PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

Contractor use only

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 CHIEF FINANCIAL 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 KENTUCKIANA MEDICAL CENTER (15-0176) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
	• •
Title	
11 (1)	=
Date	

number of times reopened = 0-9.

			Title XVIII				
	Cost Center Description		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	91, 776	70, 452	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	91, 776	70, 452	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. 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.

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0176 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 4:16 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4601 MEDICAL PLAZA WAY 1.00 PO Box: 1.00 City: CLARKSVILLE State: IN Zip Code: 47129 2.00 County: CLARK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal KENTUCKIANA MEDICAL 150176 31140 1 09/18/2009 3.00 CENTER Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 01/01/2017 20.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2017 Type of Control (see instructions) 21.00 21.00 4 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 2 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. | In-State | In-State | Out-of | Out-of | Medicaid | Other

		Medicaid	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	el i gi bl e	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	33	0	278	0	514	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							
25. 00	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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid deligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	O O	0	0	0	0		25. 00

Health Financial Systems KENTUCKI	ANA ME	DICAL CENTER		In Li	eu of Form (CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC		eriod: rom 01/01/201	Worksheet	
				o 12/31/201		
					S Date of Ge	
26.00 Enter your standard geographic classification (not wa	ige) sta	atus at the bed	inning of the	1.00	2.00	26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa	rural.		J		1	27. 00
reporting period. Enter in column 1, "1" for urban or	. "2" fo	or rural. If ap			1	27.00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the			CH status in		0	35. 00
effect in the cost reporting period.				Dogi ppi pg.	- Fading	
				Begi nni ng: 1. 00	Endi ng: 2. 00	
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number			36. 00
37.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	ls MDH status		0	37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the	ne MDH [.]	transitional pa	yment in	N		37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" fo	r yes o	or "N" for no.	(see			
38.00 If line 37 is 1, enter the beginning and ending dates						38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	perio	ds in excess of	one and			
				Y/N 1. 00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital				N N	N N	39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil						
with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column						
instructions) 40.00 Is this hospital subject to the HAC program reduction				Υ	Υ	40. 00
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or "N" for			
, and the second	(333					XI X
Prospective Payment System (PPS)-Capital					00 2.00 3.	. 00
45.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	it for (di sproporti onat	e share in acc	cordance [N N	N 45.00
46.00 Is this facility eligible for additional payment exce					N N	N 46.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, P	t. III and WKST	. L-I, PT. I	tnrougn		
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 48.00 Is the facility electing full federal capital payment						N 47.00 N 48.00
Teachi ng Hospi tal s						
56.00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y" 1	for yes 1	N	56. 00
57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for						57. 00
is "Y" did residents start training in the first mont	h of th	his cost report	ing period? I	Enter "Y"		
for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	′″, comp . ifan	plete Worksheet oplicable.	E-4. If colur	nn 2 is		
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	urseme	nt for physicia	ıns' services a	as l	V	58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		v l	59. 00
			NAHE 413.85 Y/N	Worksheet A	Pass-Thro	
					Criterion (Code
			1. 00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (N			60. 00
party programs that most the strictly under 3713.00:	Y/N	IME	Direct GME	IME	Direct G	ME
	1. 00	2. 00	3. 00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.		0.00 61.00
column 1. (see instructions)						
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61. 01
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care						61. 02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
ACA). (see instructions)						61. 03
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						01.03
determining compliance with the 75% test. (see instructions)						
	•			*	•	•

HOSPITAL AND HOSPITAL	HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 4:1	pared:
			Y/N	IME	Direct GME	IME	Direct GME	Pili
			1. 00	2. 00	3. 00	4. 00	5. 00	1
current cost re 1.05 Enter the diffe	hic and/or osteop porting period.(s rence between the	athic FTEs in the ee instructions).						61. 0
61.04 minus lin 1.06 Enter the amoun used for cap re	e 61.03). (see ir t of ACA §5503 aw	ard that is being that are nonprimary						61.0
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2. 00	3.00	4. 00	
specialty, if a for each new pr column 1, the p program code. E	ny, and the numbe ogram. (see instr rogram name. Ente nter in column 3, t. Enter in colum	fy each new program r of FTE residents uctions) Enter in r in column 2, the the IME FTE n 4, the direct GME	1			0.00	0.00	61. 10
residents for e instructions) E Enter in column 3, the IME FTE	ty, if any, and t ach expanded prog nter in column 1, 2, the program c	he number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0. 00	0. 00	61. 2
							1.00	
		II th Resources and Sers that your hospital				riod for which	0.00	62.0
2.01 Enter the numbe during in this	r of FTE resident cost reporting pe	funding (see instructs that rotated from a riod of HRSA THC prog	reachi Iram. (s	<u>ee instructio</u>		o your hospital	0.00	62.0
3.00 Has your facili	ty trained reside	esidents in Nonprovider ents in nonprovider se	ettings	during this c			N	63. 0
T TOT YES OF	N FOI HO TH COI	umn 1. If yes, comple	ite iiile	s o4 till ough	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	-
		r FTE Residents in No						
4.00 Enter in column in the base yea resident FTEs a settings. Ente resident FTEs t	period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0. 000000	64.0
		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	1

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 4:16 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems KENTUCKIANA MEDI				u of Form CMS		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0176	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part I Date/Time Pr 5/30/2018 4:	epared:	
				1. 00		
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00	
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded				N	85. 00 86. 00	
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	cl assi fi ed	under sectio	n	N	87. 0	
1800(u)(1)(b)(vi): Litter 1 101 yes of N 101 Ho.			V 1.00	XI X 2. 00		
70.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? F	nter "Y" for	N	Υ	90. 0	
yes or "N" for no in the applicable column.						
91.00 Is this hospital reimbursed for title V and/or XIX through th full or in part? Enter "Y" for yes or "N" for no in the appli			N	N	91.0	
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicab		ion)? (see		N	92. 0	
93.00 Does this facility operate an ICF/IID facility for purposes o "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 0	
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for n	o in the	N	N	94. 0	
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 00 96. 00	
97.00 If line 96 is "Y", enter the reduction percentage in the appl 98.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo						
P8.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					
P8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or	title XIX. O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					
for title V, and in column 2 for title XIX. 18.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 0	
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			d N	N	98. 0	
in column 2 for title XIX. 18.05 Does title V or XIX follow Medicare (title XVIII) and add bac 18.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0	
98.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	reimbursed fo 1 for title	r Wkst. D, V, and in	Y	Y	98. 0	
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105. 0	
106.00 If this facility qualifies as a CAH, has it elected the all-ifor outpatient services? (see instructions)	nclusive met	hod of payme			106. 0	
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see inst	ructions) If			107. 0	
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	•	J			108. 0	
STA SECTION 3712. 115(c). Linter 1 101 yes of 14 101 110.	Physi cal	Occupation		Respi ratory		
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.	1. 00 N	2. 00 N	3. 00 N	4.00 N	109. 0	
			·	1.00		
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y	Demonstrati	on project (§410A If ves	1. 00 N	110. 0	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	N: 15-0176	Peri od:	Worksheet S	S-2552- -2
THE THE HOST THE HEALTH SINCE SOME LEX TREATH TO ATT ON DATA	10 0170	From 01/01/20 To 12/31/20	17 Part I	repared
<u>'</u>				, , , , , , , , , , , , , , , , , , ,
 1.00 f this facility qualifies as a CAH, did it participate in the Frontier Co	ummuni tv	1. 00 N	2.00	111.
Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter enter the column 2.			111.
		1	. 00 2. 00 3. 0	10
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in	column 1 I	f column 1	N O	115.
is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long terp sychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	s "E", enter m care (incl me definition	in column udes		
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 s this facility legally-required to carry malpractice insurance? Enter "Y no.		"N" for	Y	116. 117.
18.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	1	118.
grafili liade. Effet 2 11 the portey 13 occurrence.	Premi ums	Losses	Insurance	
	4.00	0.00	2.00	
8.01 List amounts of malpractice premiums and paid losses:	1. 00 126, 3	2. 00	3. 00	0 118.
		1.00	0.00	
8.02 Are malpractice premiums and paid losses reported in a cost center other t	han the	1. 00 N	2.00	118
Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 9.00 DO NOT USE THIS LINE	st centers			119
0.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or ne Outpatient		N	120
1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Y		121
2.00 Does the cost report contain healthcare related taxes as defined in §1903(122
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.	in column 2			
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N		125
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 f this is a Medicare certified kidney transplant center, enter the certif	ication date			126
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certifi	cation date			127
in column 1 and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter the certifi	cation date			128
in column 1 and termination date, if applicable, in column 2. 9.00If this is a Medicare certified lung transplant center, enter the certific		n		129
column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, enter the cert				130
date in column 1 and termination date, if applicable, in column 2. 1.00 f this is a Medicare certified intestinal transplant center, enter the ce				131
date in column 1 and termination date, if applicable, in column 2.				
2.00 f this is a Medicare certified islet transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.				132
3.00 f this is a Medicare certified other transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.				133
4.00 f this is an organ procurement organization (0P0), enter the 0P0 number i and termination date, if applicable, in column 2.	n column 1			134.
ALL Provi ders	5.1.15.1			140
10.00 Are there any related organization or home office costs as defined in CMS	Pub. 15-1	Υ		

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0176 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/30/2018 4:16 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 N 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00

rical til Till of matron reciliology (ill i) Tilcenti ve Til tile Tiller can recevel y and recilives tillent	7101		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the	(168. 00
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	9. 9	9169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	01/01/2017	12/31/2017	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

	Financial Systems KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II	epared:
				Y/N	Date	To pill
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	lfor all NO re	sponses. Ente	r all dates in t	the	
1. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
0.00	The second secon	0.16	1.00	2. 00	3. 00	0.00
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	Trefationships: (300 Filsti dottons)		Y/N	Туре	Date	
			1.00	2.00	3. 00	
4 0-	Financial Data and Reports	. 6				
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	N			4.00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		N/ /NI		
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		e provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	Ü	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10.00
11. 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	roved	N		11. 00
					Y/N 1. 00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructions.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst t A		N t B	15. 00
		Y/N	Date	Y/N	Date	
	DCOD D-+-	1. 00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	04/18/2018	Y	04/18/2018	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems KENTUCKIANA ME	EDICAL CENTER		In Lie	u of Form CMS	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S- Part II Date/Time Pr 5/30/2018 4:	epared:		
		Descri	pti on	Y/N	Y/N	TO pin		
		(1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)					
22.00	Capi tal Related Cost	- ! + + !			N	1 22 00		
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N N	22. 00 23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporti ng	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00				
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30. 00					
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	, see	N	31. 00				
32. 00								
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	sed physicians?	Υ	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35. 00		
				Y/N	Date			
	U 066: 0t-			1.00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00		
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00		
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			· N		38. 00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	1.00 2.							
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41. 00		
42. 00		BLUE AND CO.,	LLC			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7957		KCSMI TH@BLUEANI	OCO. COM	43. 00		

Heal th	Financial Systems KENTU	JCKIANA MED	ICAL CENTER		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE	Provi der CCM		Period: From 01/01/2017 To 12/31/2017		epared:	
		-	3. 0	0				
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/posi held by the cost report preparer in columns 1, 2, respectively.	I .	ENIOR MANAGER				41. 00	
42. 00	Enter the employer/company name of the cost report preparer.	t					42. 00	
43. 00	Enter the telephone number and email address of the report preparer in columns 1 and 2, respectively.	ne cost					43. 00	

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

					''	0 12/31/201/	5/30/2018 4:10	
							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		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		46	16, 790	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			46	16, 790	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			46	16, 790	0.00		14.00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			46	1			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							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0176

				T	o 12/31/2017	Date/Time Pre 5/30/2018 4:1	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		о рііі
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	4, 310	33	8, 017			1. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	1, 073 0	792 0				2. 00 3. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0	0			4. 00 5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	4, 310	0 33	0 8, 017			6. 00 7. 00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						8. 00 9. 00
10. 00 11. 00 12. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10. 00 11. 00 12. 00
13. 00 14. 00	NURSERY Total (see instructions)	4, 310	33	8, 017	0.00	230. 00	13. 00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	0	0	0			15. 00 16. 00
17. 00 18. 00 19. 00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY						17. 00 18. 00 19. 00
20. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00
24. 00 24. 10 25. 00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0	0	0			24. 00 24. 10 25. 00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00 28. 00 29. 00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0	0	503	0.00	230. 00	27. 00 28. 00 29. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF			0			30. 00 31. 00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	0	0			32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	O O					33. 00 33. 01

