 54. 01 05401 ULTRASOUND ULTRASOUND 0.000000 54.01 0.5402 0NCOLOGY 0.240618 54.02 0.5600 RADI OI SOTOPE 0.75211 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5800 MRI 0.045481 58.00 0.6000 LABORATORY 0.090828 60.00 0.6500 RESPI RATORY THERAPY 0.094656 65.00 0.6500 RESPI RATORY THERAPY 0.094656 0.0600 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	51.00	05100 RECOVERY ROOM	0. 262571			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 285653 54. 00 54. 01 05401 ULTRASOUND 0. 000000 54. 01 54. 02 05402 ONCOLOGY 0. 240618 54. 02 56. 00 05600 RADI OI SOTOPE 0. 075211 56. 00 57. 00 05700 CT SCAN 0. 018867 57. 00 58. 00 05800 MRI 0. 045481 58. 00 60. 00 06000 LABORATORY 0. 090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 045122 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 70. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 <	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 375589			52. 00
54. 01 05401 ULTRASOUND 0.000000 54. 01 54. 02 05402 ONCOLOGY 0.240618 54. 02 56. 00 05500 RADI OI SOTOPE 0.075211 56. 00 57. 00 05700 CT SCAN 0.018867 57. 00 58. 00 05800 MRI 0.045481 58. 00 60. 00 06000 LABORATORY 0.090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.265209 67. 00 68. 00 06800 SPECH PATHOLOGY 0.212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.045122 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.183361 72. 00 70. 00 07300 DRUGS CHARGED TO PATI ENTS 0.071868 73. 00 76. 00 03950 <td< td=""><td>53.00</td><td>05300 ANESTHESI OLOGY</td><td>0. 000000</td><td></td><td></td><td>53.00</td></td<>	53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54. 02 05402 0NCOLOGY 0. 240618 54. 02 56. 00 05600 RADI OI SOTOPE 0. 075211 56. 00 57. 00 05700 CT SCAN 0. 018867 57. 00 58. 00 05800 MRI 0. 045481 58. 00 60. 00 06000 LABORATORY 0. 090828 60. 00 65. 00 05500 RESPI RATORY THERAPY 0. 094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 70. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 0. 000000 76. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 285653			54.00
56. 00 05600 RADI OI SOTOPE 0. 075211 56. 00 57. 00 05700 CT SCAN 0. 018867 57. 00 58. 00 05800 MRI 0. 045481 58. 00 60. 00 06500 LABORATORY 0. 090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 08800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00	54. 01	05401 ULTRASOUND	0. 000000			54. 01
57. 00 05700 CT SCAN 0.018867 57. 00 58. 00 05800 MRI 0.045481 58. 00 60. 00 06000 LABORATORY 0.090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.457909 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.045122 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0.000000 76. 00	54.02	05402 ONCOLOGY	0. 240618			54. 02
58. 00 05800 MRI 0.045481 58. 00 60. 00 06000 LABORATORY 0.090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.094656 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.457909 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.053289 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.045122 71. 00 72. 00 072200 IMPL. DEV. CHARGED TO PATI ENTS 0.183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0.000000 76. 00	56.00	05600 RADI OI SOTOPE	0. 075211			56. 00
60. 00 06000 LABORATORY 0. 090828 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 094656 65. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 06800 SPECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000	57.00	05700 CT SCAN	0. 018867			57. 00
65. 00	58.00	05800 MRI	0. 045481			58. 00
66. 00 06600 PHYSI CAL THERAPY 0. 457909 66. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 06800 SPECH PATHOLOGY 0. 212883 68. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 183361 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00	60.00	06000 LABORATORY	0. 090828			60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 265209 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 183361 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 07390 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00	65.00	06500 RESPI RATORY THERAPY	0. 094656			65. 00
68. 00 06800 SPECH PATHOLOGY 0. 212883 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	66.00	06600 PHYSI CAL THERAPY	0. 457909			66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 053289 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00	67.00	06700 OCCUPATI ONAL THERAPY	0. 265209			67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 045122 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 183361 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 071868 73. 00 03950 OTHER ANCI LLARY SERVI CE COST 0. 000000 76. 00 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	68.00	06800 SPEECH PATHOLOGY	0. 212883			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 183361 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 071868 73. 00 03950 OTHER ANCILLARY SERVICE COST 0. 000000 76. 00	69.00	06900 ELECTROCARDI OLOGY	0. 053289			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 071868 73. 00 03950 OTHER ANCILLARY SERVICE COST 0. 000000 76. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045122			71. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST 0. 0000000 76. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 183361			72. 00
	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 071868			73. 00
76. 01 03610 SLEEP LAB 0. 000000 76. 01	76.00	03950 OTHER ANCILLARY SERVICE COST	0. 000000			76. 00
	76. 01	03610 SLEEP LAB	0. 000000			76. 01
76. 03 03951 WOUND CARE 0. 000000 76. 03	76. 03	03951 WOUND CARE	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS		OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC 0. 225784 90. 00	90.00	09000 CLI NI C	0. 225784			90.00
91. 00 09100 EMERGENCY 0. 131718 91. 00	91.00	09100 EMERGENCY	0. 131718			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 257998 92. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 257998			92.00
200.00 Subtotal (see instructions) 200.00	200.0	O Subtotal (see instructions)				200. 00
201.00 Less Observation Beds 201.00	201.0	O Less Observation Beds				201. 00
202.00 Total (see instructions) 202.00	202. 0	0 Total (see instructions)				202. 00

Heal th Financial Systems KOSCIUSKO COCALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 03/01/2016	Part II
To 02/28/2017	Date/Time Prepared:
7/31/2017	3:14 pm

						7/31/2017 3: 1	4 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5, 016, 464	583, 092			0	50.00
	05100 RECOVERY ROOM	1, 376, 289	52, 298			0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 068, 066	125, 331	942, 73	5 0	0	52.00
	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 561, 740	441, 891	4, 119, 84	9 0	0	54.00
	05401 ULTRASOUND	0	0	1	0	0	54. 01
54. 02	05402 ONCOLOGY	3, 053, 921	356, 862	2, 697, 05	9 0	0	54.02
	05600 RADI 0I S0T0PE	528, 075	24, 725	503, 35	0 0	0	56.00
57.00	05700 CT SCAN	841, 549	90, 034	751, 51	5 0	0	57.00
58. 00	05800 MRI	567, 333	101, 069	466, 26	4 0	0	58.00
60.00	06000 LABORATORY	4, 979, 155	272, 242	4, 706, 91	3 0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 185, 925	106, 697	1, 079, 22	8 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 298, 098	317, 914	2, 980, 18	4 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	280, 965	5, 531	275, 43	4 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	32, 090	3, 220	28, 87	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	367, 870	10, 603	357, 26	7 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	687, 496	18, 310	669, 18	6 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 854, 149	74, 396	2, 779, 75	3 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 445, 120	265, 013	10, 180, 10	7 0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST	O	O		0 0	0	76.00
76. 01	03610 SLEEP LAB	o	0)	0 0	0	76. 01
76. 03	03951 WOUND CARE	o	0)	0 0	0	76. 03
Ī	OUTPATIENT SERVICE COST CENTERS				<u>'</u>		
90.00	09000 CLI NI C	1, 105, 369	126, 495	978, 87	4 0	0	90.00
91.00	09100 EMERGENCY	3, 863, 593	439, 665	3, 423, 92	8 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 698, 860	264, 723	1, 434, 13	7 0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	47, 812, 127	3, 680, 111	44, 132, 01	6 0	0	200.00
201.00	Less Observation Beds	1, 698, 860			7 0	0	201. 00
202. 00	Total (line 200 minus line 201)	46, 113, 267		42, 697, 87	9 0	0	202. 00
		•		•	•	•	

Health Financial Systems	KOSCIUSKO COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet C Part II Date/Time Prepared: 7/31/2017 3:14 pm

						7/31/2017 3:	14 pm
			Ti tl	e XIX	Hospi tal	PPS	
Cost	Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge	9		
		Operating Cost	Part I, column				
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	SERVI CE COST CENTERS						
50. 00 05000 OPERA		5, 016, 464					50. 00
51. 00 05100 RECO\		1, 376, 289					51. 00
	/ERY ROOM & LABOR ROOM	1, 068, 066	2, 843, 710	0. 375589	9		52. 00
53. 00 05300 ANEST	THESI OLOGY	0	0	0. 000000			53.00
	DLOGY-DI AGNOSTI C	4, 561, 740	15, 969, 502				54.00
54. 01 05401 ULTRA		0	0	0.000000			54. 01
54. 02 05402 ONCOL	_OGY	3, 053, 921	12, 691, 991	0. 240618	3		54. 02
56. 00 05600 RADI (OI SOTOPE	528, 075	7, 021, 252	0. 075211			56. 00
57. 00 05700 CT SC	CAN	841, 549	44, 603, 413	0. 018867	7		57. 00
58.00 05800 MRI		567, 333	12, 474, 059	0. 045481			58. 00
60. 00 06000 LABOF	RATORY	4, 979, 155	54, 819, 884	0. 090828	3		60.00
65. 00 06500 RESPI	RATORY THERAPY	1, 185, 925	12, 528, 768	0. 094656	5		65. 00
66. 00 06600 PHYSI	CAL THERAPY	3, 298, 098	7, 202, 524	0. 457909	9		66. 00
67. 00 06700 OCCUP	PATIONAL THERAPY	280, 965	1, 059, 409	0. 265209	9		67. 00
68. 00 06800 SPEE0	CH PATHOLOGY	32, 090	150, 740	0. 212883	3		68. 00
69. 00 06900 ELECT	FROCARDI OLOGY	367, 870	6, 903, 251	0.053289	9		69. 00
71. 00 07100 MEDI 0	CAL SUPPLIES CHARGED TO PATIENT	687, 496	15, 236, 402	0. 045122	2		71. 00
72. 00 07200 I MPL.	DEV. CHARGED TO PATIENTS	2, 854, 149	15, 565, 732	0. 183361	ı		72. 00
73. 00 07300 DRUGS	S CHARGED TO PATIENTS	10, 445, 120	145, 337, 457	0. 071868	3		73. 00
76. 00 03950 OTHER	R ANCILLARY SERVICE COST	0	0	0.000000			76. 00
76. 01 03610 SLEEF	P LAB	0	0	0. 000000			76. 01
76. 03 03951 WOUND) CARE	0	0	0. 000000			76. 03
OUTPATI ENT	SERVICE COST CENTERS						
90. 00 09000 CLI NI	С	1, 105, 369	4, 895, 688	0. 225784	1		90. 00
91. 00 09100 EMERO	GENCY	3, 863, 593	29, 332, 279	0. 131718	3		91.00
92. 00 09200 OBSEF	RVATION BEDS (NON-DISTINCT PART	1, 698, 860			3		92.00
200. 00 Subto	otal (sum of lines 50 thru 199)	47, 812, 127	460, 042, 546				200. 00
	Observation Beds	1, 698, 860		1			201.00
202. 00 Total	(line 200 minus line 201)	46, 113, 267	460, 042, 546				202. 00
	•		•	•			•