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0176

Full Time Discharges Full Time Discharges Full Time Full Time Patients P						To	12/31/2017	Date/Time Pre 5/30/2018 4:1	
Component						Di scha	arges		,
1.00		Component	Nonpai d	Title V		Title XVIII	Title XIX		
1.00				10.00		40.00	44.00		
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1 00		11.00	12.00					1 00
3.00 HMO PF Subprovider 0 3.00 4.00 MO RF Subprovider 0 0 4.00 MO RF Subprovider 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 NTRSIVE CARE UNIT 9.00 11.00 SURGICAL INTENSIVE CARE UNIT 9.00 11.00 SURGICAL INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00	1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2			O	760	8	1, 382	1.00
4.00						156	163		
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 Intensity Care Unit 9.00 CORONARY CARE UNIT 9.00 11.00 SURRICAL INTENSIVE CARE UNIT 10.00 11.00 SURRICAL INTENSIVE CARE UNIT 10.00 11.00 SURRICAL INTENSIVE CARE UNIT 11.00 12.00 Total (See instructions) 12.00 13.00 NURSERY 12.00 13.00 NURSERY 13.00 16.00 SUBPROVIDER - IFF 17.00 15.00 16.00 SUBPROVIDER - IFF 17.00 18.00 SUBPROVIDER - IRF 19.00 18.00 SUBPROVIDER - IRF 19.00 18.00							0		
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 11. 00 TOTAL (See Instructions) 11. 00 SURSPROVIDER - IPF 15. 00 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 HOSPICE ROLLITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOSPICE SURGICAL CENTER (D.P.) 24. 00 HOSPICE CHMC CHMC 25. 00 CMC - CMC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 28. 00 Mobulance Trips 28. 00 29. 00 Ambulance Trips 29. 00 20. 00 Ambulance Trips 20. 00 21. 00 Employee discount days (see instructions) 22. 01 23. 00 Labor & delivery days (see instructions) 24. 00 Labor & delivery days (see instructions) 25. 01 26. 01 27. 01 28. 00 29. 00 Labor & delivery days (see instructions) 31. 00 20. 01 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 33. 00 Lich for non-covered days See instructions) 32. 01 33. 00 Lich for non-covered days See instructions)		•					0		
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 9. 00 TOTAL (SURGICAL INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 TOTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 OMBURSING FACILITY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE (non-distinct part) 25. 00 CMC - CMHC 26. 00 ROME - CMHC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 20. 00 Labor & delivery days (see instruction) 31. 00 Employee di scount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 Labor & delivery days (see instructions) 31. 00 LTCH non-covered days 30. 00 Left non-covered days 30. 00 Left covered days									
BedS) (see instructions)									
8. 00 INTENSIVE CARE UNIT	7.00	· ·							7. 00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 TOTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 15.00 CAH visits 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 23.00 HOME HEALTH AGENCY 24.00 HOSPICE (non-distinct part) 25.00 CAMP C (non-distinct part) 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CENTER 27.00 TOTAL (Sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instructions) 31.00 32.01 Total (sum of lines 14-26) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days									
10. 00 BURN INTENSIVE CARE UNIT									
11. 00 SURGICAL INTENSIVE CARE (UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 13. 00 NURSERY 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 17. 00 SUBPROVIDER 17. 00 SUBPROVIDER 17. 00 SUBPROVIDER 17. 00 SUBPROVIDER 18. 00 OTHER LONG FACILITY 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 19. 00 OTHER		1							
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - I RF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 ON NURSING FACILITY 20. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL MEALTH CLINIC 26. 00 Experience of the second of the									
13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 15.00 CAH visits 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 19.00 TOTHER LONG TERM CARE 20.00 MURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days									
14.00 Total (see instructions) 0.00 0 760 8 11,382 14.00 15.00 CAH visits 16.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 20.00 HOME HEALTH AGENCY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE 24.10 ORHC - CMHC 25.00 CMHC - CMHC 26.25 FEDERALLY OUALIFIED HEALTH CENTER 26.00 Subervation Bed Days 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambul ance Trips 28.00 Subprovious first struction) 28.00 Employee discount days (see instructions) 30.00 31.00 Employee discount days (see instructions) 31.00 Labor & delivery days (see instructions) 33.00 LTCH non-covered days									
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 4. 10 HOSPICE 4. 10 HOSPICE 5. 00 CMHC - CMHC 8. 00 RURAL HEALTH CLINIC 8. 00 CMC - CMHC 8. 00 RURAL HEALTH CLINIC 9. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 17. 00 17. 00 17. 00 18. 00 18. 00 19.			0.00			7.0		4 000	
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 20. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 21. 00 23. 00 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 24. 10 25. 00 CMHC - CMHC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 CMB or observation Bed Days 28. 00 29. 00 Mnbul ance Trip S 29. 00 29. 00 20			0.00		O	760	8	1, 382	
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 17. 00 18. 00 SUBPROVI DER 18. 00 19. 00 20. 00									
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LITY 19.00 ONLRSI NG FACI LITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGI CAL CENTER (D.P.) 23.00 AMBULATORY SURGI CAL CENTER (D.P.) 24.00 HOSPI CE Con-distinct part) 24.10 HOSPI CE Con-distinct part) 24.10 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINI C 26.00 RURAL HEALTH CLINI C 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 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) 31.00 Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.00 LTCH non-covered days 0 33.00									
19. 00 20. 00 10									
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 FEDERALLY QUALIFIED MEALTH CENTER 26.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 Total home covered days 0 OSSIGNATION OF THE CONTROL									
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) 0.00 Observation Bed Days 9.00 Ambul ance Trips Employee discount days (see instruction) 31.00 Employee discount days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 121.00 22.00 22.00 23.00 24.10 24.00 25.00 26.00 27.00 26.25 27.00 27.00 28.00 29.00 30.00 31.00 Employee discount days (see instruction) 31.00 32.00 33.00 32.01									
22. 00 23. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20									
23. 00 24. 00 10 HOSPICE 24. 10 10 HOSPICE (non-distinct part) 25. 00 26. 00 10 RURAL HEALTH CLINIC 26. 00 10 Total (sum of lines 14-26) 10 Observation Bed Days 10 Observation Bed Days 11 Observation Bed iscount days (see instruction) 12 Employee discount days (see instructions) 13 Observation Italy labor & delivery room outpatient days (see instructions) 13 Observation Italy labor & delivery room outpatient days (see instructions) 13 Observation Italy labor & delivery room outpatient days (see instructions) 14 Observation Italy labor & delivery room outpatient days (see instructions) 15 Observation Italy labor & delivery room outpatient days (see instructions) 16 Observation Italy labor & delivery room outpatient days (see instructions) 17 Observation Italy labor & delivery room outpatient days (see instructions) 18 Observation Italy labor & delivery room outpatient days (see instructions) 18 Observation Italy labor & delivery room outpatient days (see instructions) 19 Observation Italy labor & delivery room outpatient days (see instructions) 10 Observation Italy labor & delivery room outpatient days (see instructions) 10 Observation Italy labor & delivery room outpatient days (see instructions) 11 Observation Italy labor & delivery room outpatient days (see instructions) 12 Observation Italy labor & delivery room outpatient days (see instructions)		1							
24. 00 24. 10 HOSPICE HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Deservation Bed Days 29. 00 Ambul ance Tri ps 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 24. 00 24. 10 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 01 36. 02 37. 02 38. 00 39. 00 30.		1							
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 32. 01 Total ancillary sistematics of the control of									
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 28. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 25. 00 26. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 30. 00 31. 00 32. 01 32. 01 33. 00 33. 00 33. 00		1							
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 26. 00 26. 25 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 32. 01 32. 01 33. 00 33. 00									
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 28. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 31. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 33. 00 33. 00									
27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 0bservation Bed Days 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.00		·	0.00						
28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 LTCH non-covered days 33. 00 LTCH non-covered days		I and the second							
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 29.00 30.00 31.00 32.00 32.01 33.00			0.00						
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 31.00 32.00 32.00 32.01		1							
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 32.00 32.01									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 32.01									
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01		1 . 3							
outpati ent days (see instructions) 33.00 LTCH non-covered days 0 33.00									
33.00 LTCH non-covered days 0 33.00	JZ. U1								J2. U1
	33.00	, ,				0			33. 00
						-			

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | P Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0176

Number N						To	12/31/2017	Date/Time Prep 5/30/2018 4:10	
SAPET II - WAGE DATA					on of Salaries (from Wkst.	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷	
SAAMES			1. 00	2. 00				6. 00	
1.00 Total satianies (see 1.00 10,836,349 0 10,836,349 479,563,00 22,60 1.0									
Amp-physic claim anesthetist Part	1.00		200. 00	10, 836, 349	О	10, 836, 349	479, 563. 00	22. 60	1. 00
4. 00 Physician-Part A - Administrative and programment and other part and programment and ot	2.00	,		0	C	0	0.00	0. 00	2. 00
Administrative Admi	3. 00	Non-physician anesthetist Part		0	a	0	0.00	0. 00	3. 00
4.01 Physicians - Part A - Teaching 0 0 0 0.00 0.00 0.00 5.00	4.00			0	d	0	0. 00	0. 00	4. 00
Mon-physic clan-Part B for 0 0 0 0 0 0 0 0 0		Physicians - Part A - Teaching		0	_				
Interest & residents (in an approved program)	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	C	0	0.00	0.00	6. 00
Contracted interins and residents (in an approved programs) Contracted interins and programs) Contract programs) Contract programs) Contract programs) Contract programs Con	7. 00	Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
Nome office and/or related organization personnel organization o	7. 01	Contracted interns and residents (in an approved		0	C	О	0.00	0.00	7. 01
9.00 SNF 44.00 0 0 0 0 0 0 0 0 0	8.00	Home office and/or related		0	О	0	0. 00	0. 00	8. 00
11.00 Contract labor: Direct Patient Care		SNF Excluded area salaries (see	44. 00	0	_	· ·			
Care	11 00			1 002 041		1 002 041	9 102 00	122 42	11 00
management and other management and other management and administrative services management and administrative management a		Care			-				
A - Administrative		management and other management and administrative							
Orgalization salaries and Wage-rel ated costs Wage-rel ated wage-rel wag	13. 00			90, 743	O	90, 743	507. 00	178. 98	13. 00
14. 02 Related organization salaries 0 0 0 0.00 0.00 14. 02 15. 00 Home office: Physician Part A 0 0 0 0.00 0.00 15. 00 16. 00 Home office and contract 0 0 0 0 0.00 0.00 15. 00 16. 00 Physicians Part A - Teaching 17. 00 Wage-related costs (core) (see instructions)	14. 00	orgainzation salaries and		0	С	О	0.00	0. 00	14. 00
15.00 Home office Physician Part A 0 0 0 0.00 0.00 15.00		1		0	0	1 4			
16.00 Home office and Contract		Home office: Physician Part A		0	ď				
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00 2,500,296 0 2,500,296 18. 00 18. 00 18. 00 19. 00	16. 00	Home office and Contract Physicians Part A - Teaching		0	O	0	0.00	0. 00	16. 00
18. 00 Wage-related costs (other) (see instructions) 18. 00 0 0 0 19. 00 19. 00 20. 00 19. 00 20. 00 19. 00 20. 00 19. 00 20. 00	17. 00			2, 500, 296	0	2, 500, 296			17. 00
19. 00 Excluded areas	18. 00	Wage-related costs (other)		0	С	0			18. 00
21.00 Non-physician anesthetist Part B		Excluded areas		0	_	1			
B		A		0	_				
Administrative Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		В		0	_				
23.00 Physician Part B		Admi ni strati ve		0	_				
24.00 Wage-related costs (RHC/FOHC) 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 25.00 25.50 Home office wage-related (core) 0 0 0 0 0 25.50 25.51 Related organization wage-related (core) 0 0 0 0 0 25.51 25.52 Home office: Physician Part A wage-related (core) 0 0 0 0 25.52 25.53 Home office & Contract wage-related (core) 0 0 0 0 25.53 Physicians Part A - Teaching - wage-related (core) 0 0 0 0 25.53 26.00 Employee Benefits Department 4.00 166,689 0 166,689 5,545.00 30.06 26.00				0		· ·			
approved program Home office wage-related 0	24.00	Wage-related costs (RHC/FQHC)		0	0				24. 00
25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A		approved program)		0					
25. 52 Home office: Physician Part A		(core) Related organization		0	C	0			
wage-related (core)	25. 52	Home office: Physician Part A		0	C	О			25. 52
Physicians Part A - Teaching -	25 52	wage-related (core)		0					25 52
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 166, 689 0 166, 689 5, 545. 00 30. 06 26. 00	20.00	Physicians Part A - Teaching -		0					۷. ی
	26 00	OVERHEAD COSTS - DIRECT SALARIE		144 400		147 700	E E 4 E 00	20.00	26 00
					l e				