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0133	Period: Worksheet C

COMPO	ATTON OF NATIO OF COSTS TO CHANGES		Frovider C		From 03/01/2016 To 02/28/2017	Part I Date/Time Pre 7/31/2017 3:1	pared: 4 pm
			Ti t	le V	Hospi tal	Cost	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDIATRICS	8, 615, 174		8, 615, 17	4 0	8, 615, 174	30.00
	03100 INTENSIVE CARE UNIT	2, 639, 864		2, 639, 86			1
	04300 NURSERY	402, 153		402, 15			1
43.00	ANCI LLARY SERVI CE COST CENTERS	402, 133		102,13	5 0	402, 100	1 43.00
50. 00	05000 OPERATI NG ROOM	5, 016, 464		5, 016, 46	4 0	5, 016, 464	50.00
51. 00	05100 RECOVERY ROOM	1, 376, 289		1, 376, 28		1, 376, 289	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 068, 066		1, 068, 06			1
53. 00	05300 ANESTHESI OLOGY	0			0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 561, 740		4, 561, 74	o o	4, 561, 740	
54. 01	05401 ULTRASOUND	0			0 0	0	54. 01
54. 02	05402 ONCOLOGY	3, 053, 921		3, 053, 92	1 0	3, 053, 921	54. 02
56.00	05600 RADI OI SOTOPE	528, 075		528, 07	5 0	528, 075	56. 00
57.00	05700 CT SCAN	841, 549		841, 54	9 0	841, 549	57. 00
58.00	05800 MRI	567, 333		567, 33	3 0	567, 333	58. 00
60.00	06000 LABORATORY	4, 979, 155		4, 979, 15	5 0	4, 979, 155	60.00
65.00	06500 RESPIRATORY THERAPY	1, 185, 925	0	1, 185, 92	5 0	1, 185, 925	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 298, 098	0	3, 298, 09	8 0	3, 298, 098	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	280, 965	0	280, 96	5 0	280, 965	67. 00
68. 00	06800 SPEECH PATHOLOGY	32, 090	0	32, 09	0 0	32, 090	1
69. 00	06900 ELECTROCARDI OLOGY	367, 870		367, 87	0 0	367, 870	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	687, 496		687, 49		687, 496	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 854, 149		2, 854, 14		2, 854, 149	
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 445, 120		10, 445, 12	0	10, 445, 120	1
76. 00	03950 OTHER ANCILLARY SERVICE COST	0			0	0	76. 00
	03610 SLEEP LAB	0			0 0	0	76. 01
76. 03	03951 WOUND CARE	0			0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	1 105 0/0		1 405 0/	ما	1 105 0/0	
	09000 CLINIC	1, 105, 369		1, 105, 36			
	09100 EMERGENCY	3, 863, 593		3, 863, 59		-,,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 698, 860	^	1, 698, 86		1, 698, 860	
200.00		59, 469, 318	0				
201.00		1, 698, 860	0	1, 698, 86		1, 698, 860	
202.00	Total (see instructions)	57, 770, 458	0	57, 770, 45	8 0	57, 770, 458	J2U2. UU

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Peri od: From 03/01/2016		

					o 02/28/2017	Date/Time Pre 7/31/2017 3:1	
			Ti t	le V	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
	03000 ADULTS & PEDI ATRI CS	37, 791, 618		37, 791, 618			30. 00
31. 00	03100 NTENSI VE CARE UNI T	3, 721, 898		3, 721, 898			31. 00
43.00	04300 NURSERY	1, 220, 749		1, 220, 749			43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	20, 135, 498	39, 444, 623			0. 000000	
51. 00	05100 RECOVERY ROOM	1, 747, 323	3, 494, 257			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	2, 571, 121	272, 589	2, 843, 710		0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	C	0.000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 752, 730	14, 216, 772	15, 969, 502	l l	0. 000000	
	05401 ULTRASOUND	0	0	C	0.000000	0. 000000	
	05402 ONCOLOGY	59, 637	12, 632, 354		1	0. 000000	
56. 00	05600 RADI OI SOTOPE	610, 777	6, 410, 475		1	0. 000000	
57. 00	05700 CT SCAN	7, 589, 766	37, 013, 647		1	0. 000000	
58. 00	05800 MRI	1, 053, 062	11, 420, 997		1	0. 000000	
60.00	06000 LABORATORY	14, 838, 289	39, 981, 595			0. 000000	
65.00	06500 RESPI RATORY THERAPY	8, 652, 718	3, 876, 050			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 202, 304	6, 000, 220			0. 000000	
67. 00	06700 OCCUPATIONAL THERAPY	102, 212	957, 197			0. 000000	
	06800 SPEECH PATHOLOGY	75, 390	75, 350			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 827, 437	5, 075, 814			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 509, 808	8, 726, 594			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 094, 724	5, 471, 008			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	48, 247, 025	97, 090, 432	145, 337, 457		0.000000	
	03950 OTHER ANCILLARY SERVICE COST	0	0	C	0. 000000	0.000000	
	03610 SLEEP LAB	0	0	C	0. 000000	0.000000	
76. 03	03951 WOUND CARE	0	0	C	0.000000	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	583, 917	4, 311, 771			0.000000	
	09100 EMERGENCY	6, 132, 000	23, 200, 279			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 771, 674	4, 813, 110			0.000000	
200.00		178, 291, 677	324, 485, 134	502, 776, 811			200. 00
201.00							201. 00
202.00	Total (see instructions)	178, 291, 677	324, 485, 134	502, 776, 811			202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-013	From 03/01/2016	Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm
	Title V	Hospi tal	Cost

				7/31/2017 3:14 pm
		Ti tle V	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50. 00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
54. 02 05402 ONCOLOGY	0. 000000			54. 02
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 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	0. 000000			76. 00
76. 01 03610 SLEEP LAB	0. 000000			76. 01
76. 03 03951 WOUND CARE	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
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 COMMU	JNITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 03/01/2016	Worksheet D Part I	
				To 02/28/2017	Date/Time Pre	
		T' 11	20/11/1		7/31/2017 3:1	4 pm
	1 2		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Rel ated 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, 342, 451	0	1, 342, 45	1 10, 908	123. 07	30.00
31.00 INTENSIVE CARE UNIT	313, 142		313, 14	2 1, 540	203. 34	31.00
43. 00 NURSERY	32, 941		32, 94	1 969	33. 99	43.00
200.00 Total (lines 30-199)	1, 688, 534		1, 688, 53	4 13, 417		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 116	383, 486				30. 00
31.00 INTENSIVE CARE UNIT	629	127, 901				31.00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30-199)	3, 745	511, 387				200. 00

Health Financial Systems	KOSCI USKO COMMUNI 7	TY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	Y SERVICE CAPITAL COSTS	Provider CCN: 15-0133	Peri od:	Worksheet D