Provider CCN: 15-0176

							5/30/2018 4:10	5 pm
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		4, 979, 585	0	4, 979, 585	58, 188. 00	85. 58	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	125, 449			29. 00
30.00	Operation of Plant	7. 00		0	0	0.00	0.00	30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	0	0	0	0. 00	0.00	32.00
33.00	Housekeeping under contract		347, 200	0	347, 200	13, 440. 00	25. 83	33.00
	(see instructions)							
34.00	Di etary	10. 00	288, 983	-137, 238	151, 745	13, 334. 00	11. 38	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	137, 238	137, 238	12, 060. 00	11. 38	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	284, 861	0	284, 861	6, 490. 00	43. 89	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	260, 269	0	260, 269	11, 645. 00	22. 35	40.00
41.00	Medical Records & Medical	16. 00	142, 523	0	142, 523	6, 946. 00	20. 52	41.00
	Records Library							
42.00	Social Service	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

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part III |
| To 12/31/2017 | Date/Time Prepared: | 5/30/2018 4:16 pm | Provider CCN: 15-0176

							5/30/2018 4: 10	5 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4	·	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		16, 163, 134	0	16, 163, 134	551, 191. 00	29. 32	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0	C	0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		16, 163, 134	0	16, 163, 134	551, 191. 00	29. 32	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 093, 684	0	1, 093, 684	8, 699. 00	125. 73	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		2, 500, 296	0	2, 500, 296	0.00	15. 47	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		19, 757, 114	0	19, 757, 114	559, 890. 00	35. 29	6.00
7.00	Total overhead cost (see		7, 775, 781	0	7, 775, 781	179, 012. 00	43. 44	7.00
	instructions)							
				•	•	•		

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0176	Peri od:	Worksheet S-3
		From 01/01/2017	
			D I TT

	To 12/31/2017	Date/Time Prep 5/30/2018 4:10	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	165, 883	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		
8.00	Health Insurance (Purchased or Self Funded)	1, 416, 155	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	-48, 194	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	39, 069	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	161, 495	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)		l
	TAXES		
17.00	FICA-Employers Portion Only	632, 265	17. 00
18.00	Medicare Taxes - Employers Portion Only	149, 737	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	9, 532	20. 00
	OTHER		l
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	2, 525, 942	24. 00
	Part B - Other than Core Related Cost		l
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0176	From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared:

		10 12/31/2017	5/30/2018 4:10			
	Cost Center Description	Contract Labor		D pili		
	555 55.155. 2555. P. 1.5.	1. 00	2. 00			
	PART V - Contract Labor and Benefit Cost					
Hospital and Hospital-Based Component Identification:						
1.00	Total facility's contract labor and benefit cost	0	0	1. 00		
2.00	Hospi tal	0	0	2. 00		
3.00	Subprovi der - 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		

IOSPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 15-0176	Peri od:	Worksheet S-10	0
			From 01/01/2017 To 12/31/2017	Date/Time Pre	parad
			10 12/31/201/	5/30/2018 4: 10	
				1. 00	
	Uncompensated and indigent care cost computation				
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ded by line 202 colu	mn 8)	0. 405868	1.0
. 00	Medicaid (see instructions for each line) Net revenue from Medicaid	1, 182, 914	2.0		
. 00	Did you receive DSH or supplemental payments from Medicaid?			N 1, 102, 714	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplements	al payments from Medi	cai d?	N	4. 0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from		0		
. 00	Medi cai d charges		17, 995, 668		
. 00	Medicaid cost (line 1 times line 6)	: 2 5 :-	7, 303, 866		
. 00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	The / minus sum of i	rnes 2 and 5; ir	6, 120, 952	8.0
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP	,		0	9.0
0. 00	Stand-al one CHIP charges			0	
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
2. 00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	ine 11 minus line 9;	if < zero then	0	12.0
	Other state or local government indigent care program (see insti	ructions for each line	e)		
3. 00	Net revenue from state or local indigent care program (Not included in the control of the contro			0	13.0
4. 00	Charges for patients covered under state or local indigent care	program (Not include	d in lines 6 or	0	14.0
	10)			_	
5.00	State or local indigent care program cost (line 1 times line 14)		: 15! !!	0	
6. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	gent care program (1	ine is minus iine	0	16. C
	Grants, donations and total unreimbursed cost for Medicaid, CHII	and state/local ind	igent care progran	ns (see	1
7. 00	instructions for each line) Private grants, donations, or endowment income restricted to ful	ading charity care		0	1 17. C
8. 00	Government grants, appropriations or transfers for support of he	9		0	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and Local 8, 12 and 16)		ms (sum of lines	6, 120, 952	1
	0, 12 and 10)	Uni nsured	d Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line)	Li tv	0 0	0	20. C
0.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	TILY	0	U	20.0
1. 00	Cost of patients approved for charity care and uninsured discour	nts (see	0 0	0	21.0
	instructions)				
2. 00	Payments received from patients for amounts previously written	off as	0 0	0	22.0
3. 00	charity care Cost of charity care (line 21 minus line 22)		0 0	0	23. 0
3.00	cost of charity care (fine 2) minus fine 22)		0 0	O	23.0
				1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patien		h of stay limit		24.0
5. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the		am's Length of	0	25. C
6. 00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)		4, 580, 405	26.0
7. 00	Medicare reimbursable bad debts for the entire hospital complex	,		178, 957	
7. 01	Medicare allowable bad debts for the entire hospital complex (se			275, 318	
8. 00	,	,		4, 305, 087	
9.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruction	s)	1, 843, 658	1
				1 0/0 / [0	1 20 0
80. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line)	20)		1, 843, 658 7, 964, 610	

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL E	ALANCE OF EXPENSES	Provider CCN: 15-0176	Period: From 01/01/2017 To 12/31/2017	Worksheet A Date/Time Prepared: 5/30/2018 4:16 pm
Cost Center Description	Salaries	Other Total (col	1 Reclassificati	Reclassified

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 4:1	pared: 6 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		0.055.070	0.055.07	0.40 700		
1.00	00100 CAP REL COSTS-BLDG & FIXT		3, 955, 360		1		
2.00	00200 CAP REL COSTS-MVBLE EQUIP	4// /00	2, 500, 469				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	166, 689	2, 532, 498			_, -, -, , , -, .	
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 180, 222	8, 534, 460				1
6.00	00600 MAI NTENANCE & REPAI RS	125, 449	1, 436, 026			.,,	
8.00	00800 LAUNDRY & LINEN SERVICE	0	670, 272			670, 272	
9.00	00900 HOUSEKEEPI NG	0	407, 950			407, 950	1
10.00	01000 DI ETARY	288, 983	441, 019				1
11. 00	01100 CAFETERI A	0	0		346, 357		1
13. 00	01300 NURSI NG ADMI NI STRATI ON	284, 861	3, 574				1
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	4, 787, 794			.,	
15. 00	01500 PHARMACY	260, 269	1, 632, 000				
16. 00	01600 MEDI CAL RECORDS & LI BRARY	142, 523	66, 222	208, 74!	5 0	208, 745	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 829, 280	206, 950	4 027 227	0	4 024 220	30.00
30.00	ANCILLARY SERVICE COST CENTERS	3, 829, 280	200, 950	4, 036, 230	<u>)</u>	4, 036, 230	30.00
50.00	05000 OPERATING ROOM	1, 254, 246	1, 266, 123	2, 520, 369	9 0	2, 520, 369	50.00
53. 00	05300 ANESTHESI OLOGY	1, 254, 240	1, 200, 123				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	615, 524	359, 317	1	-		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	010,021	007, 017		0	0	1
56. 00	05600 RADI OI SOTOPE		0			Ö	
57. 00	05700 CT SCAN		0		0	0	1
58. 00	05800 MRI		0	1		Ö	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	606, 013	111, 605		-	-	
60.00	06000 LABORATORY	430, 337	2, 022, 275	1			
65. 00	06500 RESPI RATORY THERAPY	562, 188	40, 014			602, 202	
69. 00	06900 ELECTROCARDI OLOGY	316, 512	117			316, 629	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	0		0		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		0	0	1
	OUTPATIENT SERVICE COST CENTERS	1					1
91.00	09100 EMERGENCY	773, 253	852, 059	1, 625, 312	2 0	1, 625, 312	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		3, 426, 150	3, 426, 150	-3, 426, 150	0	113. 00
118.00		10, 836, 349	35, 252, 254	46, 088, 603	3 0	46, 088, 603	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	•	0		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
	07951 MARKETI NG/ ADVERTI SI NG	0	11, 312	1			194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	10, 836, 349	35, 263, 566	46, 099, 91	5 0	46, 099, 915	200. 00

Provider CCN: 15-0176

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared:

				5/30/2018 4:	: 16 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	-2, 880, 426	1, 417, 654		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	2, 517, 741	•	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 699, 187		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-4, 749, 898	8, 030, 942	•	5. 00
6.00	00600 MAINTENANCE & REPAIRS	-18, 033	1, 543, 442		6. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	670, 272		8. 00
9.00	00900 HOUSEKEEPI NG	0	407, 950		9. 00
10.00	01000 DI ETARY	0	383, 645		10. 00
11. 00	01100 CAFETERI A	-151, 827	194, 530		11. 00
13.00	01300 NURSING ADMINISTRATION	0	288, 435		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	4, 787, 794		14. 00
15.00	01500 PHARMACY	0	1, 892, 269		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2, 388	206, 357		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	4, 036, 230		30. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-810, 000	1, 710, 369		50.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-191, 962	782, 879		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	0		57. 00
58.00	05800 MRI	o	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	717, 618		59. 00
60.00	06000 LABORATORY	o	2, 452, 612		60.00
65.00	06500 RESPI RATORY THERAPY	o	602, 202		65. 00
69.00	06900 ELECTROCARDI OLOGY	O	316, 629		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0		73. 00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-829, 323	795, 989		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 NTEREST EXPENSE	0	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-9, 633, 857	36, 454, 746		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19100 RESEARCH	o	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0	•	192. 00
	07951 MARKETING/ ADVERTISING	o	11, 312		194. 00
200.00		-9, 633, 857		•	200. 00
				!	