Provider CCN: 15-0133	Health Financial Systems	KOSCIUSKO COMMU	JNITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		From 03/01/2016	Part II Date/Time Pre	
Related Cost (From Wisst. C, Col. 1 + col. 2 + col. Charges Col um 3 x Col um 4)			Title	: XVIII	Hospi tal		
CFrom Wkst. B, Part II, col. Col. 1 * col. Col. 1 * col. Col. 1 * col. Col. m/s	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent		
Part II, col. 26)							
ANCILLARY SERVICE COST CENTERS		(from Wkst. B,			. Charges	column 4)	
NO 1.00 2.00 3.00 4.00 5.00		· ·	8)	2)			
ANCILLARY SERVICE COST CENTERS 5.00							
50. 00 05000 OPERATI NG ROOM 583, 092 59, 580, 121 0.009787 4,890,793 47,866 50. 00 51. 00 05100 RECOVERY ROOM & LABOR ROOM 125,331 2,843,710 0.004073 0 0.52. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 125,331 2,843,710 0.0040073 0 0.52. 00 0.000000 0 0 0.000000 0		1. 00	2. 00	3. 00	4. 00	5. 00	
51.00 05100 RECOVERY ROOM 52, 298 5, 241, 580 0.009978 415, 695 4, 148 51.00							
52. 00 05200 DELI VERY ROOM & LABOR ROOM 125, 331 2, 843, 710 0. 044073 0 0. 040073 0 0. 52. 00 0. 05300 0. 08500 ARESTHESI LOGY 0 0 0. 000000 0 0 0. 53. 00 0. 05400 0. 0000000 0 0 0. 54. 00 0. 0000000 0 0 0. 54. 00 0. 0000000 0 0 0. 54. 00 0. 0000000 0 0 0. 54. 01 0. 04010 0. 0000000 0 0 0. 0000000 0				1			
53.00 0 5300 ANESTHESI OLOGY 0 0 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 441,891 15,969,502 0.027671 1,611,582 44,594 54.00 54.01 05401 ULTRASOUND 0 0.000000 0.000000 0 0.54.01 54.02 05402 ONCOLOGY 356,862 12,691,991 0.028117 24,480 688 54.02 55.00 05600 RADI OI SOTOPE 24,725 7,021,252 0.003521 250,091 881 56.00 57.00 05700 CT SCAN 90,034 44,603,413 0.002019 3,488,481 7,043 57.00 65.00 05800 MRI 101,069 12,474,059 0.008102 415,725 3,368 58.00 60.00 06000 LABORATORY 272,242 54,819,884 0.004966 5,953,341 29,564 60.00 65.00 06500 RESPI RATORY THERAPY 106,697 12,528,768				1	· ·	4, 148	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 441, 891 15, 969, 502 0.027671 1, 611, 582 44, 594 54. 00 54. 01 05401 ULTRASOUND 0 0.000000 0.000000 0 0.54. 01 54. 01 54. 01 05401 ULTRASOUND 0 0.000000 0.000000 0 0.54. 01 54. 01 54. 01 54. 02 05402 ONCOLOGY 356, 862 12, 691, 991 0.028117 24, 480 688 54. 02 54. 01 55. 00 05600 RADI OLOGY-DI AGNOSTI C 441, 891 15, 969, 502 0.003521 250, 091 881 56. 00 55. 00 55. 00 05600 CT SCAN 90, 034 44, 603, 413 0.002019 3, 488, 481 7, 043 57. 00 55. 00 55. 00 0500 CT SCAN 90, 034 44, 603, 413 0.002019 3, 488, 481 7, 043 57. 00 55. 00 0500 MRI 101, 069 12, 474, 059 0.008102 415, 725 3, 368 58. 00 56. 00 06000 LABORATORY 272, 242 54, 819, 884 0.004966 5,953, 341 29, 564 60. 00 66. 00 06600 PHYSI CAL THERAPY 106, 697 12, 528, 768 0.008516 3, 867, 070 32, 932 65. 00 66. 00 06600 PHYSI CAL THERAPY 317, 914 7, 202, 524 0.044139 483, 099 21, 324 66. 00 67. 00 06600 PHYSI CAL THERAPY 5,531 1, 059, 409 0.005221 39, 718 207 67. 00 69. 00 06900 PHYSI CAL THERAPY 5,531 1, 059, 409 0.005221 39, 718 207 67. 00 69. 00 06900 ELECTROCARDI OLOGY 3,220 150, 740 0.021361 41, 267 882 68. 00 69. 00 06900 ELECTROCARDI OLOGY 10,603 6, 903, 251 0.001536 1, 801, 289 2, 767 69. 00 69. 00 07000 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 74, 396 15, 565, 732 0.004779 3, 437, 048 16		125, 331	2, 843, 710	1			
54. 01 05401 ULTRASOUND 0 0 0.000000 0 0.000000 54. 01 54. 02 05402 ONCOLOGY 356, 862 12, 691, 991 0.028117 24, 480 688 54. 02 56. 00 05600 RADI OI SOTOPE 24, 725 7, 021, 252 0.003521 250, 091 881 56. 00 57. 00 05700 CT SCAN 90, 034 44, 603, 413 0.002019 3, 488, 481 7, 043 57. 00 58. 00 05800 MRI 101, 069 12, 474, 059 0.008102 415, 725 3, 368 58. 00 65. 00 06500 RESPI RATORY 106, 697 12, 528, 768 0.008516 3, 867, 070 32, 932 65. 00 66. 00 06600 PHYSI CAL THERAPY 317, 914 7, 202, 524 0.044139 483, 099 21, 324 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 5, 531 1, 059, 409 0.005221 39, 718 207 67. 00 69. 00 OE300 <		0	0	1			
54. 02 05402 ONCOLOGY 356, 862 12, 691, 991 0.028117 24, 480 688 54. 02 56. 00 05600 RADI OI SOTOPE 24, 725 7, 021, 252 0.003521 250, 091 881 56. 00 57. 00 05700 CT SCAN 90, 034 44, 603, 413 0.002019 3, 488, 481 7, 043 57. 00 58. 00 05800 MRI 101, 069 12, 474, 059 0.008102 415, 725 3, 368 58. 00 60. 00 06000 LABORATORY 272, 242 54, 819, 884 0.004966 5, 953, 341 29, 564 60. 00 65. 00 06500 RESPI RATORY THERAPY 106, 697 12, 528, 768 0.008516 3, 867, 070 32, 932 65. 00 66. 00 06600 PHYSI CAL THERAPY 317, 914 7, 202, 524 0.044139 483, 099 21, 324 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 5, 531 1, 059, 409 0.005221 39, 718 207 67. 00 68. 00 <td></td> <td>441, 891</td> <td>15, 969, 502</td> <td>1</td> <td></td> <td>44, 594</td> <td></td>		441, 891	15, 969, 502	1		44, 594	
56. 00 05600 RADI OI SOTOPE 24, 725 7, 021, 252 0. 003521 250, 091 881 56. 00 5700 CT SCAN 90, 034 44, 603, 413 0. 002019 3, 488, 481 7, 043 57. 00 05800 MRI 101, 069 12, 474, 059 0. 008102 415, 725 3, 368 58. 00 05800 MRI 101, 069 12, 474, 059 0. 008102 415, 725 3, 368 58. 00 05800 MRI 101, 069 12, 474, 059 0. 008102 415, 725 3, 368 58. 00 05800 MRI 101, 069 12, 474, 059 0. 008102 415, 725 3, 368 58. 00 05800 MRI 101, 069 12, 474, 059 0. 008102 415, 725 3, 368 58. 00 05800 MRI 101, 069 12, 528, 768 0. 008516 3, 867, 070 32, 932 05. 00 05800 MRI 101, 069 00 06600 PHYSI CAL THERAPY 106, 697 12, 528, 768 0. 008516 3, 867, 070 32, 932 05. 00 06700 0CCUPATI ONAL THERAPY 110, 069 0. 00521 39, 718 207 67. 00 06700 0CCUPATI ONAL THERAPY 10, 603 0. 9920 150, 740 0. 021361 41, 267 882 06. 00 06900 ELECTROCARDI OLOGY 10, 603 0. 903, 251 0. 001536 1, 801, 289 2, 767 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 18, 310 15, 236, 402 0. 001202 1, 951, 633 2, 346 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 18, 310 15, 236, 402 0. 004779 3, 437, 048 16, 426 72. 00 07300 DRUGS CHARGED TO PATI ENTS 265, 013 145, 337, 457 0. 001823 16, 561, 118 30, 191 73. 00 07300 DRUGS CHARGED TO PATI ENTS 265, 013 145, 337, 457 0. 001823 16, 561, 118 30, 191 73. 00 076. 01 03610 SLEEP LAB 0 0 0 0. 000000 0 0 0 76. 01 03610 SLEEP LAB 0 0 0 0. 000000 0 0 0 76. 01 03610 SLEEP LAB 0 0 0 0. 000000 0 0 0 76. 00 000000 0 0 0 76. 00 000000 0 0 0 0 76. 00 000000 0 0 0 0 76. 00 000000 0 0 0 000000 0 0 0 0 76. 00 000000 0 0 0 000000 0 0 0 000000 0 0		0	0			- 1	1
57. 00				1	· ·		1
58.00 05800 MRI 101,069 12,474,059 0.008102 415,725 3,368 58.00 60.00 06000 LABORATORY 272,242 54,819,884 0.004966 5,953,341 29,564 60.00 65.00 06500 RESPI RATORY THERAPY 106,697 12,528,768 0.008516 3,867,070 32,932 65.00 66.00 06600 PHYSI CAL THERAPY 317,914 7,202,524 0.044139 483,099 21,324 66.00 67.00 06700 OCCUPATI ONAL THERAPY 5,531 1,059,409 0.05221 39,718 207 67.00 68.00 06800 SPEECH PATHOLOGY 3,220 150,740 0.021361 41,267 882 68.00 69.00 06900 ELECTROCARDI OLOGY 10,603 6,903,251 0.001536 1,801,289 2,767 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18,310 15,236,402 0.001202 1,951,633 2,346 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 265,013 145,337,457 0.004779 3,437,048 16,561,118 30,191 73.00 76.01 039							1
60. 00							1
65. 00					· ·		1
66. 00		272, 242	54, 819, 884				1
67. 00	65. 00 06500 RESPIRATORY THERAPY	106, 697	12, 528, 768	0. 00851	6 3, 867, 070	32, 932	65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	317, 914	7, 202, 524	0. 04413	9 483, 099	21, 324	66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	5, 531	1, 059, 409	0.00522	1 39, 718	207	67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	3, 220	150, 740	0. 02136	1 41, 267	882	68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	10, 603	6, 903, 251	0. 00153	6 1, 801, 289	2, 767	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 265, 013 145, 337, 457 0. 001823 16, 561, 118 30, 191 73. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST 0 0 0. 000000 0 0 76. 00 76. 01 03610 SLEEP LAB 0 0 0. 000000 0 0 0 76. 01 76. 03 03951 WOUND CARE 0 0 0. 000000 0 0 0 76. 01 76. 03 017PATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1 126, 495 4, 895, 688 0. 025838 124, 297 3, 212 90. 00 91. 00 09100 EMERGENCY 439, 665 29, 332, 279 0. 014989 2, 374, 703 35, 594 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 264, 723 6, 584, 784 0. 040202 644, 037 25, 892 92. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 310	15, 236, 402	0.00120	2 1, 951, 633	2, 346	71. 00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	74, 396	15, 565, 732	0.00477	9 3, 437, 048	16, 426	72. 00
76. 01 03610 SLEEP LAB 0 0.000000 0 0 76. 01 76. 03 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	265, 013	145, 337, 457	0. 00182	3 16, 561, 118	30, 191	73. 00
76. 03 03951 WOUND CARE 0 0 0.000000 0 0 0 0 0	76.00 03950 OTHER ANCILLARY SERVICE COST	0	0	0.00000	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 126, 495 4, 895, 688 0. 025838 124, 297 3, 212 90. 00 91.00 09100 EMERGENCY 439, 665 29, 332, 279 0. 014989 2, 374, 703 35, 594 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 264, 723 6, 584, 784 0. 040202 644, 037 25, 892 92. 00	76. 01 03610 SLEEP LAB	0	0	0.00000	0	0	76. 01
90. 00	76. 03 03951 WOUND CARE	0	0	0.00000	0	0	76. 03
91. 00 09100 EMERGENCY 439, 665 29, 332, 279 0. 014989 2, 374, 703 35, 594 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 264, 723 6, 584, 784 0. 040202 644, 037 25, 892 92. 00							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 264, 723 6, 584, 784 0. 040202 644, 037 25, 892 92. 00		126, 495	4, 895, 688			3, 212	90.00
		439, 665	29, 332, 279	0. 01498			
200. 00 Total (Lines 50-199) 3, 680, 111 460, 042, 546 48, 375, 467 309, 925 200. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	264, 723	6, 584, 784	0.04020	2 644, 037		
	200.00 Total (lines 50-199)	3, 680, 111	460, 042, 546	,	48, 375, 467	309, 925	200. 00

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-25!						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 03/01/2016 Fo 02/28/2017		narod:
				10 02/20/2017	7/31/2017 3:1	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)		
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	0) C)	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0) C)	O	0	31.00
43. 00 04300 NURSERY	0) C))	0	43.00
200.00 Total (lines 30-199)	0) C))	0	200.00
Cost Center Description	Total Patient	Per Diem (col.		I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 908	I			!	30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 540			9 0	,	31. 00
43. 00 04300 NURSERY	969	I	•	0	1	43. 00
200.00 Total (lines 30-199)	13, 417	1	3, 74	5 0	J	200. 00

| Peri od: | Worksheet D | From 03/01/2016 | Part IV | To 02/28/2017 | Date/Time Prepared: Provi der CCN: 15-0133 THROUGH COSTS

				'	0 02/20/2017	7/31/2017 3: 1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician No	ursing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
	1	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		_				
50.00	05000 OPERATING ROOM	0	0	(0	0	
51.00	05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01	05401 ULTRASOUND	0	0	(0	0	54. 01
54. 02	05402 ONCOLOGY	0	0	(0	0	54. 02
56. 00	05600 RADI OI SOTOPE	0	0	(0	0	56. 00
57. 00	05700 CT SCAN	0	0	(0	0	57. 00
58. 00	05800 MRI	0	0	(0	0	58. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST	0	0	(0	76. 00
76. 01	03610 SLEEP LAB	0	0	(0	0	76. 01
76. 03	03951 WOUND CARE	0	0	() 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS			_			
90.00	09000 CLINIC	0	0	(0	90.00
91.00	09100 EMERGENCY	0	0	(0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0	92.00
200.00	Total (lines 50-199)	ا	O	() 0	0	200. 00

Health Financial Systems	KOSCIUSKO COMMUN	ITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	
		Title XVIII	Hospi tal	PPS
Cost Center Description	Total	otal Charges Ratio of Cos	t Outpatient	Inpati ent

					0 02/28/201/	7/31/2017 3:1	oared: 4 nm
			Title	xVIII	Hospi tal	PPS	ГРШ
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 + col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	59, 580, 121			4, 890, 793	
	05100 RECOVERY ROOM	0	5, 241, 580	1		415, 695	
	D5200 DELIVERY ROOM & LABOR ROOM	0	2, 843, 710			0	52.00
	05300 ANESTHESI OLOGY	0	0	1 0.00000		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	15, 969, 502	1		1, 611, 582	54.00
	05401 ULTRASOUND	0	0	0.00000		0	54. 01
	05402 ONCOLOGY	0	12, 691, 991	0. 000000	0. 000000	24, 480	54. 02
	05600 RADI OI SOTOPE	0	7, 021, 252	0.000000	0.000000	250, 091	56.00
	05700 CT SCAN	0	44, 603, 413	0.000000	0. 000000	3, 488, 481	57.00
58. 00 C	05800 MRI	0	12, 474, 059	0.000000	0.000000	415, 725	58. 00
60.00	06000 LABORATORY	0	54, 819, 884	0.000000	0.000000	5, 953, 341	60.00
65. 00 C	06500 RESPIRATORY THERAPY	0	12, 528, 768	0.000000	0.000000	3, 867, 070	65.00
66. 00 C	06600 PHYSI CAL THERAPY	0	7, 202, 524	0.000000	0.000000	483, 099	66.00
67. 00 C	06700 OCCUPATIONAL THERAPY	0	1, 059, 409	0.000000	0.000000	39, 718	67.00
68. 00 C	06800 SPEECH PATHOLOGY	0	150, 740	0.000000	0.000000	41, 267	68.00
69.00	06900 ELECTROCARDI OLOGY	0	6, 903, 251	0.000000	0.000000	1, 801, 289	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15, 236, 402	0.000000	0.000000	1, 951, 633	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 565, 732	0.000000	0.000000	3, 437, 048	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	145, 337, 457	0.000000	0.000000	16, 561, 118	73.00
76. 00 C	03950 OTHER ANCILLARY SERVICE COST	0	0	0. 000000	0. 000000	0	76.00
76. 01 C	03610 SLEEP LAB	0	0	0.000000	0.000000	0	76. 01
76. 03 C	03951 WOUND CARE	0	0	0.000000	0.000000	0	76. 03
O	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	4, 895, 688	0.000000	0.000000	124, 297	90.00
91.00	09100 EMERGENCY	0	29, 332, 279	0. 000000	0. 000000	2, 374, 703	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 584, 784	0.000000	0. 000000	644, 037	92.00
200.00	Total (lines 50-199)	0	460, 042, 546			48, 375, 467	200. 00

Tilloodi 66515			То	02/28/2017	Date/Time Pro 7/31/2017 3: 1	epared: 14 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	5, 595, 489				50. 00
51.00 05100 RECOVERY ROOM	0	413, 870	0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 440, 269				54. 00
54. 01 05401 ULTRASOUND	0	0	0			54. 01
54. 02 05402 0NC0L0GY	0	3, 007, 327				54. 02
56. 00 05600 RADI 01 SOTOPE	0	1, 586, 560				56. 00
57. 00 05700 CT SCAN	0	7, 157, 803	1			57. 00
58. 00 05800 MRI	0	2, 046, 205	1			58. 00
60. 00 06000 LABORATORY	0	3, 455, 410				60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 465, 492				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	29, 062				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 998				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	814				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	791, 232				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 075, 558				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	793, 137				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 600, 841				73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST	0	0	0			76. 00
76. 01 03610 SLEEP LAB	0	0	0			76. 01
76. 03 03951 WOUND CARE	0	0	0			76. 03
OUTPATIENT SERVICE COST CENTERS	,		,			
90. 00 09000 CLI NI C	0	829, 225				90. 00
91. 00 09100 EMERGENCY	0	3, 618, 217				91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 023, 287				92. 00
200.00 Total (lines 50-199)	0	53, 933, 796	0			200. 00