Heal th	Financial Systems		KENTUCKIANA M	EDICAL CENTER		In Lieu of Form CMS-2552-1			
RECLAS	SIFICATIONS			Provi der C	CCN: 15-0176	Period: From 01/01/2017 To 12/31/2017		epared:	
		Increases				<u> </u>	5/30/2018 4:	lo pili	
	Cost Center	Li ne #	Sal ary	Other					
	2. 00	3.00	4.00	5. 00					
	A - CAFETERIA COSTS								
1.00	CAFETERI A	1100	137, 238	209, 119				1.00	
	0		137, 238	209, 119					
	D - CAPITAL COSTS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	342, 720				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17, 272				2. 00	
3.00	ADMINISTRATIVE & GENERAL		0	3, 426, 150				3. 00	
	0		0	3, 786, 142					
500.00	Grand Total: Increases		137, 238	3, 995, 261				500.00	

Heal th	Financial Systems		KENTUCKIANA M	EDICAL CENTER		In Lie	u of Form CMS	-2552-10
RECLAS	SSI FI CATI ONS			Provi der (Peri od: From 01/01/2017 To 12/31/2017	Worksheet A- Date/Time Pr 5/30/2018 4:	
		Decreases		<u> </u>				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	.		
	6. 00	7. 00	8. 00	9. 00	10. 00			
	A - CAFETERIA COSTS							
1.00	DI ETARY	10.00	137, 238	209, 119		0		1. 00
	0 — — — — —		137, 238	209, 119		7		
	D - CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	359, 992	1	1		1. 00
2.00	INTEREST EXPENSE	113.00	o	3, 426, 150	1	1		2. 00
3.00		0.00	o	0		o		3. 00
				2 706 1/2		7		1

137, 238

3, 786, 142

3, 995, 261

500.00

500.00 Grand Total: Decreases

Provider CCN: 15-0176

				-	To 12/31/2017	Date/Time Pre 5/30/2018 4:1	pared: 6 pm
				Acqui si ti ons		0,00,2010 111	<u>Б</u>
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	0	(0	0	
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	1, 620, 018	25, 871	(0 25, 871	0	4. 00
5. 00	Fixed Equipment	639, 027	354, 865	(0 354, 865		5. 00
6.00	Movable Equipment	13, 693, 416	1, 693, 935	(0 1, 693, 935	0	6. 00
7. 00	HIT designated Assets	0	0	(0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	15, 952, 461	2, 074, 671	(0 2, 074, 671	0	8. 00
9. 00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	15, 952, 461	2, 074, 671	(0 2, 074, 671	0	10.00
		Ending Balance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES	_				
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	1, 645, 889	0				4. 00
5.00	Fi xed Equipment	993, 892	0				5. 00
6.00	Movable Equipment	15, 387, 351	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	18, 027, 132	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	18, 027, 132	0				10. 00

Hoal th	Financial Systems	KENTUCKI ANA ME	DICAL CENTED		In Lieu of Form CMS-25			
	CILIATION OF CAPITAL COSTS CENTERS	KLINTOCKTANA WIL	Provi der CO	CN: 15-0176	Peri od:	Worksheet A-7		
					From 01/01/2017	Part II		
					To 12/31/2017	Date/Time Pre 5/30/2018 4:1		
			SI	JMMARY OF CAP	I TAI	3/30/2016 4.1	O pili	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)	instructions)		
		9. 00	10.00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	177, 418	3, 777, 942		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2, 500, 469	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	2, 677, 887	3, 777, 942		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	3, 955, 360				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 500, 469				2. 00	
	1		, ,== 000	I				

0 0

3, 955, 360 2, 500, 469 6, 455, 829

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)

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-0176			Worksheet A-7 Part III Date/Time Prep 5/30/2018 4:16		
	COM	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio (col. 1 - col 2)	instructions)			
	1.00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00 CAP REL COSTS-BLDG & FLXT	2, 639, 780	C	2, 639, 78	0. 146434	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	15, 387, 352	C	15, 387, 35	2 0. 853566	0	2.00	
3.00 Total (sum of lines 1-2)	18, 027, 132		18, 027, 13			3. 00	
	ALLOCATION OF OTHER CAPITAL			SUMMARY O			
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Relate					
		d Costs	through 7)				
	6. 00	7. 00	8. 00	9. 00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS C		1 -	1				
1. 00 CAP REL COSTS-BLDG & FLXT	0	_)	0 -2, 703, 008		1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP	0	_)	0 2, 500, 469		2.00	
3.00 Total (sum of lines 1-2)	0	· · · · · · · · · · · · · · · · · · ·)	0 -202, 539	3, 777, 942	3. 00	
			JMMARY OF CAPI				
Cost Center Description	Interest	Insurance (see			Total (2) (sum		
		instructions)	instructions)	Capi tal -Relate			
				d Costs (see	through 14)		
	44.00	10.00	40.00	instructions)	45.00		
PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12. 00	13.00	14. 00	15. 00		
1.00 CAP REL COSTS-BLDG & FIXT	342, 720	C	1	0 0	1, 417, 654	1. 00	
2.00 CAP REL COSTS-BLDG & FIXT	17, 272	l .	1	0 0	2, 517, 741	2. 00	
3.00 Total (sum of lines 1-2)	359, 992	l .	l	0 0	3, 935, 395		
5. 00 Total (Suiii Of Titles 1-2)	307, 992		' I	0	3, 730, 390	3.00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 KENTUCKIANA MEDICAL CENTER Period: Worksheet A-8 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 4:16 pm Provider CCN: 15-0176

					72/31/2017	5/30/2018 4: 1	6 pm
				Expense Classification on To/From Which the Amount is 1			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00		
5. 00	di scounts (chapter 8) Refunds and rebates of	В	-30 626	ADMINISTRATIVE & GENERAL	5. 00		
	expenses (chapter 8)		-37, 020	ADMINISTRATIVE & GENERAL			
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00		6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter 21)		0		0. 00	0	7. 00
8.00	Television and radio service (chapter 21)	А	-18, 033	MAINTENANCE & REPAIRS	6.00	10	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 831, 285		0.00	0	
11. 00			0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-6, 244, 423			0	12. 00
13. 00	Laundry and linen service		0		0. 00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-151, 827 0	CAFETERI A	11. 00 0. 00		14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0. 00		
10.00	supplies to other than		0		0.00		10.00
17. 00	3		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	В	-2, 388	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	0 59, 918-	ADMINISTRATIVE & GENERAL	0. 00 5. 00	l .	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-6-3	0	RESTITATORY THERAFT	05.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	*** Cost Center Deleted ***	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2. 00		27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	Cost Center Dereted	0.00		
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	MISC INCOME	В	-16, 000	ADMINISTRATIVE & GENERAL	5. 00	О	33. 00

He	alth Financial Systems		KENTUCKI ANA ME	EDICAL CENTER	In Lieu of Form CMS-2552-			
Α[JUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 01/01/2017			
					To 12/31/2017			
_						5/30/2018 4: 1	6 pm	
				Expense Classification o				
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1.00	2.00	3. 00	4. 00	5. 00		
35	5. 00 NON-ALLOWABLE EXPENSES	Α	-61, 831	ADMINISTRATIVE & GENERAL	5. 00	9	35. 00	
40). 00 HAF	A	-1, 208, 526	ADMINISTRATIVE & GENERAL	5.00	0	40.00	
40	0. 01 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40. 01	
	(3)					- 1		
50	0.00 TOTAL (sum of lines 1 thru 49)		-9, 633, 857				50.00	
-	(Transfer to Worksheet A,		.,,					
	column 6, line 200.)						l	
(1) Description - all chapter referer	ocos in this col	Lump portain to	CMS Dub 15 1		1		
(2	· · · · · · · · · · · · · · · · · · ·		ruilli pertarii to	J CW3 Pub. 15-1.				
•								
	B. Amount Received - if cost cannot			6				

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

Heal th	Financial Systems	KENTUCKIANA M	EDICAL CENTER	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2017 To 12/31/2017		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1. 00	CAP REL COSTS-BLDG & FIXT	FACILITY LEASE	0	3, 777, 941	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	897, 515	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	INTEREST	0	3, 363, 997	3.00
4.00	0.00			0	o	4.00
5.00	TOTALS (sum of lines 1-4).			897, 515	7, 141, 938	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.

 p	cor anno i aria, or 2, tho amoun				
			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 RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	A	CARDI OVASCULAR	51.00	KMCREI	10. 25	6. 00
7.00	A	VARIOUS PHYSICI	49.00	KMCREI	86. 45	7.00
8.00	В	RIALTO CAP MGT	80.00	KMCREI	100.00	8. 00
9.00	В	RIALTO CAPT MGT	100.00	KMC	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

- 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				KENTUCKIANA MEDICAL CENTER					In Lieu of Form CMS-2552			-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS A	AND HOME	Provi der	CCN:	15-0176	Peri od:		Worksheet A-	8-1
OFFICE	COSTS								From 01/0			
									To 12/3	1/2017		
		1							L.		5/30/2018 4:	16 pm
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTI	MENTS RE	QUI RED AS A RESI	ULT OF TRA	NSACTI ONS	WI TH	RELATED C	ORGANI ZATI O	NS OR C	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	-3, 777, 941	9										1.00
2.00	897, 515	9										2.00
3.00	-3, 363, 997	0										3.00
4.00	0	0										4.00
5.00	-6, 244, 423											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriate)	are trans	sferred in	deta	ail to Wor	ksheet A, o	col umn	6, lines as	
annronr	iato Positivo	amounte incrose	o cost	and pogative ame	unte docre	aca cact	For i	rolated or	aani zati on	or hom	o office cost	whi ch

appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	REAL ESTATE	6.00			
7.00	REAL ESTATE	7.00			
8.00	REAL ESTATE	8.00			
	HOSPI TAL	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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0176

Period: Worksheet A-8-2 From 01/01/2017

1, 831, 285

200.00

12/31/2017 Date/Time Prepared: 5/30/2018 4:16 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 7.00 1. 00 2.00 3. 00 4. 00 5. 00 6. 00 1. 00 50.00 OPERATING ROOM 1. 00 810,000 810,000 239, 400 0 0 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 191, 962 191, 962 0 271, 900 2.00 3.00 91. 00 EMERGENCY 829, 323 829, 323 211, 500 0 3.00 4.00 0.00 0 0 0 4.00 C 0.00 5.00 0 0 0 0 5.00 6.00 0.00 0 0 0 6.00 0 0 7.00 0.00 0 0 0 7.00 0.00 8.00 0 0 0 8.00 0 9.00 0.00 9.00 10.00 0.00 0 10.00 1, 831, 285 1,831,285 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 50.00 OPERATING ROOM 1. 00 1.00 0 0 0 0 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 2.00 3.00 91. 00 EMERGENCY 0 0 0 0 3.00 0 0 4.00 0.00 0 0 0 0 0 0 0 0 4.00 0.00 5.00 0 5 00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 0 7.00 0 0 0.00 0 8.00 8.00 0.00 0 0 9.00 9.00 10.00 0.00 10.00 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 50. 00 OPERATING ROOM 1. 00 1.00 810,000 0 0 0 0 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 191, 962 2.00 3.00 91. 00 EMERGENCY 0 0 829, 323 3.00 0 4.00 0.00 0 0 0 4.00 0.00 5.00 0 0 5 00 0 6.00 0.00 0 0 0 6.00 7.00 0.00 0 0 0 7.00 0.00 0 0 0 0 8.00 8.00 0.00 9.00 0 0 9.00 10.00 0.00 0 0 0 10.00

200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176 Peri od: Worksheet B From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 4:16 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 1 00 00100 CAP REL COSTS-BLDG & FIXT 1, 417, 654 1 00 1, 417, 654 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 517, 741 2, 517, 741 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 699, 187 19, 965 35, 457 2, 754, 609 4.00 00500 ADMINISTRATIVE & GENERAL 8, 030, 942 228. 079 304, 700 8, 692, 144 5.00 5 00 128, 423 6.00 00600 MAINTENANCE & REPAIRS 1,543,442 402, 698 715, 188 32, 387 2, 693, 715 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 670, 272 21, 688 38, 518 730, 478 8.00 9.00 00900 HOUSEKEEPI NG 407, 950 31, 389 55, 747 0 495, 086 9.00 01000 DI ETARY 10.00 53, 232 94 540 39, 176 570, 593 10 00 383 645 11.00 01100 CAFETERI A 194, 530 29, 104 51, 689 35, 431 310, 754 11.00 01300 NURSING ADMINISTRATION 288, 435 10, 069 17, 883 389, 930 13.00 13.00 73, 543 01400 CENTRAL SERVICES & SUPPLY 4, 787, 794 38, 574 68, 506 4, 894, 874 14.00 14.00 9, 992 01500 PHARMACY 17, 746 1, 987, 201 15.00 15.00 1, 892, 269 67.194 16.00 01600 MEDICAL RECORDS & LIBRARY 206, 357 26, 316 46, 737 36, 795 316, 205 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 410, 580 6, 164, 611 30.00 4, 036, 230 729, 185 988, 616 30.00 ANCILLARY SERVICE COST CENTERS 142, 772 50.00 05000 OPERATING ROOM 1, 710, 369 323, 811 50.00 253, 562 2, 430, 514 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 782,879 39, 116 69, 469 158, 911 1,050,375 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 Λ 55.00 05600 RADI 0I S0T0PE 56.00 56.00 0 0 0 0 0 57.00 05700 CT SCAN 0 0 0 57.00 0 58.00 05800 MRI 58.00 0 0 0 0 05900 CARDIAC CATHETERIZATION 59.00 717, 618 28, 233 50, 142 156, 456 952, 449 59.00 06000 LABORATORY 18, 984 111, 101 2, 593, 386 60.00 2, 452, 612 10, 689 60.00 65.00 06500 RESPIRATORY THERAPY 602, 202 3, 524 6, 259 145, 141 757, 126 65.00 06900 ELECTROCARDI OLOGY 69.00 316, 629 4,706 8, 357 81, 715 411, 407 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 Ω 0 0 O 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72 00 72 00 C Λ 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 795, 989 199, 632 1, 013, 898 91.00 6.584 11, 693 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 118 00 SUBTOTALS (SUM OF LINES 1 through 117) 36, 454, 746 2, 517, 741 2, 754, 609 36, 454, 746 118. 00 1, 417, 654 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 194. 00 07951 MARKETING/ ADVERTISING 11, 312 0 0 0 11, 312 194. 00 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201. 00

36, 466, 058

1, 417, 654

2, 754, 609

36, 466, 058 202. 00

2, 517, 741

202.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0176

					12/31/201/	5/30/2018 4:1			
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY			
	'	& GENERAL	REPAI RS	LINEN SERVICE					
		5. 00	6. 00	8. 00	9. 00	10.00			
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		
5.00	00500 ADMINISTRATIVE & GENERAL	8, 692, 144					5. 00		
6.00	00600 MAINTENANCE & REPAIRS	843, 028	3, 536, 743				6. 00		
8.00	00800 LAUNDRY & LINEN SERVICE	228, 611	88, 515	1, 047, 604			8. 00		
9.00	00900 HOUSEKEEPI NG	154, 943	128, 110	0	778, 139		9. 00		
10.00	01000 DI ETARY	178, 573	217, 258	0	50, 919	1, 017, 343	10.00		
11.00	01100 CAFETERI A	97, 254	118, 784	0	27, 840	0	11. 00		
13.00	01300 NURSI NG ADMI NI STRATI ON	122, 033	41, 096	0	9, 632	0	13.00		
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 531, 905	157, 431	0	36, 897	0	14. 00		
15. 00	01500 PHARMACY	621, 916			9, 558	0	15. 00		
16. 00	01600 MEDICAL RECORDS & LIBRARY	98, 960			25, 172	0	16. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDI ATRI CS	1, 929, 275	1, 675, 708	1, 047, 604	392, 736	1, 017, 343	30. 00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATI NG ROOM	760, 656	582, 700	0	136, 568	0	50.00		
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	328, 726	159, 644	0	37, 416	0	54.00		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	55. 00		
56.00	05600 RADI OI SOTOPE	0	0	0	o	0	56. 00		
57.00	05700 CT SCAN	0	0	0	o	0	57. 00		
58.00	05800 MRI	0	0	0	o	0	58. 00		
59.00	05900 CARDI AC CATHETERI ZATI ON	298, 079	115, 228	0	27, 006	0	59. 00		
60.00	06000 LABORATORY	811, 629	l		10, 225	0	60.00		
65.00	06500 RESPIRATORY THERAPY	236, 951	14, 384		3, 371	0	65. 00		
69.00	06900 ELECTROCARDI OLOGY	128, 754	19, 205		4, 501	0	69. 00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00		
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	317, 311	26, 871	0	6, 298	0	91. 00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00		
	SPECIAL PURPOSE COST CENTERS								
113.00	11300 I NTEREST EXPENSE						113. 00		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 688, 604	3, 536, 743	1, 047, 604	778, 139	1, 017, 343	118. 00		
	NONREI MBURSABLE COST CENTERS								
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00		
191.00	19100 RESEARCH	0	0	0	0	0	191. 00		
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	O	0	192. 00		
194.00	07951 MARKETING/ ADVERTISING	3, 540	0	0	O	0	194. 00		
200.00	Cross Foot Adjustments						200. 00		
201.00	Negative Cost Centers	0	0	0	o		201. 00		
202.00	TOTAL (sum lines 118 through 201)	8, 692, 144	3, 536, 743	1, 047, 604	778, 139	1, 017, 343	202. 00		
				•	·				

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176

				То	12/31/2017	Date/Time Pre 5/30/2018 4:1	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11. 00	13.00	SUPPLY 14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
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
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 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	554, 632	1				11. 00
13. 00	01300 NURSING ADMINISTRATION	8, 111	1				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		6, 621, 107			14.00
15.00	01500 PHARMACY	16, 782		0	2, 676, 237	550 070	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	11, 532	! 0	0	0	559, 273	16. 00
30. 00	03000 ADULTS & PEDIATRICS	233, 268	342, 804	0	0	69, 510	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	233, 200	342, 604	U	<u> </u>	07, 510	30.00
50.00	05000 OPERATING ROOM	70, 490	103, 573	0	ol	57, 838	50.00
53. 00	05300 ANESTHESI OLOGY	70,470		0	Ö	0.7,030	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	28, 727	1 -1	0	ol	60, 126	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	ol ol	ō	ol	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	o	0	o	0	56. 00
57.00	05700 CT SCAN	0	o	0	o	0	57. 00
58.00	05800 MRI	0	ol ol	0	o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	52, 322	38, 447	0	0	102, 532	59. 00
60.00	06000 LABORATORY	24, 126		0	0	103, 852	60.00
65.00	06500 RESPI RATORY THERAPY	33, 387		0	0	17, 522	
69. 00	06900 ELECTROCARDI OLOGY	25, 099	36, 903	0	0	14, 168	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2, 441, 389	0	16, 763	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	4, 179, 718	0	28, 702	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	2, 676, 237	61, 396	73. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	50, 788	l ol	0	ol	24 944	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	50, 788	Y Y	U	٩	26, 864	91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113 00	11300 I NTEREST EXPENSE						113. 00
118.00	1 1	554, 632	570, 802	6, 621, 107	2, 676, 237	559, 273	1
	NONREI MBURSABLE COST CENTERS			57 5= 17 151	_,,,		1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	o	0	o	0	191. 00
	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		o	0	o	0	192. 00
	07951 MARKETING/ ADVERTISING	0) o	0	o	0	194. 00
200.00	3						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	554, 632	570, 802	6, 621, 107	2, 676, 237	559, 273	202. 00

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176 Peri od: Worksheet B From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 4:16 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 12, 872, 859 0 12, 872, 859 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 4, 142, 339 4, 142, 339 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 665, 014 0 1, 665, 014 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 0 0 05600 RADI 0I SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 1, 586, 063 59 00 1, 586, 063 59 00 60.00 06000 LABORATORY 3, 586, 843 3, 586, 843 60.00 06500 RESPIRATORY THERAPY 1, 111, 816 1, 111, 816 65.00 65.00 06900 ELECTROCARDI OLOGY 640, 037 640, 037 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 458, 152 0 2, 458, 152 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 4, 208, 420 4, 208, 420 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 73.00 2, 737, 633 2, 737, 633 73.00 91.00 09100 EMERGENCY 1, 442, 030 1, 442, 030 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 36, 451, 206 0 36, 451, 206 118.00 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 \cap 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 194.00 07951 MARKETING/ ADVERTISING 0 194. 00 14, 852 14,852 200.00 Cross Foot Adjustments 0 0 C 200. 00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 36, 466, 058 36, 466, 058 202.00

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

				То	12/31/2017	Date/Time Pre 5/30/2018 4:1	
			CAPI TAL REI	ATED COSTS		7 307 2010 4. 1	O pili
		D	BLDO & ELVE	10/DLE EQUID		END! OVEE	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DELAKTIMENT	
		0	1. 00	2.00	2A	4. 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	0	19, 965	· ·	55, 422	55, 422	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	128, 423		356, 502	6, 130	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	402, 698		1, 117, 886	652	6. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	21, 688 31, 389		60, 206 87, 136	0	8. 00 9. 00
10. 00	01000 DI ETARY	0	53, 232		147, 772	788	10.00
11. 00	01100 CAFETERI A	0	29, 104		80, 793	713	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	10, 069	· ·	27, 952	1, 480	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	38, 574		107, 080	0	14. 00
15. 00	01500 PHARMACY	0	9, 992		27, 738	1, 352	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	26, 316		73, 053	740	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	410, 580	729, 185	1, 139, 765	19, 892	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	142, 772		396, 334	6, 515	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	39, 116		108, 585	3, 197	54.00
55. 00 56. 00	05600 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0	0		0	0	57.00
58. 00	05800 MRI	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	28, 233	-	78, 375	3, 148	ł
60.00	06000 LABORATORY	0	10, 689		29, 673	2, 235	60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 524	6, 259	9, 783	2, 920	65. 00
69. 00	06900 ELECTROCARDI OLOGY	0	4, 706	8, 357	13, 063	1, 644	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS	0	(504	11 (02	10 077	4.017	01 00
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 584	11, 693	18, 277 0	4, 016	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS				U		92.00
113 00	11300 I NTEREST EXPENSE						113. 00
118.00	1	0	1, 417, 654	2, 517, 741	3, 935, 395	55, 422	ł
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	1, 117, 001	2,017,711	0, 700, 070	00, 122	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	О		192. 00
	07951 MARKETING/ ADVERTISING	0	0	0	0	0	194. 00
200.00					0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 417, 654	2, 517, 741	3, 935, 395	55, 422	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

				T	o 12/31/2017	Date/Time Pre 5/30/2018 4:1	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	O pili
	occi conton boson per on	& GENERAL	REPAI RS	LINEN SERVICE	HOUGENEEL THE	51211111	
		5. 00	6. 00	8. 00	9. 00	10.00	
	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
5.00	00500 ADMINISTRATIVE & GENERAL	362, 632					5. 00
6.00	00600 MAINTENANCE & REPAIRS	35, 172	1, 153, 710				6. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 538					8. 00
9.00	00900 HOUSEKEEPI NG	6, 464			135, 390		9. 00
10.00	01000 DI ETARY	7, 450		0	8, 859	235, 740	10.00
11. 00	01100 CAFETERI A	4, 058	38, 748	0	4, 844	0	11. 00
13.00	01300 NURSING ADMINISTRATION	5, 091	13, 406	0	1, 676	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	63, 912	51, 355		6, 420	0	14. 00
15. 00	01500 PHARMACY	25, 947	13, 303		1, 663	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 129	35, 036	0	4, 380	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00	03000 ADULTS & PEDI ATRI CS	80, 479	546, 628	98, 618	68, 332	235, 740	30. 00
	ANCILLARY SERVICE COST CENTERS		1				
50. 00	05000 OPERATI NG ROOM	31, 735	l		23, 762	0	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 715	l		6, 510	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	
56. 00	05600 RADI OI SOTOPE	0	0		0	0	
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0	·	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 436			4, 699	0	59. 00
60.00	06000 LABORATORY	33, 862			1, 779	0	60.00
65.00	06500 RESPI RATORY THERAPY	9, 886			587	0	65.00
69. 00	06900 ELECTROCARDI OLOGY	5, 372	l	0	783	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	_	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS	12 220	0.7/5		1 00/		01 00
91.00	09100 EMERGENCY	13, 238	8, 765	0	1, 096	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
112 00		1					112 00
	11300 INTEREST EXPENSE	2/2 404	1 150 710	00 (10	125 200	225 740	113. 00
118.00	,	362, 484	1, 153, 710	98, 618	135, 390	235, 740	1118.00
100.00	NONREI MBURSABLE COST CENTERS	1 0		1	0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		ĭ		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	140	0		0		192. 00 194. 00
	07951 MARKETING/ ADVERTISING	148	"		U	0	
200.00	1 1	_	_	_		^	200. 00 201. 00
201.00	1 3	362, 632	1 152 710	98, 618	135, 390	235, 740	
202.00	TOTAL (Suil Titles To through 201)	302, 032	1, 153, 710	70,018	130, 390	230, 740	1202.00