Health Financial Systems	KOSCI USKO COMMUNI 7	TY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTLONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0133	Peri od:	Worksheet D

From 03/01/2016 Part V 02/28/2017 Date/Time Prepared: 7/31/2017 3:14 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 084197 5, 595, 489 471, 123 50.00 51.00 05100 RECOVERY ROOM 0. 262571 413, 870 0 0 108, 670 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.375589 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 285653 5, 440, 269 0 1, 554, 029 54.00 54.01 05401 ULTRASOUND 0.000000 0 0 54 01 0 0 54.02 05402 ONCOLOGY 0. 240618 3,007,327 723, 617 54.02 56.00 05600 RADI OI SOTOPE 0.075211 1, 586, 560 0 119, 327 56.00 05700 CT SCAN 0 57.00 0.018867 7, 157, 803 0 135, 046 57.00 05800 MRI O 58 00 0.045481 2, 046, 205 93.063 58 00 60.00 06000 LABORATORY 0.090828 3, 455, 410 1,998 313, 848 60.00 65.00 06500 RESPIRATORY THERAPY 0.094656 1, 465, 492 1, 449 138, 718 0 65.00 06600 PHYSI CAL THERAPY 0.457909 29, 062 13, 308 66.00 0 66,00 06700 OCCUPATIONAL THERAPY 67.00 0 1,060 67.00 0.265209 3, 998 68.00 06800 SPEECH PATHOLOGY 0. 212883 814 0 0 173 68.00 06900 ELECTROCARDI OLOGY 0.053289 791, 232 42, 164 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 48, 531 71.00 0.045122 1,075,558 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 793, 137 0 72 00 0.183361 0 145, 430 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.071868 15, 600, 841 27, 852 1, 121, 201 73.00 03950 OTHER ANCILLARY SERVICE COST 0.000000 0 76.00 76.00 0 0 03610 SLEEP LAB 0 76.01 0.000000 0 76.01 0 03951 WOUND CARE 0.000000 0 76.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 225784 829, 225 187, 226 90.00 91.00 09100 EMERGENCY 0. 131718 0 91.00 3, 618, 217 0 476, 584 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 257998 1,023,287 0 264,006 92.00 200.00 53, 933, 796 27, 852 5, 957, 124 200. 00 Subtotal (see instructions) 3, 447 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 +/- line 201) 5, 957, 124 202. 00 202.00 53, 933, 796 3, 447 27, 852

Health Financial Systems		KOSCI USKO COMML	JNITY HOSPITAL		In Lie	u of Form CMS-2	2552-1
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi der CO	CN: 15-0133		Worksheet D Part V Date/Time Pre 7/31/2017 3:1	pared: 4 pm
			Title	: XVIII	Hospi tal	PPS	
·		Cos	sts				
Cost Center [escription	Cost	Cost				
	·	Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				

| Cost Center Description Cost |
|--|---------|
| Servi ces Servi ces Not | |
| Subject To Subject To | |
| Ded. & Coins. Ded. & Coins. | |
| (see inst.) (see inst.) | |
| 6.00 7.00 | |
| ANCILLARY SERVICE COST CENTERS | |
| 50. 00 05000 0PERATING 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 0LOGY-DI AGNOSTI C 0 0 | 54.00 |
| 54. 01 05401 ULTRASOUND 0 0 | 54. 01 |
| 54. 02 05402 0NCOLOGY 0 0 | 54. 02 |
| 56. 00 05600 RADI 0I SOTOPE 0 0 | 56.00 |
| 57. 00 05700 CT SCAN 0 0 | 57.00 |
| 58. 00 05800 MRI 0 0 0 | 58.00 |
| 60. 00 06000 LABORATORY 181 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY 137 0 | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 | 66. 00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY 0 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY 0 0 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 | 71.00 |
| 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 | 72. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 002 | 73. 00 |
| 76.00 03950 OTHER ANCILLARY SERVICE COST 0 0 | 76. 00 |
| 76. 01 03610 SLEEP LAB 0 0 | 76. 01 |
| 76. 03 03951 WOUND CARE 0 0 | 76. 03 |
| OUTPATIENT SERVICE COST CENTERS | |
| 90. 00 09000 CLI NI C 0 0 | 90. 00 |
| 91. 00 09100 EMERGENCY 0 0 | 91. 00 |
| 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 | 92. 00 |
| 200.00 Subtotal (see instructions) 318 2,002 | 200. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program 0 | 201. 00 |
| Only Charges | |
| 202.00 Net Charges (line 200 +/- line 201) 318 2,002 | 202. 00 |

Health Financial Systems	KOSCIUSKO COMMU	INITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 03/01/2016 To 02/28/2017	Part I Date/Time Pre	narod:
				10 02/20/2017	7/31/2017 3: 1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00 ADULTS & PEDIATRICS	1, 342, 451	0	1, 342, 45	1 10, 908	123. 07	30. 00
31.00 INTENSIVE CARE UNIT	313, 142		313, 14	2 1, 540	203. 34	31.00
43. 00 NURSERY	32, 941		32, 94	1 969	33. 99	43.00
200.00 Total (lines 30-199)	1, 688, 534		1, 688, 53	4 13, 417		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 080					30. 00
31.00 INTENSIVE CARE UNIT	229					31. 00
43. 00 NURSERY	435		1			43. 00
200.00 Total (lines 30-199)	1, 744	194, 267				200. 00

Health Financial Systems	KOSCI USKO COMMUNI T	Y HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT	ANGLILLADY CEDVICE CADITAL COCTO	D: -I CON 1E 0100	D!I	Wasaliala a A. D

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0133	Peri od:	Worksheet D	
				From 03/01/2016 To 02/28/2017	Part II Date/Time Pre	narod:
				10 02/20/2017	7/31/2017 3:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATING ROOM	583, 092				1, 599	
51. 00 05100 RECOVERY ROOM	52, 298		l .			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	125, 331	2, 843, 710				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	441, 891	15, 969, 502			2, 810	54.00
54. 01 05401 ULTRASOUND	0	0	0.00000		0	54. 01
54. 02 05402 0NCOLOGY	356, 862				0	54. 02
56. 00 05600 RADI OI SOTOPE	24, 725		l .		11	56. 00
57. 00 05700 CT SCAN	90, 034		l .	· ·		57. 00
58. 00 05800 MRI	101, 069					58. 00
60. 00 06000 LABORATORY	272, 242				1, 554	60.00
65. 00 06500 RESPI RATORY THERAPY	106, 697	12, 528, 768				65. 00
66. 00 06600 PHYSI CAL THERAPY	317, 914				1, 070	
67. 00 06700 OCCUPATI ONAL THERAPY	5, 531					67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 220		l .	· ·		68. 00
69. 00 06900 ELECTROCARDI OLOGY	10, 603					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 310					71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	74, 396		l .		90	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	265, 013	145, 337, 457			1, 743	73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST	0	0	0. 00000		0	76. 00
76. 01 03610 SLEEP LAB	0	0	0. 00000		0	76. 01
76. 03 03951 WOUND CARE	0	0	0. 00000	00 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	T .		T .	. 1		
90. 00 09000 CLI NI C	126, 495					
91. 00 09100 EMERGENCY	439, 665					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	264, 723				555	
200.00 Total (lines 50-199)	3, 680, 111	460, 042, 546	1	2, 106, 218	14, 744	200. 00

Health Financial Systems	KOSCIUSKO COMML	'T INL	Y HOSPITAL		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS	Provider CO		Period: From 03/01/2016 To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Al I	ied Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t 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 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0)	0		0	0	31.00
43. 00 04300 NURSERY	0)	0		0	0	43.00
200.00 Total (lines 30-199)	0)	0		0	0	200. 00
Cost Center Description	Total Patient	Per	Diem (col.	Inpati ent	Inpati ent		
	Days	5	÷ col . 6)	Program Days			
			ĺ		Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6.00		7. 00	8. 00	9. 00]	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	10, 908	3	0.00	1, 08	3O O		30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 540		0.00	22	.9		31.00
43. 00 04300 NURSERY	969		0. 00	43	5 0		43.00
200.00 Total (lines 30-199)	13, 417			1, 74			200. 00

Provider CCN: 15-0133 THROUGH COSTS

			1	0 02/28/201/	7/31/2017 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician N	lursing School	Allied Health	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	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	0	0	0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01 05401 ULTRASOUND	0	0	0	0	0	54. 01
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 RESPIRATORY 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	0	0	0	0	0	76. 00
76. 01 03610 SLEEP LAB	0	0	0	0	0	76. 01
76. 03 03951 WOUND CARE	0	0	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	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	92. 00
200.00 Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552				552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A THROUGH COSTS	NCILLARY SERVICE OTHER PASS	ILLARY SERVICE OTHER PASS Provider CCN: 15-0133			pared:
		Title XIX	Hospi tal	PPS	
Cost Center Description		tal Charges Ratio of Cos		Inpati ent	

Cost Center Description				'	0 02/20/2017	7/31/2017 3: 1	
ANCILLARY SERVICE COST CENTERS Part			Ti tl	e XIX	Hospi tal	PPS	
Cost (sum of col 2, 2, 3 and 4)	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
ANCILLARY SERVICE COST CENTERS			(from Wkst. C,		Ratio of Cost	Program	
ANCI LLARY SERVI CE COST CENTERS 50.00 5		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
ANCI LLARY SERVI CE COST CENTERS		col . 2, 3 and	8)	7)			
ANCILLARY SERVICE COST CENTERS							
50.00 05000 0FERATI NG ROOM 0 0 59, 580, 121 0.000000 0.000000 163, 341 50.00 51.00 05100 RECOVERY ROOM 0 0 52, 241, 580 0.000000 0.000000 20, 276 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 2, 843, 710 0.000000 0.000000 0.000000 47, 753 52.00 05300 AMESTHESI OLOGY 0 0 0.000000 0.000000 0.000000 0.53.00 05400 RADI OLOGY-DI AGNOSTI C 0 15, 969, 502 0.000000 0.000000 0.000000 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.55.00 0.54.02 0.56.00 0.54.02 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.56.00 0.000000 0.000000 0.000000 0.000000 0.56.00 0.56.00 0.000000 0.000000 0.000000 0.000000 0.56.00 0.000000 0.000000 0.000000 0.000000 0.56.00 0.0000000 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000		6. 00	7. 00	8. 00	9. 00	10. 00	
51.00 05100 RECOVERY ROOM 0 5, 241, 580 0.000000 0.000000 20, 276 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 2, 843, 710 0.000000 0.000000 47, 753 52.00 05300 ANESTHESI OLOGY 0 0.000000 0.000000 0.53.00 0.000000 0.000000 0.53.00 0.00000		_		1			
52.00 05200 DELI VERY ROM & LABOR ROOM 0 2,843,710 0.000000 0.000000 47,753 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 0.000000 0.53.00 53.00 54.01 05401 ULTRASOUND 0 0.000000 0.000000 0.54.01 0.000000 0.000000 0.000000 0.54.01 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0		0	1	•			
53. 00 05300 ANESTHESI OLOGY 0 0.000000 0.000000 0.000000 0.53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 15, 969, 502 0.000000 0.000000 101, 551 54.00 54. 01 05401 ULTRASOUND 0 0.000000 0.000000 0.54.01 54. 02 05402 ONCOLOGY 0 12, 691, 991 0.000000 0.000000 3.207 56.00 56. 00 05600 RADI OI SOTTOFE 0 7, 021, 252 0.000000 0.000000 3.207 56.00 57. 00 05700 CT SCAN 0 44, 603, 413 0.000000 0.000000 150, 127 57.00 58. 00 05800 MRI 0 12, 474, 059 0.000000 0.000000 315, 987 58.00 60. 00 06600 LABBORATORY 0 54, 819, 884 0.000000 0.000000 312, 987 60.00 65. 00 06500 RESPI RATORY THERAPY 0 12, 528, 768 0.000000	· · · · · · · · · · · · · · · · · · ·	0					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 15, 969, 502 0.000000 0.000000 0.000000 0.54.01 54. 00 54. 01 05401 ULTRASOUND 0 0.000000 0.000000 0.000000 0.54.01 54. 01 54. 02 05402 ONCOLOGY 0 12, 691, 991 0.000000 0.000000 0.000000 3, 207 56. 00 56. 00 05600 RADI OLOGY 0 7, 021, 252 0.000000 0.000000 0.000000 3, 207 56. 00 57. 00 05700 CT SCAN 0 44, 603, 413 0.000000 0.000000 0.000000 150, 127 57. 00 58. 00 05800 MRI 0 12, 474, 059 0.000000 0.000000 0.000000 312, 987 80.0 66. 00 60. 00 06000 LABORATORY 0 54, 819, 884 0.000000 0.000000 0.000000 34, 287 58. 00 65. 00 06500 PHYSI CAL THERAPY 0 7, 202, 524 0.000000 0.000000 0.000000 24, 241 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 7, 202, 524 0.000000 0.000000 0.000000 24, 241 66. 00 67. 00 06900 ELECTROCARDI OLOGY 0 150, 740 0.000000 0.000000 0.000000 2, 047 88.0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 0.000000 2, 148 891 72.0 71. 00 07200 IMPL. DEV. CHARGED TO PATI		0	2, 843, 710				
54. 01 05401 ULTRASOUND 0 0.000000 0.000000 0.000000 0.54. 01 54. 02 05402 0NCOLOGY 0 12,691,991 0.000000 0.000000 0.54. 02 56. 00 05600 RADI OI SOTOPE 0 7,021,252 0.000000 0.000000 3.207 56. 00 57. 00 05700 CT SCAN 0 44,603,413 0.000000 0.000000 150,127 57. 00 58. 00 05800 MRI 0 12,474,059 0.000000 0.000000 15,998 58. 00 60. 00 06500 LABORATORY 0 54,819,884 0.000000 0.000000 312,987 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 12,528,768 0.000000 0.000000 94,149 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 7,202,524 0.000000 0.000000 24,241 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 1,059,409 0		0	0			- 1	
54. 02 05402 05600 NCOLOGY 0 12, 691, 991 0 0.000000 0,000000 0.000000 0,000000 0.000000 3, 207 56, 00 56, 00 56, 00 56, 00 58, 00 60, · · · · · · · · · · · · · · · · · · ·	0	15, 969, 502					
56. 00 05600 RADI OI SOTOPE 0 7, 021, 252 0.000000 0.000000 3, 207 56. 00		0	0			0	
57. 00 05700 CT SCAN 0 44, 603, 413 0.000000 0.000000 150, 127 57. 00 58. 00 05800 MRI 0 12, 474, 059 0.000000 0.000000 15, 998 58. 00 60. 00 06000 LABORATORY 0 54, 819, 884 0.000000 0.000000 312, 987 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 12, 528, 768 0.000000 0.000000 94, 149 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 7, 202, 524 0.000000 0.000000 24, 241 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1, 059, 409 0.000000 0.000000 2, 110 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 150, 740 0.000000 0.000000 2, 047 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 6, 903, 251 0.000000 0.000000 21, 148 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 15, 565, 732 0.000000 0.00		0				0	
58. 00 05800 MRI MRI 0 12, 474, 059 MRI 0.000000 0.000000 15, 998 MRI 58. 00 60. 00 06000 LABORATORY 0 54, 819, 884 MRI 0.000000 0.000000 312, 987 MRI 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 12, 528, 768 MRI 0.000000 0.000000 94, 149 MRI 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 7, 202, 524 MRI 0.000000 0.000000 0.000000 24, 241 MRI 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1, 059, 409 MRI 0.000000 0.000000 0.000000 2, 110 MRI 66. 00 68. 00 06800 SPECH PATHOLOGY 0 150, 740 MRI 0.000000 0.000000 0.000000 2, 047 MRI 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 6, 903, 251 MRI 0.000000 0.000000 0.000000 21, 148 MRI 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 15, 565, 732 MRI 0.000000 0.000000 0.000000 18, 891 M		0					
60. 00		0					
65. 00		0					
66. 00 06600 PHYSI CAL THERAPY 0 7, 202, 524 0.000000 0.000000 24, 241 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 1, 059, 409 0.000000 0.000000 2, 110 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 150, 740 0.000000 0.000000 2, 047 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 6, 903, 251 0.000000 0.000000 21, 148 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 15, 236, 402 0.000000 0.000000 52, 165 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 565, 732 0.000000 0.000000 18, 891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 145, 337, 457 0.000000 0.000000 955, 952 73. 00 76. 01 03610 SLEEP LAB 0 0 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000		0					
67. 00 06700 0CCUPATI ONAL THERAPY 0 1,059,409 0.000000 0.000000 2,110 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 150,740 0.000000 0.000000 2,047 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 6,903,251 0.000000 0.000000 21,148 69. 00 0.000000 0.000000 21,148 69. 00 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000		0					
68. 00 06800 SPEECH PATHOLOGY 0 150, 740 0.000000 0.000000 2, 047 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 6, 903, 251 0.000000 0.000000 21, 148 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 15, 236, 402 0.000000 0.000000 52, 165 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 565, 732 0.000000 0.000000 18, 891 72. 00 73. 00 0.00000 0.000000 0.000000 955, 952 73. 00 76. 00 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000		0					
69. 00 06900 ELECTROCARDI OLOGY 0 6, 903, 251 0. 000000 0. 000000 21, 148 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 15, 236, 402 0. 000000 0. 000000 52, 165 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 565, 732 0. 000000 0. 000000 18, 891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 145, 337, 457 0. 000000 0. 000000 955, 952 73. 00 76. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 000		0					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 15, 236, 402 0.000000 0.000000 52, 165 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15, 565, 732 0.000000 0.000000 18, 891 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 145, 337, 457 0.000000 0.000000 955, 952 73. 00 76. 00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000		0					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15, 565, 732 0.000000 0.000000 18, 891 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 145, 337, 457 0.000000 0.000000 955, 952 73. 00 76. 00 0.3950 OTHER ANCILLARY SERVICE COST 0 0 0.000000 0.000000 0.000000 0.76. 00 76. 01 76. 03 0.3951 WOUND CARE 0 0 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	· · · · · · · · · · · · · · · · · · ·	0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 145, 337, 457 0 000000 0 000000 0 000000 0 76. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST 0 0 0 0 000000 0 000000 0 076. 00 03951 WOUND CARE 0 0 0 0 000000 0 0 000000		0	15, 236, 402				
76. 00		0					
76. 01 03610 SLEEP LAB 0 0 0 0 000000 0 000000 0 76. 01 76. 03 03951 WOUND CARE 0 0 0 0 000000 0 0 76. 03 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 4, 895, 688 0 000000 0 000000 2, 240 90. 00 91. 00 09100 EMERGENCY 0 29, 332, 279 0 000000 0 000000 104, 228 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 6, 584, 784 0 000000 0 000000 13, 807 92. 00		0	145, 337, 457			955, 952	
76. 03 03951 WOUND CARE 0 0 0 0 000000 0 000000 0		0	0			0	76. 00
OUTPATI ENT SERVICE COST CENTERS 0 4,895,688 0.000000 0.000000 2,240 90.00 91.00 09100 EMERGENCY 0 29,332,279 0.000000 0.000000 104,228 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 6,584,784 0.000000 0.000000 13,807 92.00	76. 01 03610 SLEEP LAB	0	0	0.000000	0. 000000	0	76. 01
90. 00 09000 CLI NI C 0 4,895,688 0.000000 0.000000 2,240 90.00 91.00 09100 EMERGENCY 0 29,332,279 0.000000 0.000000 104,228 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 6,584,784 0.000000 0.000000 13,807 92.00		0	0	0. 000000	0.000000	0	76. 03
91. 00 09100 EMERGENCY 0 29, 332, 279 0. 000000 0. 000000 104, 228 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 6, 584, 784 0. 000000 0. 000000 13, 807 92. 00							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 6, 584, 784 0.000000 0.000000 13, 807 92. 00	90. 00 09000 CLI NI C	0	4, 895, 688	0.000000	0. 000000	2, 240	90.00
		0		•			
200. 00 Total (lines 50-199) 0 460, 042, 546 2, 106, 218 200. 00		0		•	0. 000000		
	200.00 Total (lines 50-199)	0	460, 042, 546			2, 106, 218	200. 00

TIROUGH COSTS				To 02/28/2017	Date/Time Pre 7/31/2017 3:	epared: 14 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS	T		T	T		
50.00 05000 OPERATING ROOM	0	C)	0		50. 00
51.00 05100 RECOVERY ROOM	0	C)	0		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	C)	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0		54. 00
54. 01 05401 ULTRASOUND	0	C)	0		54. 01
54. 02 05402 0NCOLOGY	0	C)	0		54. 02
56. 00 05600 RADI 0I SOTOPE	0	C)	0		56. 00
57. 00 05700 CT SCAN	0	C)	0		57. 00
58. 00 05800 MRI	0	C)	0		58. 00
60. 00 06000 LABORATORY	0	C)	0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C)	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST	0	C)	0		76. 00
76. 01 03610 SLEEP LAB	0	C)	0		76. 01
76. 03 03951 WOUND CARE	0	C)	0		76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C)	0		90. 00
91. 00 09100 EMERGENCY	0	C		0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	O	C)	o		200. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0133	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			<u>-</u>	Period: From 03/01/2016 Fo 02/28/2017	Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 pm					
			Titl	e XIX	Hospi tal	PPS				
				Charges		Costs				
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services				
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)				
			inst.)	Servi ces	Services Not					
				Subject To	Subject To					
				Ded. & Coins.						
				(see inst.)	(see inst.)					
		1.00	2.00	3. 00	4. 00	5. 00				
	ANCI LLARY SERVI CE COST CENTERS									
	05000 OPERATING ROOM	0. 084197	0) (240, 927	0				
	05100 RECOVERY ROOM	VERY ROOM 0. 262571 0) (29, 407	0	0 00			
	05200 DELIVERY ROOM & LABOR ROOM	0. 375589	0)	9, 585	0	52. 00			
53.00	05300 ANESTHESI OLOGY	0. 000000	0)	0	0	53. 00			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 285653) (282, 212	0	54. 00			
54. 01	05401 ULTRASOUND	0. 000000	0)	0	0	54. 01			
54.02	05402 ONCOLOGY	0. 240618	0) (88, 492	0	54. 02			
56.00	05600 RADI 0I S0T0PE	0. 075211	0) (41, 934	0	56.00			
57.00	05700 CT SCAN	0. 018867	0) (578, 844	0	57. 00			
58. 00	05800 MRI	0. 045481	0) (97, 069	0	58. 00			
60.00	06000 LABORATORY	0. 090828	0)	581, 500	0	60.00			
65. 00	06500 RESPI RATORY THERAPY	0. 094656	0)	64, 016	0	65. 00			
66.00	06600 PHYSI CAL THERAPY	0. 457909	0		40, 020	0	66.00			
67.00	06700 OCCUPATI ONAL THERAPY	0. 265209	0		5, 846	0	67.00			
68.00	06800 SPEECH PATHOLOGY	0. 212883	0		1, 997	0	68. 00			
69.00	06900 ELECTROCARDI OLOGY	0. 053289	0		43, 548	0	69.00			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 045122	0		58, 373		71.00			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 183361	0		7, 823	0	72.00			
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 071868	0		659, 402	0	73.00			
	03950 OTHER ANCILLARY SERVICE COST	0. 000000			0	0	76.00			
	03610 SLEEP LAB	0. 000000	l .		0	0	76. 01			
	03951 WOUND CARE	0. 000000			0	0	1			
	OUTPATIENT SERVICE COST CENTERS				-					
	09000 CLI NI C	0. 225784	0		35, 047	0	90.00			
	09100 EMERGENCY	0. 131718	l .	,	631, 727	0	91.00			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 257998	l .	,	78, 833	0	1			
200.00	Subtotal (see instructions)		0		3, 576, 602		200. 00			
201. 00	Less PBP Clinic Lab. Services-Program	1			0		201. 00			
	Only Charges]						
202.00	Net Charges (line 200 +/- line 201)		0		3, 576, 602	0	202. 00			