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

				То	12/31/2017	Date/Time Pre 5/30/2018 4:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16. 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
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 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	129, 156					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 889	1	000 7/7			13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	0		228, 767	70 011		14. 00
15. 00	01500 PHARMACY	3, 908		0	73, 911	100 000	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 685	l U	0	0	120, 023	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	54, 320	30, 926	0	0	14, 913	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	34, 320	30, 920	U	<u> </u>	14, 913	30.00
50. 00	05000 OPERATING ROOM	16, 415	9, 344	0	ol	12, 409	50.00
53. 00	05300 ANESTHESI OLOGY	10, 413	7, 344	0	0	12, 407	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 690		ő	0	12, 900	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0,070	Ö	Ö	0	0	55. 00
56. 00	05600 RADI OI SOTOPE		o	Ö	o	0	1
57. 00	05700 CT SCAN	0	ol	ō	o	0	57. 00
58. 00	05800 MRI	0	ol	ō	o	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 184	3, 468	0	o	21, 998	59. 00
60.00	06000 LABORATORY	5, 618	o	0	0	22, 313	60.00
65.00	06500 RESPI RATORY THERAPY	7, 775	4, 427	0	0	3, 759	65.00
69.00	06900 ELECTROCARDI OLOGY	5, 845	3, 329	0	0	3, 040	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	84, 353	0	3, 596	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	144, 414	0	6, 158	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73, 911	13, 173	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	11, 827	0	0	0	5, 764	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.00	SPECIAL PURPOSE COST CENTERS						110 00
	11300 I NTEREST EXPENSE	120 15/	F1 404	220 7/7	70 011	100 000	113.00
118.00		129, 156	51, 494	228, 767	73, 911	120, 023	1118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol	0	ol	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		191.00
	07951 MARKETING/ ADVERTISING			0	0		194. 00
200.00			1	o _l	٩	U	200.00
201.00	3	0	٥	0	٥	0	201.00
202.00		129, 156	51, 494	228, 767	73, 911	120, 023	
	1 1 1 1 2 (3 3 1 1 1 1 1 3 3 1 1 2 3 1		3., 1, 1	223, 707	. 5, 711	.20,020	1-32. 00

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10

Health Financial Systems	KENTUCKTANA ME	DICAL CENTER		In Lieu of Form CMS	5-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Pi 5/30/2018 4	repared:
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	0,00,2010	. 10 рш
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1. 00 O0100 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
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
6.00 00600 MAINTENANCE & REPAIRS					6. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11. 00
13.00 01300 NURSING ADMINISTRATION					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 289, 613	0	2, 289, 61	3	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	686, 595	1	686, 59	5	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	203, 674	1	203, 67	4	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	0		0	56. 00
57. 00 05700 CT SCAN	0	0		ט	57. 00
58. 00 05800 MRI	170 000	0	470.00	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	173, 896		173, 89		59. 00
60. 00 06000 LABORATORY	109, 711		109, 71		60.00
65. 00 06500 RESPI RATORY THERAPY	43, 829	0	43, 82		65. 00
69. 00 06900 ELECTROCARDI OLOGY	39, 341		39, 34		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 949	١	87, 94	0	70. 00 71. 00
72. 00 07700 MPL. DEV. CHARGED TO PATIENTS	150, 572	1	87, 94 150, 57		71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	87, 084		87, 08		73.00
OUTPATIENT SERVICE COST CENTERS	07,004	ı o	67,00	+	— /3.00
91. 00 09100 EMERGENCY	62, 983	O	62, 98	3	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	02, 703		02, 70	3	92. 00
SPECIAL PURPOSE COST CENTERS		<u> </u>			72.00
113. 00 11300 NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 935, 247	o	3, 935, 24	7	118.00
NONREI MBURSABLE COST CENTERS	0,700,217	٩	0, 700, 21	,	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	o		0	190. 00
191. 00 19100 RESEARCH	0			0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				0	192.00
194. 00 07951 MARKETI NG/ ADVERTI SI NG	148		14	-	194. 00
200.00 Cross Foot Adjustments	0			0	200. 00
201.00 Negative Cost Centers		o		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 935, 395	Ö	3, 935, 39	5	202. 00
1 1 (21 11 11 11 11 11 11 11 11 11 11 11 11 1		-1	-,,,		

Hear th	Financial Systems	KENTUCKTANA ME	DICAL CENTER		In Lie	eu of Form CMS	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0176 I	Peri od:	Worksheet B-1	
					From 01/01/2017		
					Γο 12/31/2017		pared:
						5/30/2018 4:1	
		CAPITAL REL	ATED COSTS				
		OALLIAE REL	_ATED 00313				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
		(===:,	(,	DEPARTMENT			
						(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2. 00	4.00	5A	5. 00	
	CENEDAL CEDALCE COCT CENTEDO	1.00	2.00	7.00	374	3.66	
	GENERAL SERVICE COST CENTERS						4
1.00	00100 CAP REL COSTS-BLDG & FLXT	73, 210					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1	73, 210				2.00
	I I	1 021					
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 031	l			1	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 632	6, 632	1, 180, 22	2 -8, 692, 144	27, 773, 914	5. 00
6.00	00600 MAINTENANCE & REPAIRS	20, 796	20, 796	125, 44	ol le	2, 693, 715	6.00
			l				
8.00	00800 LAUNDRY & LINEN SERVICE	1, 120	l		ا ا	730, 478	1
9.00	00900 HOUSEKEEPI NG	1, 621	1, 621		0 0	495, 086	9. 00
10.00	01000 DI ETARY	2, 749	2, 749	151, 74	5 0	570, 593	10.00
11. 00	01100 CAFETERI A		l				1
		1, 503				310, 754	
13. 00	01300 NURSING ADMINISTRATION	520	520	284, 86	1 0	389, 930	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 992	1, 992	1	0	4, 894, 874	14.00
15. 00	01500 PHARMACY	1			-		1
		516					1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 359	1, 359	142, 52	3 0	316, 205	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		21, 203	21, 203	3, 829, 280	0 0	4 144 411	30.00
30.00		21, 203	21, 203	3, 029, 20	<u>J</u>	6, 164, 611	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 373	7, 373	1, 254, 24	5 0	2, 430, 514	50.00
53. 00	05300 ANESTHESI OLOGY	0	1		0		1
		1			-	_	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 020	2, 020	615, 52	4 0	1, 050, 375	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		ol o	0	55.00
56. 00	05600 RADI OI SOTOPE		1	1		1	56.00
		0	١	1	ع ا	1	
57. 00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MRI	0	0		ol o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 458	1, 458	606, 01		952, 449	1
			1				1
60. 00	06000 LABORATORY	552	552	430, 33	7 0	2, 593, 386	60.00
65.00	06500 RESPI RATORY THERAPY	182	182	562, 18	3 0	757, 126	65.00
69. 00	06900 ELECTROCARDI OLOGY	243	243			411, 407	
	I I		243				•
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		ol o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	۱ ،	1	0		72.00
		-	0				
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	[0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	340	340	773, 25	3 0	1, 013, 898	91.00
		340	340	173,23	9	1,013,070	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
113 00	11300 I NTEREST EXPENSE						113. 00
		72 210	72 210	10 //0 ///	0 (00 144	27 7/2 /02	1
118.00		73, 210	73, 210	10, 669, 660	-8, 692, 144	27, 762, 602]118.00
	NONREI MBURSABLE COST CENTERS						
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	1190. 00
	I I	1 0	0				
	19100 RESEARCH	0	0	1	0	l .	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192. 00
	07951 MARKETI NG/ ADVERTI SI NG	0	l o	1	n n	11 312	194. 00
				1	9	11,312	
200.00	, , , , , , , , , , , , , , , , , , ,						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 417, 654	2, 517, 741	2, 754, 60	9	8, 692, 144	202. nn
	Part I)	1,, 501	_, , , , , , , , ,	_, , 00		-, 3,2,	
000 5		40.0445:-	04 000/=:				000 05
203.00		19. 364213	34. 390671	•		0. 312961	
204.00				55, 42	2	362, 632	204.00
	Part II)						
205 00				0.00510	4	0.012057	205 00
205.00				0. 00519	+	0. 013057	∠∪ɔ. ∪∪
							1
206.00						1	206. 00
	(per Wkst. B-2)						
207.00	NAUE unit and multiplica (Wint 5						207 20
207.00				1		[207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0176 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 4:16 pm Cost Center Description MAINTENANCE & LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) REPAIRS (FTFS) (SQUARE FEET) (PATIENT DA YS) 6.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 44, 751 6.00 00800 LAUNDRY & LINEN SERVICE 8, 017 8.00 1.120 8.00 00900 HOUSEKEEPI NG 9.00 1,621 42,010 9.00 10.00 01000 DI ETARY 2,749 0 2,749 29, 172 10.00 11.00 01100 CAFETERI A 1,503 1,503 18, 805 0 11.00 01300 NURSING ADMINISTRATION 13.00 520 Λ 520 275 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 992 C 1, 992 0 0 14.00 15.00 01500 PHARMACY 516 516 0 569 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 359 16.00 1, 359 391 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21, 203 8, 017 21, 203 29, 172 7, 909 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 390 7, 373 7, 373 50 00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,020 2,020 0 974 54.00 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 C 05600 RADI OI SOTOPE 56.00 0 O Ω 0 56 00 0 57.00 05700 CT SCAN 0 0 0 0 57.00 05800 MRI 58.00 0 0 0 0 0 58.00 1, 774 59 00 05900 CARDIAC CATHETERIZATION 1 458 Ω 59 00 1 458 06000 LABORATORY 60.00 552 552 818 60.00 06500 RESPIRATORY THERAPY 182 182 1, 132 65.00 65.00 0 06900 ELECTROCARDI OLOGY 69.00 243 0 243 851 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 Ω 70 00 0 C0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 340 0 340 0 1, 722 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00|11300| I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 44, 751 8,017 42, 010 29, 172 18, 805 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191.00 191. 00 19100 RESEARCH 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.00 194. 00 07951 MARKETING/ ADVERTISING 0 O o 0 194. 00 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 3, 536, 743 1,047,604 778, 139 1, 017, 343 554, 632 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 79. 031597 130. 672820 18. 522709 34. 873954 29. 493858 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 153, 710 98, 618 135, 390 235, 740 129, 156 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 25. 780653 12. 301110 3. 222804 8.081037 6. 868173 205. 00 205.00 II)206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Heal th	Financial Systems	KENTUCKI ANA MED	DICAL CENTER		In Lie	u of Form CMS-2552-	10
COST A	ALLOCATION - STATISTICAL BASIS		Provider CC	N: 15-0176	Peri od:	Worksheet B-1	_
					From 01/01/2017 To 12/31/2017	Date/Time Prepared	ı.
					10 12/31/201/	5/30/2018 4:16 pm	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(DIRECT NRSING	SUPPLY	REQUI S.)	LI BRARY		
		HRS)	(COSTED REQUIS.)		(GROSS CHAR GES)		
		13. 00	14.00	15. 00	16. 00		
	GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	10.00		_
1.00	00100 CAP REL COSTS-BLDG & FLXT					1. (00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.0	00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. (00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 0	00
6.00	00600 MAINTENANCE & REPAIRS					6.0	
8.00	00800 LAUNDRY & LINEN SERVICE					8.0	
9. 00	00900 HOUSEKEEPI NG					9. (
10.00	01000 DI ETARY					10. (
11.00	01100 CAFETERI A	070 040				11. (
13.00	01300 NURSI NG ADMI NI STRATI ON	273, 918	7 004 (00			13. (
14.00	01400 CENTRAL SERVICES & SUPPLY	0	7, 301, 623 0	7/7 7	00	14. (
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	ol Ol	767, 7	0 89, 810, 398	15. (16. (
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l o	<u> </u>		0	10. (JU
30. 00	03000 ADULTS & PEDIATRICS	164, 506	0		0 11, 162, 694	30.0	20
30.00	ANCI LLARY SERVI CE COST CENTERS	104, 300	<u> </u>		0 11, 102, 074	30. (,0
50. 00	05000 OPERATING ROOM	49, 703	o		0 9, 288, 229	50.0	00
53. 00	05300 ANESTHESI OLOGY	0	ō		0 0	53. 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	0		0 9, 655, 676	54.0	00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	o		0 0	55.0	00
56.00	05600 RADI OI SOTOPE	0	o		0 0	56.0	00
57. 00	05700 CT SCAN	0	0		0 0	57. (00
58. 00	05800 MRI	0	0		0 0	58.0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	18, 450	0		0 16, 465, 720	59. (
60.00	06000 LABORATORY	0	0		0 16, 673, 976	60.0	
65. 00	06500 RESPI RATORY THERAPY	23, 550	0		0 2, 813, 868	65. (
69. 00	06900 ELECTROCARDI OLOGY	17, 709	0		0 2, 275, 282	69. (
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0 (02 215		0 0 2, 691, 935	70. (
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 692, 315 4, 609, 308		0 2, 691, 935 0 4, 609, 309	71. (
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 609, 306	767, 7		73.0	
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	707, 7	9, 037, 071	75. (50
91. 00	09100 EMERGENCY	0	ol		0 4, 314, 038	91. (20
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ		1, 511, 555	92. (
,2.00	SPECIAL PURPOSE COST CENTERS					/21	, ,
113.00	11300 NTEREST EXPENSE					113. (00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	273, 918	7, 301, 623	767, 7	88 89, 810, 398	118. (00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. (00
	19100 RESEARCH	0	0		0 0	191. (
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	192. (
	07951 MARKETING/ ADVERTISING	0	0		0 0	194. (
200.00	1					200. (
201 00	Negative Cost Centers	1			1	201 (.)()