Health Financial Systems	KOSCI USKO COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 pm

				To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0					50.00
51.00 05100 RECOVERY ROOM	0	7, 721	1			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 600	1			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	80, 615				54.00
54. 01 05401 ULTRASOUND	0	0				54. 01
54. 02 05402 ONCOLOGY	0	21, 293				54. 02
56. 00 05600 RADI 0I SOTOPE	0	3, 154				56. 00
57. 00 05700 CT SCAN	0	10, 921				57. 00
58. 00 05800 MRI	0	4, 415				58. 00
60. 00 06000 LABORATORY	0	52, 816				60.00
65. 00 06500 RESPI RATORY THERAPY	0	6, 059	1			65.00
66. 00 06600 PHYSI CAL THERAPY	0	18, 326				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 550	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	425				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 321	İ			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 634				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 434				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	47, 390	1			73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST	0	0	1			76. 00
76. 01 03610 SLEEP LAB	0	0				76. 01
76. 03 03951 WOUND CARE	0	0	1			76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	7, 913				90.00
91. 00 09100 EMERGENCY	0	83, 210				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	20, 339				92.00
200.00 Subtotal (see instructions)	0	396, 421				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	396, 421				202. 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0133	Peri od: From 03/01/2016	Worksheet D-1	
			Date/Time Pre 7/31/2017 3:1	pared: 4 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

			Title XVIII	Hospi tal	PPS	
Impatient days (Including private room days and saing-bed days, excluding newtorn) 10,008 1,00		Cost Center Description			1 00	
Inpart Int Int No. Inpart int days (including pri vate room days and seting-bed days; excluding neaborn) 10,088 1.0 Inpart int days (including pri vate room days, sexcluding seting-bed and neaborn days) 10,088 2.0 10,088 2.0 10,088 2.0 10,088 2.0 10,088 2.0 10,088 2.0 2		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpartient days (Including private room days, excluding swing-bed and newborn days) 10,968 2,00						
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,461,017 41.00		,	-		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 461, 017	41.00

	Financial Systems TATION OF INPATIENT OPERATING COST	KOSCI USKO COMMUN	Provider C	CN: 15-0133	Period:	wof Form CMS-2 Worksheet D-1	
OOWII- U I	ALLOW OF THE ATTENT OF ENATING COST		1. Ovider C	UI4. 1J-U1JJ	From 03/01/2016		
					To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatrent bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit	2, 639, 864	1, 540	1, 714.	20 629	1, 078, 232	43. 00
44. 00	CORONARY CARE UNIT	2, 039, 004	1, 540	1, 714	20 029	1, 076, 232	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	I control of the cont						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			4, 749, 523	48. 00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(s	ee instructio	ons)		8, 288, 772	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS	anationt routing o	and one (from	Wka+ D au	m of Donto L and	511, 387	F0 00
50. 00	Pass through costs applicable to Program in	ipatrent routine s	services (iron	I WKSt. D, Sui	ii or Parts r and	511, 387	50.00
51. 00	Pass through costs applicable to Program in	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	309, 925	51.00
FO 5-	and IV)	F0 1.53				20.5	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		ated non nh	eician anac+	natist and	821, 312 7, 467, 460	
JJ. UU	medical education costs (line 49 minus line		ateu, non-pny	sician anesti	ictist, dilu	7,407,400	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					1
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					l e	55. 00 56. 00
57. 00	,	ating cost and tar	get amount (I	ine 56 minus	line 53)		
58. 00	Bonus payment (see instructions)	g	g (.			0	
59. 00	Lesser of lines 53/54 or 55 from the cost i	reporting period e	endi ng 1996, ι	ipdated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	r cost report line	lated by the m	arket hasket		0.00	60.00
61. 00	1				the amount by	0.00	
	which operating costs (line 53) are less the		(lines 54 x	60), or 1% of	f the target ´		
42.00	amount (line 56), otherwise enter zero (see	e instructions)				0	62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	vment (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	,	, , , , , , , , , , , , , , , , , , , ,				
64. 00		osts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after Decembe	or 31 of the d	ost renortino	nerind (See	0	65. 00
00.00	instructions)(title XVIII only)	osts arter becombe	or or the c	ost reperting	g perrou (occ		00.00
66. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	no costs through	Docombor 21 o	of the cost re	operting period	0	67. 00
07.00	(line 12 x line 19)	The costs through	becember 31 c	i the cost is	eporting period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)	·	! /7 !:				(0.00
69.00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0	69. 00
70. 00	Skilled nursing facility/other nursing faci)		70. 00
71. 00	Adjusted general inpatient routine service		ne 70 ÷ line	2)			71. 00
72.00			(1: 14 1:	25)			72.00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
	26, line 45)						
76.00	Per diem capital related costs (line 75 ÷ 1						76. 00 77. 00
77. 00 78. 00	Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min						78.00
79. 00	Aggregate charges to beneficiaries for exce		ovi der record	ls)			79. 00
	Total Program routine service costs for cor	•	st limitation	ı (line 78 miı	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lin Inpatient routine service cost limitation						81. 00 82. 00
83. 00	Reasonable inpatient routine service cost	*					83.00
84. 00	Program inpatient ancillary services (see i	•	•				84.00
85. 00	Utilization review - physician compensation						85.00
86. 00			ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PART Total observation bed days (see instruction					2, 151	87. 00
	, ·		lino 2)			l	88. 00
88. 00	Adjusted general impatrent routine cost per	arem (True 27 +	11116 2)			/ 09. 00	00.00

Health Financial Systems	KOSCIUSKO COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 03/01/2016 To 02/28/2017	Date/Time Prep 7/31/2017 3:14	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 342, 451	8, 615, 174	0. 15582	4 1, 698, 860	264, 723	90.00
91.00 Nursing School cost	0	8, 615, 174	0.00000	1, 698, 860	0	91.00
92.00 Allied health cost	0	8, 615, 174	0.00000	1, 698, 860	0	92.00
93 00 All other Medical Education	0	8 615 174	0.00000	1 698 860	0	93 00

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0133	Peri od: From 03/01/2016		
		To 02/28/2017	Date/Time Pre 7/31/2017 3:1	pared: 4 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				1

	Title XIX	Hospi tal	PPS	
	Cost Center Description		4.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days, excluding newbor	n)	10, 908	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days,		10, 908	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have or	nly private room days,	0	3. 00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8, 757	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through De	ecember 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Dece	omher 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	singer or or the cost		0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through Dec	cember 31 of the cost	0	7. 00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after Decem	nber 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)		4 000	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excl newborn days)	uding swing-bed and	1, 080	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including priv	vate room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	ate room days)		10.00
11. 00		vate room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line			
12. 00		orivate room days)	0	12. 00
12 00	through December 31 of the cost reporting period	univers many days)	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including pafter December 31 of the cost reporting period (if calendar year, enter 0 on thi		0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing		0	14. 00
15. 00		,,	969	15. 00
16.00	Nursery days (title V or XIX only)		435	16. 00
	SWI NG BED ADJUSTMENT			
17. 00		31 of the cost	0.00	17. 00
10.00	reporting period	11 -6 +1	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 3 reporting period	31 of the cost	0.00	18. 00
19. 00		31 of the cost	0.00	19. 00
	reporting period	0. 0. 1 3001	0.00	. , , , ,
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31	of the cost	0.00	20. 00
	reporting period			
21. 00			8, 615, 174	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost $r = 5 \times 1$ ine 17)	reporting period (line	0	22. 00
23. 00	,	porting period (line 6	0	23. 00
20.00	x line 18)	ter tring period (initial)		20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost re	eporting period (line	0	24.00
	7 x line 19)			
25. 00] 3 11	orting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)		0	26. 00
27. 00	· · · · · · · · · · · · · · · · · · ·	26)	8, 615, 174	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	. 20)	0,010,171	27.00
28. 00		oed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	29. 00
30. 00			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32. 00 33. 00			0. 00 0. 00	32. 00 33. 00
34. 00		etructions)	0.00	34. 00
35. 00		.5 40 6115)	0.00	35. 00
36. 00			0	36. 00
37. 00	· · · · · · · · · · · · · · · · · · ·	st differential (line	8, 615, 174	37. 00
	27 minus line 36)	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		700.00	20 00
38. 00 39. 00			789. 80 852, 984	38. 00 39. 00
40. 00		35)	032, 964	40. 00
41. 00		/	852, 984	

	Financial Systems ATION OF INPATIENT OPERATING COST	KOSCIUSKO COMMU	NITY HOSPITAL Provider C	^N: 15_0133	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COIVIPUI	ALION OF INFALLENT OFFICALING COST		Trovider C		From 03/01/2016		
					To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Innationt Days	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent cost	inpatrent bays	col. 2)		4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	402, 153	969	415. 0	2 435	180, 534	42.00
43. 00	INTENSIVE CARE UNIT	2, 639, 864	1, 540	1, 714. 2	0 229	392, 552	43.00
44. 00	CORONARY CARE UNIT	2,007,001	.,	.,,		0,2,002	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	oost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					212, 702	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ns)		1, 638, 772	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	patient routine	services (from	ı Wkst D sum	of Parts L and	194, 267	50.00
00.00		atrent reatine	301 11 003 (11 011	mot. b, sam	or rares r and	171,207	00.00
51. 00	Pass through costs applicable to Program inc	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	14, 744	51.00
E2 00	and IV)	EO and E1)				200 011	52.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	209, 011 1, 429, 761	
	medical education costs (line 49 minus line					.,,]
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56.00
57. 00	, ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)		l' 4007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996, u	ipaatea ana coi	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	Thisti detrons)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	to theorem Door	mbox 21 of the	annt mananti	na naniad (Caa	0	(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through bece	iliber 31 of the	cost reporti	ng period (see	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions) (title XVIII only)	no costo (lino	(4 plug lips (E) (+: +1 o V)///	l anly) Fan		// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (iine	o4 prus rine d	os)(title xvii	i oniy). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 c	of the cost re	porting period	0	67. 00
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after D	ecember 31 or	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70.00
71.00	Program routine service cost (line 9 x line		THE 70 + TIME	2)			72.00
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from W	lorksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
78. 00	1 '			1->			78.00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp			. (70 111111	, , ,		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00							86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00	Total observation bed days (see instructions	•	Line 2)			2, 151	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)			789. 80 1, 698, 860	88.00
57.00	lopacing tion ped coat (Time of X Time 00) (26	e matructions)				1, 070, 000	1 09.00

Health Financial Systems	KOSCI USKO COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 03/01/2016	Worksheet D-1	
				To 02/28/2017	Date/Time Prep 7/31/2017 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 342, 451	8, 615, 174	0. 15582	4 1, 698, 860	264, 723	90.00
91.00 Nursing School cost	0	8, 615, 174	0.00000	0 1, 698, 860	0	91.00
92.00 Allied health cost	0	8, 615, 174	0.00000	0 1, 698, 860	0	92.00
93.00 All other Medical Education	0	8, 615, 174	0.00000	0 1, 698, 860	0	93.00

NPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0133	Peri od:	Worksheet D-3	
				From 03/01/2016 To 02/28/2017	Date/Time Pre	narec
					7/31/2017 3: 1	
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges		Program Costs (col. 1 x col.	
				Chai ges	2)	
			1.00	2. 00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			7, 536, 824		30.
	O INTENSIVE CARE UNIT			2, 330, 873		31.
	0 NURSERY					43.
	LLARY SERVICE COST CENTERS		0.0044	4 000 700	444 700	
	O OPERATING ROOM		0. 0841	· · · · · ·	411, 790	
	0 RECOVERY ROOM 0 DELIVERY ROOM & LABOR ROOM		0. 2625 0. 3755		109, 149 0	
	O ANESTHESI OLOGY		0. 0000		0	•
	O RADI OLOGY-DI AGNOSTI C		0. 2856		460, 353	54.
	1 ULTRASOUND		0.0000		0	
	2 ONCOLOGY		0. 2406		5, 890	
6. 00 0560	O RADI OI SOTOPE		0. 0752	11 250, 091	18, 810	56.
7. 00 0570	OCT SCAN		0. 0188		65, 817	57.
8. 00 0580			0. 0454		18, 908	
	0 LABORATORY		0. 0908	· · · · · ·	540, 730	
	O RESPI RATORY THERAPY		0. 0946		366, 041	65.
	O PHYSI CAL THERAPY		0. 4579	· ·	221, 215	
	O OCCUPATI ONAL THERAPY		0. 2652		10, 534	
	O SPEECH PATHOLOGY O ELECTROCARDI OLOGY		0. 2128 0. 0532		8, 785 95, 989	
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0332		88, 062	
	O I MPL. DEV. CHARGED TO PATIENTS		0. 1833		630, 221	72.
	O DRUGS CHARGED TO PATIENTS		0. 0718		1, 190, 214	•
	O OTHER ANCILLARY SERVICE COST		0.0000		0	
	O SLEEP LAB		0.0000	00	0	76.
	1 WOUND CARE		0.0000	00	0	76.
	AȚIENT SERVICE COST CENTERS					
0.00 0900			0. 2257	· ·	28, 064	
	O EMERGENCY		0. 1317	,	312, 791	
	O OBSERVATI ON BEDS (NON-DISTINCT PART		0. 2579		166, 160	
00. 00 01. 00	Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges	(line (1)		48, 375, 467	4, 749, 523	
OT UU	THESS PER CLUME LADORATORY SERVICES-PROGRAM ONLY CHARGES	. (LIDE 61)	1	0		201.

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 03/01/2016 To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			340, 954		30.00
31. 00 03100 NTENSI VE CARE UNIT			184, 976		31.00
43. 00 04300 NURSERY			66, 420		43.00
ANCI LLARY SERVI CE COST CENTERS			00, 420		75.00
50. 00 05000 OPERATING ROOM		0. 08419	7 163, 341	13, 753	50.00
51. 00 05100 RECOVERY ROOM		0. 26257		5, 324	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 37558		17, 936	
53. 00 05300 ANESTHESI OLOGY		0. 00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28565	3 101, 551	29, 008	54.00
54. 01 05401 ULTRASOUND		0.00000	0 0	0	54. 01
54. 02 05402 ONCOLOGY		0. 24061	8 0	0	54. 02
56. 00 05600 RADI OI SOTOPE		0. 07521	1 3, 207	241	56.00
57. 00 05700 CT SCAN		0. 01886		2, 832	
58. 00 05800 MRI		0. 04548		728	
60. 00 06000 LABORATORY		0. 09082		28, 428	
65. 00 06500 RESPI RATORY THERAPY		0. 09465			
66. 00 06600 PHYSI CAL THERAPY		0. 45790		11, 100	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26520		560	
68. 00 06800 SPEECH PATHOLOGY		0. 21288		436	
69. 00 06900 ELECTROCARDI OLOGY		0. 05328		1, 127	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 04512		2, 354	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 18336		3, 464	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 07186		68, 702	
76. 00 03950 OTHER ANCILLARY SERVICE COST		0.00000		0	76.00
76. 01 03610 SLEEP LAB 76. 03 03951 WOUND CARE		0. 00000 0. 00000		0	76. 01 76. 03
OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	1 /0.03
90. 00 09000 CLINI C		0. 22578	2, 240	506	90.00
91. 00 09100 EMERCENCY		0. 22370 0. 13171			

2, 240 104, 228

13, 807 2, 106, 218

2, 106, 218

91.00

201. 00 202. 00

3, 562 92. 00 212, 702 200. 00

13, 729

0. 131718

0. 257998

91. 00 09100 EMERGENCY

201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

Health Financial Systems	KOSCIUSKO COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet E Part A Date/Time Prepared: 7/31/2017 3:14 pm

			10 02/28/2017	7/31/2017 3: 1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see	0 4, 083, 033	1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurri</pre>	ng on or after October	1 (see	2, 794, 658	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCL for	or discharges occurring	prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	0		0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)	or ar senar ges securiting		40, 105	2. 00
2.00	Outlier reconciliation amount			40, 103	2.00
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments	,		4, 615, 639	3. 00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instru	ctions)	66. 11	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	0.00	5. 00
6. 00	or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs which meet			0. 00	6. 00
	for new programs in accordance with 42 CFR 413.79(e)		·		
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(f) under 42 CFR §412.105(f	(1) (1 V) (B) (1)) (1) (i V) (B) (2)	0. 00 0. 00	7. 00 7. 01
8. 00	If the cost report straddles July 1, 2011 then see instruction Adjustment (increase or decrease) to the FTE count for allopa		grams for	0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.1998), and 67 FR 50069 (August 1, 2002).		9		
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under section 5503 o	f the ACA. If	0.00	8. 01
8. 02	the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (see	0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre			0. 00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	sire year o year eee.			11. 00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0. 00	13.00
14. 00	Total allowable FTE count for the penultimate year if that yes otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside		ec. 412.105	0.00	23. 00
24 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			0.00	24.00
24. 00 25. 00	If the amount on line 24 is greater than -O-, then enter the	ower of line 23 or line	24 (see		24. 00 25. 00
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	1
28. 00	IME add-on adjustment amount (see instructions)			0	
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	•
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		0 0	29. 00 29. 01
	Di sproporti onate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atrent days (see instruc	tions)	2. 12	•
31.00	Percentage of Medicaid patient days (see instructions)			17. 58	•
32.00	Sum of lines 30 and 31			19. 70 5. 56	•
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	,		5. 56 95, 600	•
5 1. 00	15. 5p. 5ps. tronate share day astmont (See That detrons)		l	75, 500	0 1. 00

CALCIII	Financial Systems KOSCIUSKO COMMUNITATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Peri od:	eu of Form CMS-2 Worksheet E	2002-1
CALCUL	ATTOW OF REIMBORSEMENT SETTEEMENT	Trovider con. 13-0133	From 03/01/2016 To 02/28/2017		
		Title XVIII	Hospi tal	PPS	4 piii
			Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147] 35. 0
35. 00	Factor 3 (see instructions)		0. 000070003		
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent (see instructions)	er zero on this line)	448, 449	l e	
35. 03	Pro rata share of the hospital uncompensated care payment amo	unt (see instructions)	262, 208	168, 966	35. C
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		431, 174		36.0
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		 40. C
40. 00	652, 682, 683, 684 and 685 (see instructions)	ui schai ges Toi M3-DRGS	0		40. 0
			Before 1/1	On/After 1/1	
			1. 00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs $$ 652, $$ 682, $$ 6 instructions)	83, 684 an 685. (see	0	0	41.0
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-an 685. (see instructions)	DRGs 652, 682, 683, 684	0	0	41. C
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42. C
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by /	0. 000000		44.0
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00	0.00	45. 0
	Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)	. 01)	7 444 570		46. (
47. 00 48. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	7, 444, 570		47. 0 48. 0
	only. (see instructions)		_		
				Amount	
				1 00	
49. 00	Total payment for inpatient operating costs (see instructions)		1. 00 7, 444, 570	49.0
	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)			50.0
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.	d Pt. II, as applicable) III, see instructions)		7, 444, 570 555, 848 0	50. 0 51. 0
50. 00 51. 00 52. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii	d Pt. II, as applicable) III, see instructions)		7, 444, 570 555, 848 0 0	50. 0 51. 0 52. 0
50. 00 51. 00 52. 00 53. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.	d Pt. II, as applicable) III, see instructions)		7, 444, 570 555, 848 0	50. 0 51. 0 52. 0 53. 0
50. 00 51. 00 52. 00 53. 00 54. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	d Pt. II, as applicable) III, see instructions) ne 49 see instructions).		7, 444, 570 555, 848 0 0 0 0	50. (51. (52. (53. (54. (54. (
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9)		7, 444, 570 555, 848 0 0 0 0 0	50. 0 51. 0 52. 0 53. 0 54. 0 54. 0
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions)	brough 35)	7, 444, 570 555, 848 0 0 0 0 0 0	50. (51. (52. (53. (54. (54. (55. (
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0 0 0	50. (51. (52. (53. (54. (54. (55. (56. (57. (
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0	50. 0 51. 0 52. 0 53. 0 54. 0 55. 0 56. 0 57. 0
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0	50. 0 51. 0 52. 0 53. 0 54. 0 55. 0 56. 0 57. 0 58. 0 59. 0
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452	50. (51. (52. (53. (54. (55. (56. (57. (58. (60. (61. (
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124	50. (51. (52. (53. (54. (55. (57. (58. (59. (60. (61. (62. (
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566	50. (651. (6
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50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 64. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566 52, 108 33, 870 10, 112 6, 997, 632 0 0	50.0 51.0 52.1 53.0 54.1 55.0 56.1 57.1 60.0 62.1 63.0 64.0 64.0 64.0 67.0 68.1 69.0 70.0
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 50 70. 88 70. 89 70. 90	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566 52, 108 33, 870 10, 112 6, 997, 632 0 0 0 0	50. C 51. C 52. C 53. C 54. C 55. C 65. C 65. C 63. C 64. C 63. C 64. C 65. C 67. C 68. C 69. C 70. E 70. E 70. E 70. C 70. E 70. C 70. E 70. C
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 58 70. 88 70. 90 70. 91	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566 52, 108 33, 870 10, 112 6, 997, 632 0 0 0 0 0	50. C C 51. C 52. C 53. C 54. C 55. C 55. C 55. C 55. C 60. C 63. C 64. C 63. C 64. C 65. C 66. C 67.
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 70. 50 70. 88 70. 90 70. 91 70. 92	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRP adjustment amount (see instructions)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566 52, 108 33, 870 10, 112 6, 997, 632 0 0 0 0 0	50. C C 51. C 52. C 53. C 54. C 55. C 55. C 55. C 55. C 60. C 63. C 64. C 65. C 67. C 58. C 67. C 58. C 67. C 58. C 67. C 58. C 67. C 58. C 69. C 67. C 58. C 69.
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 66. 00 67. 00 68. 00 69. 00 60. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 70 70. 70	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 9) uctions) II, column 9, lines 30 t IV, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	7, 444, 570 555, 848 0 0 0 0 0 0 0 0 0 8, 000, 418 9, 966 7, 990, 452 1, 013, 124 13, 566 52, 108 33, 870 10, 112 6, 997, 632 0 0 0 0 0	50. CC 51. CC 52. CC 53. CC 55. CC 55. CC 55. CC 55. CC 55. CC 60. CC 63. CC 64. CC 65. CC 67. CC 68. CC 70

Heal tr	Financial Systems KOSCIUSKO COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0133	Peri od: From 03/01/2016	Worksheet E	
				To 02/28/2017	Part A Date/Time Pre	pared:
				02, 20, 201,	7/31/2017 3: 1	
		Title	XVIII	Hospi tal	PPS	
			FFY	/ (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97		in column 0		0	0	70. 97
70.00	the corresponding federal year for the period ending on or a	rter 10/1)			0	70.00
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)	(0 + 70)			0	1 . 0
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			6, 959, 173	
71. 01	Sequestration adjustment (see instructions)				139, 183	
72.00					6, 808, 837	
	Tentative settlement (for contractor use only)				0	
74.00					11, 153	
75. 00	Protested amounts (nonallowable cost report items) in accord	ance with			1, 268, 322	/5.00
	CMS Pub. 15-2, chapter 1, §115.2					
00 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	-4	1		0	00 00
90. 00 91. 00		structions)			0	
		ruoti onol			-	
92. 00 93. 00	, ,				0	
	The rate used to calculate the time value of money (see instru				0. 00	
95.00	,				0.00	
95. 00 96. 00					0	
96.00	Trille value of morey for capital ferated expenses (see fristru	CTI OHS)		Prior to 10/1		90.00
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	_
100 00	HSP bonus amount (see instructions)			0	0	100.00
.00.0	HVBP Adjustment for HSP Bonus Payment			٩,		
101.00	HVBP adjustment factor (see instructions)			0.0000000000	0.000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0		102.00
. 52. 0	HRR Adjustment for HSP Bonus Payment	/		<u> </u>		1.32.30
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instruction			0		104. 00