570, 802

2. 083843

0. 187991

51, 494

6, 621, 107

0. 906799

0. 031331

228, 767

2, 676, 237

3. 485646

0.096265

73, 911

559, 273

0.006227

0.001336

120, 023

201.00

202. 00

203. 00 204. 00

205. 00

206. 00

207. 00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

Negative Cost Centers

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

	Financial Systems	KENTUCKIANA ME				u of Form CMS-2	<u> 2552-10</u>
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2017	Worksheet C Part I	
				1	Го 12/31/2017	Date/Time Pre 5/30/2018 4:1	
			Title	XVIII	Hospi tal	PPS	<u>- </u>
			<u> </u>		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)					
	ANDATI ENT. DOUTLING OFFICE OF COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	40.070.050		10.070.050		40.070.050	00.00
	03000 ADULTS & PEDI ATRI CS	12, 872, 859		12, 872, 859	9 0	12, 872, 859	30.00
μ.	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4 142 220	Г	4 142 220		4 140 220	FO 00
	05300 ANESTHESI OLOGY	4, 142, 339		4, 142, 339	0	4, 142, 339	50. 00 53. 00
	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 665, 014		1, 665, 014	1	0 1, 665, 014	
	05500 RADI OLOGY-THERAPEUTI C	1, 000, 014		1,000,012	1	1, 665, 014	
	05600 RADI OLOGI - THERAPEUTI C	0				0	56.00
	05700 CT SCAN	0				0	57.00
	05800 MRI	0				0	58.00
	05900 CARDI AC CATHETERI ZATI ON	1, 586, 063		1, 586, 063	3	1, 586, 063	
	06000 LABORATORY	3, 586, 843		3, 586, 843		3, 586, 843	
	06500 RESPIRATORY THERAPY	1, 111, 816				1, 111, 816	
	06900 ELECTROCARDI OLOGY	640, 037		640, 03		640, 037	
	07000 ELECTROENCEPHALOGRAPHY	0.07.007		1	0	0.07.007	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 458, 152		2, 458, 152	0	2, 458, 152	
	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 208, 420		4, 208, 420		4, 208, 420	
	07300 DRUGS CHARGED TO PATIENTS	2, 737, 633	l .	2, 737, 633		2, 737, 633	
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,			
	09100 EMERGENCY	1, 442, 030		1, 442, 030	0	1, 442, 030	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	759, 983	l .	759, 983		759, 983	
	SPECIAL PURPOSE COST CENTERS				•		
	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	37, 211, 189	0	37, 211, 189	9 0	37, 211, 189	200.00

37, 211, 189 759, 983 36, 451, 206

0

37, 211, 189

36, 451, 206

759, 983

37, 211, 189 200. 00 759, 983 201. 00 36, 451, 206 202. 00

0

200. 00 201. 00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	KENTUCKI ANA MEI	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prep 5/30/2018 4:10	pared: 6 pm
		Title	XVIII	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	10, 452, 190		10, 452, 19	O		30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 607, 721	3, 680, 508	9, 288, 22			50.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0.000000		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 757, 425	5, 898, 251	9, 655, 67			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000		55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	(0.000000		56. 00
57.00 05700 CT SCAN	0	0	(0.000000	0.000000	57.00
58. 00 05800 MRI	0	0	(0.000000	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 808, 864	6, 656, 856	16, 465, 72	0. 096325	0.000000	59. 00
60. 00 06000 LABORATORY	10, 204, 741	6, 469, 235	16, 673, 97	6 0. 215116	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 711, 591	102, 277	2, 813, 86	0. 395120	0.000000	65. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 379, 274	896, 008	2, 275, 28	0. 281300	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0.000000	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 847, 204	844, 731	2, 691, 93	5 0. 913154	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 761, 804	847, 505	4, 609, 30	9 0. 913026	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 122, 260	1, 737, 411	9, 859, 67	0. 277660	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	614, 251	3, 699, 787	4, 314, 03	0. 334265	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	710, 504	710, 50	1. 069639	0. 000000	92.00
CDECLAL DUDDOCE COST CENTEDS						I

58, 267, 325

58, 267, 325

31, 543, 073

31, 543, 073

89, 810, 398

89, 810, 398

113. 00 200. 00 201. 00 202. 00

91. 00 | 09100 | EMERGENCY
92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART | SPECIAL PURPOSE COST CENTERS

113. 00 | 11300 | INTEREST EXPENSE | Subtotal (see instructions) | Less Observation Beds | Cost instructions | Cos

Total (see instructions)

202.00

Health Financial Systems	KENTUCKIANA MEDI	CAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0176	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 4:16 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 445977			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 172439			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
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
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 096325			59. 00
60. 00 06000 LABORATORY	0. 215116			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 395120			65. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 281300			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 913154			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 913026			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 277660			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 334265			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 069639			92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201 00 Less Observation Beds				201 00

113. 00 200. 00 201. 00 202. 00

Less Observation Beds Total (see instructions)

201.00 202.00

	Financial Systems	KENTUCKIANA ME				u of Form CMS-	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	nared:
					12/01/201/	5/30/2018 4: 1	
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	2.00	4.00	F 00	
	LNDATLENT DOUTLNE CEDVI OF COCT OFNITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12 072 050		12 072 05	9 0	12 072 050	30.00
30.00	ANCILLARY SERVICE COST CENTERS	12, 872, 859		12, 872, 85	9 0	12, 872, 859	30.00
50. 00		4, 142, 339		4, 142, 33	0	4, 142, 339	50.00
53. 00	05300 ANESTHESI OLOGY	4, 142, 339		4, 142, 33	0 0	4, 142, 339	1
54. 00		1, 665, 014		1, 665, 01	4	1, 665, 014	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1,005,014		1, 005, 01	0 0	1, 005, 014	1
56. 00	05600 RADI OI SOTOPE	0			0	0	
57. 00	05700 CT SCAN	0			0	0	57.00
58. 00	05800 MRI	0			0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 586, 063		1, 586, 06	3 0	1, 586, 063	
60.00	06000 LABORATORY	3, 586, 843		3, 586, 84		3, 586, 843	
65. 00	06500 RESPI RATORY THERAPY	1, 111, 816		1, 111, 81		1, 111, 816	
	06900 ELECTROCARDI OLOGY	640, 037		640, 03		640, 037	
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 458, 152		2, 458, 15	2 0	2, 458, 152	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 208, 420		4, 208, 42		4, 208, 420	
	07300 DRUGS CHARGED TO PATIENTS	2, 737, 633		2, 737, 63		2, 737, 633	
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	1, 442, 030		1, 442, 03	0 0	1, 442, 030	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	759, 983		759, 98	3	759, 983	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	37, 211, 189	0	37, 211, 18	9 0	37, 211, 189	200.00

37, 211, 189 759, 983 36, 451, 206

0

37, 211, 189

36, 451, 206

759, 983

37, 211, 189 200. 00 759, 983 201. 00 36, 451, 206 202. 00

0

200. 00 201. 00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 01/01/2017 To 12/31/2017		pared: 6 pm
		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 Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 452, 190		10, 452, 19	0		30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 607, 721	3, 680, 508	9, 288, 22			50. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0.000000		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 757, 425	5, 898, 251	9, 655, 67			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000		55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0.000000		56. 00
57.00 05700 CT SCAN	0	0		0.000000	0.000000	57.00
58. 00 05800 MRI	0	0		0.000000	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 808, 864	6, 656, 856	16, 465, 72	0. 096325	0.000000	59. 00
60. 00 06000 LABORATORY	10, 204, 741	6, 469, 235	16, 673, 97			60.00
65. 00 06500 RESPIRATORY THERAPY	2, 711, 591	102, 277	2, 813, 86	0. 395120	0.000000	65. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 379, 274	896, 008	2, 275, 28	0. 281300	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 847, 204	844, 731	2, 691, 93	0. 913154	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 761, 804	847, 505	4, 609, 30	9 0. 913026	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 122, 260	1, 737, 411	9, 859, 67	0. 277660	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	614, 251	3, 699, 787	4, 314, 03	0. 334265	0.000000	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	710, 504	710, 50	1. 069639	0. 000000	92. 00
CDECLAL DUDDOCE COST CENTEDS						1

58, 267, 325

58, 267, 325

31, 543, 073

31, 543, 073

89, 810, 398

89, 810, 398

113. 00 200. 00 201. 00 202. 00

91. 00 | 09100 | EMERGENCY
92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART | SPECIAL PURPOSE COST CENTERS

113. 00 | 11300 | INTEREST EXPENSE | Subtotal (see instructions) | Less Observation Beds | Cost instructions | Cos

Total (see instructions)

202.00

Health Financial Systems		KENTUCKIANA MED	ICAL CENTER	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS	TO CHARGES		Provi der CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 4:1	epared:
			Title XIX	Hospi tal	PPS	
Cost Center Descri	ption	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE	CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI C	S					30.00
ANCILLARY SERVICE COST (CENTERS					
50.00 05000 OPERATING ROOM		0. 445977				50.00
53. 00 05300 ANESTHESI OLOGY		0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOST	TC	0. 172439				54.00
55. 00 05500 RADI OLOGY-THERAPEU	ITI C	0. 000000				55. 00
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
59. 00 05900 CARDI AC CATHETERI Z	ATI ON	0. 096325				59. 00
60. 00 06000 LABORATORY		0. 215116				60.00
65. 00 06500 RESPIRATORY THERAP	Υ	0. 395120				65. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 281300				69. 00
70. 00 07000 ELECTROENCEPHALOGR		0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES C	HARGED TO PATIENT	0. 913154				71.00
72. 00 07200 I MPL. DEV. CHARGED		0. 913026				72. 00
73. 00 07300 DRUGS CHARGED TO P		0. 277660				73. 00
OUTPATIENT SERVICE COST	CENTERS					
91. 00 09100 EMERGENCY		0. 334265				91.00
92.00 09200 OBSERVATI ON BEDS (1. 069639				92. 00
SPECIAL PURPOSE COST CEN	ITERS					
113.00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see inst						200. 00
201.00 Less Observation B						201. 00
202.00 Total (see instruc	tions)					202. 00

Health Financial Systems	KENTUCKI ANA MEDI	In Lieu of Form CMS-2552-10			
CALCULATION OF OUTPATIENT SERVICE COS REDUCTIONS FOR MEDICALD ONLY	T TO CHARGE RATIOS NET OF	Provider CCN: 15-0176	From 01/01/2017	Worksheet C Part II Date/Time Prepared:	