Health Financial Systems	KOSCIUSKO COMMUNITY	Y HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet E Part B Date/Time Prepared: 7/31/2017 3:14 pm
•		Title XVIII	Hospi tal	PDS

			To 02/28/2017	Date/Time Pre 7/31/2017 3:1	
		Title XVIII	Hospi tal	PPS	<u> </u>
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			2, 320	1. 00
2. 00	Medical and other services reimbursed under OPPS (see instructions)	tions)		5, 957, 124	1
3. 00	PPS payments	,		5, 108, 495	1
4.00	Outlier payment (see instructions)			13, 245	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 12 lino 200		0 0	8. 00 9. 00
10. 00	Organ acquisitions	v, cor. 13, Trile 200		0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 320	
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonabl e charges				
12.00	Ancillary service charges	(0)		31, 299	1
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 31, 299	
14.00	Customary charges			31, 299	14.00
15. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)	-		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
18. 00	Total customary charges (see instructions)	: 6 ! 10	11) /	31, 299	•
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y IT ITHE 18 exceeds IT	ne II) (see	28, 979	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		2, 320	1
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	suctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		5, 121, 740	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			5, 892	•
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	· ·	221 /	1, 050, 844	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions	orus the sum of lines 22	and 23] (See	4, 067, 324	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			4, 067, 324	1
31.00	Primary payer payments			4, 167	ı
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	res)		4, 063, 157	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33.00
34.00	Allowable bad debts (see instructions)			145, 579	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			94, 626	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		102, 299	1
	Subtotal (see instructions)			4, 157, 783	
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	•	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	·	0	39. 99
40.00	Subtotal (see instructions)			4, 157, 783	40. 00
40. 01	Sequestration adjustment (see instructions)			83, 156	1
41. 00	Interim payments			4, 131, 097	1
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -56, 470	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	chanter 1	-30, 470	1
11.00	§115. 2	100 W 11 0M0 1 ub. 10 2,	chapter 1,	Ŭ	11.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	•
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	•
	1		l	,	

Health Financial Systems KOSCIU
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0133

					7/31/2017 3: 14	1 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		6, 734, 02		3, 980, 400	1. 00
2.00	Interim payments payable on individual bills, either		41, 41		83, 397	2. 00
	submitted or to be submitted to the contractor for		,			
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/19/2016	33, 40	0 08/19/2016	67, 300	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3. 05
	Provider to Program		<u>'</u>	<u>'</u>		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				o	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		33, 40	o	67, 300	3. 99
	3. 50-3. 98)		·		·	
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		6, 808, 83	7	4, 131, 097	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)					,
6. 01	SETTLEMENT TO PROVIDER		11, 15		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	56, 470	6. 02
7. 00	Total Medicare program liability (see instructions)		6, 819, 99		4, 074, 627	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	0.00
0.00	Name of Contractor				1	8. 00

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu					2552-10	
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0133 Period: Wor From 03/01/2016 Par To 02/28/2017 Dat 7.73					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	J				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		2 14	3, 309	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		3, 745	2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 547	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		10, 297	4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			502, 776, 811	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		1, 476, 652	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00	
9.00	Sequestration adjustment amount (see instructions)			0	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	000 Palanas dua providar (lina 0 (an lina 10) minus lina 20 and lina 21) (assinatrustions)					

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

0 30.00 0 31.00 0 32.00

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

Provi der CCN: 15-0133

Peri od: From 03/01/2016 To 02/28/2017 Date/Ti me Prepared: 7/31/2017 3:14 pm

OH y)					7/31/2017 3:1	4 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-431, 929		0		
2.00	Temporary investments	0	0	0		1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	20, 383, 853	0	0	0	3. 00 4. 00
5.00	Other receivable	20, 363, 633		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-4, 158, 967	1	0	Ö	
7.00	Inventory	1, 770, 436		0	0	
8.00	Prepai d expenses	944, 587		0	0	
9.00	Other current assets	155, 171		0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	18, 663, 151	0	0	0	11. 00
12. 00	Land	2, 360, 405	0	0	0	12. 00
13. 00	Land improvements	1, 127, 407		0	-	13. 00
14. 00	Accumul ated depreciation	-774, 126	1	0		14. 00
15. 00	Bui I di ngs	25, 520, 672	. 0	0	0	15. 00
16.00	Accumulated depreciation	-7, 072, 715	0	0	0	16. 00
17. 00	Leasehold improvements	14, 332, 674	1	0	0	17. 00
18.00	Accumulated depreciation	-5, 147, 798		0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	2, 300, 861	•	0	0	19.00
20.00	Automobiles and trucks	-1, 512, 067 154, 026	1	0		20.00
22. 00	Accumulated depreciation	-110, 914	1	0	0	22.00
23. 00	Major movable equipment	22, 662, 261	1	0	Ö	23. 00
24. 00	Accumulated depreciation	-15, 490, 091	1	0	Ō	24. 00
25.00	Mi nor equi pment depreci abl e	5, 173, 141	0	0	0	25. 00
26. 00	Accumulated depreciation	-4, 097, 007	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Minor equipment-nondepreciable	20 424 720	0	0	1	29. 00 30. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	39, 426, 729	1 0	U	0	30.00
31. 00	Investments	1 0	0	0	0	31.00
32. 00	Deposits on Leases	0	Ö	0	1	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	3, 848, 577	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	3, 848, 577	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	61, 938, 457	'] 0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	2, 038, 135	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 631, 497		0	1	38.00
39. 00	Payrol Laxes payable	2,031,477		0	Ö	
40. 00	Notes and Loans payable (short term)	0	Ö	0	Ō	
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	-338, 882, 683	1	0	0	
44. 00	Other current liabilities	1, 624, 945	1		0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	-332, 588, 106	0	0	0	45. 00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable	200, 000		0	1	
48. 00	Unsecured Loans	0	0	0	l	
49.00	Other long term liabilities	1, 895, 936	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2, 095, 936	1			
51. 00	Total liabilities (sum of lines 45 and 50)	-330, 492, 170	0	0	0	51.00
F0 00	CAPITAL ACCOUNTS	1 200 400 (07			I	F0 00
52.00	General fund balance	392, 430, 627	0			52. 00 53. 00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	392, 430, 627		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	61, 938, 457	0	0	0	60.00
	· · /	I	I		I	I

Health Financial Systems KOSCIUSKO COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0133
Period:
From 03/01/2016
To 02/28/2017
Date/Time Prepared:
7/31/2017 3: 14 pm

					То	02/28/2017	Date/Time Prep 7/31/2017 3:14	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		359, 268, 231			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33, 162, 396					2. 00
3.00	Total (sum of line 1 and line 2)		392, 430, 627			0		3.00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00
7. 00 8. 00					0		0	7. 00 8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		392, 430, 627			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	0,2, 100, 02,		0	ŭ	0	12. 00
13. 00	, (, (, (, (o			0		o	13. 00
14.00		0			0		0	14.00
15.00		0			0		0	15.00
16.00		0			0		0	16.00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		392, 430, 627			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	_						2. 00
3.00	Total (sum of line 1 and line 2)	0	0		0			3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6.00			0					6. 00
7. 00			0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)	o			0			10. 00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15. 00			0					15. 00
16.00			0					16.00
17. 00	Total deductions (our of lines 12 17)		O					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
17.00	sheet (line 11 minus line 18)				J			17.00
	10.100 (11.110 11.1111100 10)	ı I			1		ı	

Health Financial Systems KO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0133

			10 02/28/201/	7/31/2017 3:14	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	39, 012, 36	7	39, 012, 367	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	1		0	5. 00
6.00	Swing bed - NF	1		0	6. 00
7. 00	SKILLED NURSING FACILITY			_	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)	39, 012, 36	7	39, 012, 367	10.00
	Intensive Care Type Inpatient Hospital Services	07/012/00		07/012/007	
11. 00	INTENSIVE CARE UNIT	3, 721, 89	3	3, 721, 898	11. 00
12. 00	CORONARY CARE UNIT	, , , , , , , ,		27 . = . 7 2 . 2	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL I NTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	3, 721, 89	3	3, 721, 898	16. 00
10.00	11-15)	0,721,07	1	0, 721, 070	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	42, 734, 26	5	42, 734, 265	17. 00
18. 00	Ancillary services	126, 561, 96		419, 229, 795	18. 00
19. 00	Outpati ent servi ces	8, 487, 59		40, 812, 751	19. 00
20. 00	RURAL HEALTH CLINIC	0,407,37		40, 012, 731	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		1	0	21. 00
22. 00	HOME HEALTH AGENCY	'		U	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)			0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 177, 783, 82	324, 992, 990	-	28. 00
20.00	G-3, line 1)	177,703,02	324, 772, 770	302, 770, 011	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		69, 792, 916		29. 00
30. 00	ADD (SPECIFY)		0 07,772,710		30.00
31. 00	(SI ESTITY)		ol l		31. 00
32. 00					32. 00
33. 00			ol l		33. 00
34. 00					34. 00
35. 00			ol l		35. 00
36. 00	Total additions (sum of lines 30-35)	,	ا		36. 00
37. 00	DEDUCT (SPECIFY)	1			37. 00
38. 00	DEDUCT (SI ECTIT)				38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
41.00	Total deductions (sum of lines 37-41)	1	ر ا		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer	69, 792, 916		43. 00
45.00	to Wkst. G-3, line 4)	3101	07, 172, 710		73.00
	10 mot. 0 0, 1110 4)	ı	1	ļ	1

	The state of the s			6.5	
					2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0133 Period: V				
			From 03/01/2016 To 02/28/2017	Date/Time Pre	nared:
			10 02/20/2017	7/31/2017 3: 1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		502, 776, 811	1. 00
2.00	Less contractual allowances and discounts on patients' ac	counts		400, 240, 684	2.00
3.00	Net patient revenues (line 1 minus line 2)			102, 536, 127	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		69, 792, 916	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			32, 743, 211	5. 00
	OTHER I NCOME				
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 communica	tion 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 oth	er than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	·		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			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
0.4.00					

419, 189 24. 00

33, 162, 396 29. 00

25. 00 26. 00

27.00

28.00

419, 189 33, 162, 400

24. 00 OTHER INCOME

27. 00 ROUNDING

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems KOSCIUSKO COMMU	INITY HOSPITAL	Inlie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0133	Peri od: From 03/01/2016 To 02/28/2017	Worksheet L	
Title XVIII Hospital				PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			548, 912	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			6, 936	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			28. 21	3. 00
4.00	Number of interns & residents (see instructions)			0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)			0. 00	8. 00
9.00				0.00	9. 00
10.00				0.00	
	Disproportionate share adjustment (see instructions)			0	11. 00
12. 00	Total prospective capital payments (see instructions)			555, 848	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			U	5. 00
	DADT LLL COURTETT ON OF EVOFOTION DAVIETITO			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs (see instructions)	ances (see instructions)		0	2.00
3. 00	Net program inpatient capital costs (line 1 minus line 2)	mees (see Thisti detroils)		0	3.00
4. 00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see			0.00	
7.00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 >	(line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as app			0	9. 00
10. 00 11. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	10. 00 11. 00
11.00	Worksheet L, Part III, Line 14)	capitai payiient (110iii pii	oi yeai	U	11.00
12.00	Net comparison of capital minimum payment level to capital			0	12. 00
13.00				0	13. 00
	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the f	following period	0	14. 00
14. 00	THE THE 12 IS HEUGH VE, EILER THE AMOUNT ON THIS TIME?				
	Current year allowable operating and capital payment (see i	nstructions)		0	15. 00
15. 00 16. 00		•		0 0 0	16. 00