				10) 12/31/201/	5/30/2018 4:1	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	4, 142, 339	686, 595	3, 455, 744	0	0	
1	300 ANESTHESI OLOGY	0	(0	0	0	53. 00
	400 RADI OLOGY-DI AGNOSTI C	1, 665, 014	203, 674	1, 461, 340	0	0	54. 00
	500 RADI OLOGY-THERAPEUTI C	0	(0	0	0	55. 00
	600 RADI OI SOTOPE	0	(0	0	0	56. 00
	700 CT SCAN	0	(0	0	0	57. 00
1	800 MRI	0	(0	0	0	58. 00
	900 CARDI AC CATHETERI ZATI ON	1, 586, 063			0	0	59. 00
	000 LABORATORY	3, 586, 843			0	0	60. 00
	500 RESPI RATORY THERAPY	1, 111, 816	1		0	0	65. 00
	900 ELECTROCARDI OLOGY	640, 037	39, 341	600, 696	0	0	69. 00
1	000 ELECTROENCEPHALOGRAPHY	0	(0	0	0	70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 458, 152			0	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	4, 208, 420			0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	2, 737, 633	87, 084	2, 650, 549	0	0	73. 00
	TPATIENT SERVICE COST CENTERS						
	100 EMERGENCY	1, 442, 030			0		
	200 OBSERVATION BEDS (NON-DISTINCT PART	759, 983	135, 174	624, 809	0	0	92. 00
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE					l	113. 00
200.00	Subtotal (sum of lines 50 thru 199)	24, 338, 330			0		200. 00
201. 00	Less Observation Beds	759, 983			0		201. 00
202.00	Total (line 200 minus line 201)	23, 578, 347	1, 645, 634	21, 932, 713	0	0	202. 00

Health Financial Systems	KENTUCKIANA MEDIC	In Lieu of Form CMS-2552-10			
CALCULATION OF OUTPATIENT SERVICE COS REDUCTIONS FOR MEDICALD ONLY	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Prepared: 5/30/2018 4:16 pm	

					12, 01, 201,	5/30/2018 4:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges				
			(Worksheet C,				
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
_	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	4, 142, 339	9, 288, 229				50.00
	5300 ANESTHESI OLOGY	0	0	0. 000000			53. 00
	5400 RADI OLOGY-DI AGNOSTI C	1, 665, 014	9, 655, 676	•			54. 00
	5500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000			55. 00
1	5600 RADI OI SOTOPE	0	0	0. 000000			56. 00
	5700 CT SCAN	0	0	0. 000000			57. 00
	5800 MRI	0	0	0. 000000			58. 00
1	5900 CARDI AC CATHETERI ZATI ON	1, 586, 063	16, 465, 720	•			59. 00
1	6000 LABORATORY	3, 586, 843	16, 673, 976				60.00
	6500 RESPI RATORY THERAPY	1, 111, 816	2, 813, 868	•			65. 00
	6900 ELECTROCARDI OLOGY	640, 037	2, 275, 282				69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000			70. 00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 458, 152	2, 691, 935				71. 00
1	7200 IMPL. DEV. CHARGED TO PATIENTS	4, 208, 420	4, 609, 309				72. 00
	7300 DRUGS CHARGED TO PATIENTS	2, 737, 633	9, 859, 671	0. 277660	0		73. 00
	UTPATIENT SERVICE COST CENTERS				1		
	9100 EMERGENCY	1, 442, 030					91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	759, 983	710, 504	1. 069639	9		92. 00
	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	24, 338, 330	79, 358, 208				200. 00
201. 00	Less Observation Beds	759, 983	0				201. 00
202. 00	Total (line 200 minus line 201)	23, 578, 347	79, 358, 208				202. 00

Health Financial Systems	KENTUCKI ANA ME	EDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		nared:
				10 12/31/2017	5/30/2018 4: 1	6 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 ADULTS & PEDIATRICS	2, 289, 613	C	2, 289, 61	3 8, 520	268. 73	30. 00
200.00 Total (lines 30 through 199)	2, 289, 613		2, 289, 61	3 8, 520		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 310					30. 00
200.00 Total (lines 30 through 199)	4, 310	1, 158, 226	o			200. 00

111-4-	Figure 1 Contact	MENTUCKI ANA ME	DICAL CENTED		1 - 11 -	£ F CMC :	2552 10
	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	KENTUCKI ANA ME	Provider C	ON 15 017/		u of Form CMS-2	2552-10
APPURT	TUNMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L C0515	Provider C		Peri od: From 01/01/2017	Worksheet D Part II	
					To 12/31/2017	Date/Time Pre	pared:
						5/30/2018 4:1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00				
	ANOLULARY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	/0/ 505	0 200 220	0. 07392	1 2 000 17/	224 702	 FO 00
50.00	05300 ANESTHESI OLOGY	686, 595	9, 288, 229	•		221, 702	
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	202 (74	0 (55 (7)	0.00000		0	
55. 00	1	203, 674	9, 655, 676	l .		46, 703 0	55.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0. 00000 0. 00000		ĭ	56.00
56. 00 57. 00	05700 CT SCAN	0	0	0.00000		0 0	57.00
58.00	05800 MRI	0	0	0.00000		0	58.00
58.00	05900 CARDI AC CATHETERI ZATI ON	173, 896	16, 465, 720			58, 479	
60.00	06000 LABORATORY	109, 711				39, 339	
65. 00	06500 RESPIRATORY THERAPY	43, 829					
69. 00	06900 ELECTROCARDI OLOGY	39, 341				15, 496	
70. 00	07000 ELECTROENCEPHALOGRAPHY	39, 341				15, 490	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 949	-			_	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	150, 572			·	58, 223	1
	07300 DRUGS CHARGED TO PATIENTS	87, 084					
73.00	OUTPATIENT SERVICE COST CENTERS	07,004	9, 009, 071	0.00003	2 4, 332, 660	40, 211	73.00
91. 00	09100 EMERGENCY	62, 983	4, 314, 038	0. 01460	0 292, 660	4, 273	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	135, 174			•	4, 2/3	92.00
200.00	· · · · · · · · · · · · · · · · · · ·	1, 780, 808			26, 780, 651	539, 266	
200.00		1, 700, 000	1 7, 330, 200	1	20, 700, 031	337, 200	1200.00

Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Nursing Scho	Health Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
To 12/31/2017 Date/Time Prepared: 5/30/2018 4: 16 pm	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider CO				
Title XVIII							narod:
Title XVIII					10 12/31/2017	5/30/2018 4:1	6 pm
NPATI ENT ROUTINE SERVICE COST CENTERS			Title	XVIII	Hospi tal		
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.00	Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
1A		Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0					_		
30.00 30.0		1A	1. 00	2A	2. 00	3. 00	
Total (lines 30 through 199)							
Cost Center Description		0	0		0	ľ	
Adjustment Amount (see instructions) Secondary Col. 6 Program Days Program Days		0	0		0		200. 00
Amount (see instructions) minus col. 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS			l ,	Days	5 ÷ col. 6)	Program Days	
1 NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 0 8,520 0.00 4,310 30.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 0 0 8,520 0.00 4,310 30.00 200.00 Total (lines 30 through 199) 0 8,520 4,310 200.00							
30. 00		4. 00	5. 00	6. 00	7. 00	8. 00	
Total (lines 30 through 199) 0 8,520 4,310 200.00		_	_				
Cost Center Description		0	0				
Program Pass-Through Cost (col. 7 x col. 8) 9.00			0	8, 52)	4, 310	200.00
Pass-Through Cost (col. 7 x col. 8) 9.00	Cost Center Description						
Cost (col. 7 x col. 8) 9.00							
Col . 8) 9.00							
9. 00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00							
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00							
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00	INPATIENT ROUTINE SERVICE COST CENTERS	7.00	<u> </u>				
		0					30.00
200.00 Total (lines 30 through 199) 0 200.00	200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	KENTUCKIANA MEDIC	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 4:16 pm

						5/30/2018 4:1	6 pm
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	C	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0) c	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) c	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0) c	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	ol c	0	0	56. 00
57.00	05700 CT SCAN	0	0	ol c	0	0	57. 00
58.00	05800 MRI	0	0	ıl c	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	ol c	0	0	59. 00
60.00	06000 LABORATORY	0	0	ol c	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	ol c	0	0	65. 00
69.00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	l o		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l o		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1 0	l o		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1 0	l o		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	_				-	
91. 00	09100 EMERGENCY	0	0	l c	0	0	91. 00
92. 00	1	0				0	92. 00
200.00		0	0		0	0	200.00

Health Financial Contant	KENTHOKI ANA ME	DICAL CENTED		1 1 :-	£ F CMC /	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	KENTUCKI ANA ME		CN. 15 017/	IN_LIE Period:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	RVICE UTHER PASS	S Provider C		errou: From 01/01/2017		
TIROUGH COSTS				Γο 12/31/2017	Date/Time Pre	
					5/30/2018 4: 1	6 pm
	1		XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and 4)	8)	7)	
	4. 00	5. 00	6, 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		9, 288, 229	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		9, 655, 676	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0.000000	56. 00
57. 00 05700 CT SCAN	0	0		0	0.000000	57. 00
58. 00 05800 MRI	0	0		0	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		16, 465, 720	0.000000	59. 00
60. 00 06000 LABORATORY	0	0		16, 673, 976	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		2, 813, 868	0.000000	65. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		2, 275, 282	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 691, 935		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		4, 609, 309		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 859, 671	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS			1			
91. 00 09100 EMERGENCY	0	0	1	4, 314, 038		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	710, 504		1
200.00 Total (lines 50 through 199)	0	0	1	79, 358, 208		200. 00

Heal th	Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10								
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co		Period: From 01/01/2017	Worksheet D			
THROUG	H COSTS				To 12/31/2017	Part IV Date/Time Pre 5/30/2018 4:1			
			Title	XVIII	Hospi tal	PPS			
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent			
		Ratio of Cost	Program	Program	Program	Program			
		to Charges	Charges	Pass-Through		Pass-Through			
		(col. 6 ÷ col.		Costs (col. 8	8	Costs (col. 9			
		7)		x col. 10)		x col. 12)			
	T	9. 00	10.00	11. 00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATI NG ROOM	0. 000000	2, 999, 176	(839, 937	0	50. 00		
53.00	05300 ANESTHESI OLOGY	0. 000000	0	(0	0	53.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 214, 048	(2, 738, 249	0	54. 00		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00		
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00		
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00		
58. 00	05800 MRI	0. 000000	0	(0	0	58. 00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 537, 234	(2, 622, 095	0	59. 00		
60.00	06000 LABORATORY	0. 000000	5, 978, 532		1, 600, 033	0	60.00		
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 622, 689	(23, 063	0	65. 00		
69.00	06900 ELECTROCARDI OLOGY	0. 000000	896, 177	(313, 329	0	69. 00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	904, 934	(600, 186	0	71. 00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 782, 321	(720, 674	0	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 552, 880	(554, 673	0	73. 00		
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0. 000000	292, 660		0 685, 954	0	91. 00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		232, 708	0	92. 00		
200.00	Total (lines 50 through 199)		26, 780, 651		10, 930, 901	0	200. 00		

Health Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/30/2018 4:1	
		Titl∈	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 445977	839, 937		0	374, 593	50.00

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 445977	839, 937	0	0	374, 593	
53. 00	05300 ANESTHESI OLOGY	0. 000000		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 172439		0	0	472, 181	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	C	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0. 000000	0	C	0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0	C	0	0	57. 00
58.00	05800 MRI	0. 000000	0	C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 096325	2, 622, 095	C	0	252, 573	59. 00
60.00	06000 LABORATORY	0. 215116	1, 600, 033	C	0	344, 193	60.00
65.00	06500 RESPI RATORY THERAPY	0. 395120	23, 063	C	0	9, 113	65. 00
69.00	06900 ELECTROCARDI OLOGY	0. 281300	313, 329	C	0	88, 139	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 913154	600, 186	C	0	548, 062	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 913026	720, 674	C	0	657, 994	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 277660	554, 673	d	0	154, 011	73. 00
	OUTPATIENT SERVICE COST CENTERS	•	,				
91.00	09100 EMERGENCY	0. 334265	685, 954	C	0	229, 290	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 069639	232, 708	d	0	248, 914	92.00
200.00	Subtotal (see instructions)		10, 930, 901	d	0	3, 379, 063	200. 00
201.00	Less PBP Clinic Lab. Services-Program			l c	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		10, 930, 901	c	0	3, 379, 063	202. 00

Health Financial Systems	KENTUCKIANA M	EDICAL CENTER		In lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND			CN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V	pared:
			XVIII	Hospi tal	PPS	
	Со	șts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	_			
ANOLULADY CERVICE COCT CENTERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS		J .	,			
50. 00 05000 OPERATING ROOM						50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C						53.00
						54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE						55.00
						56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI						57. 00 58. 00
59. 00 05800 MRT 59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
						60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY						65.00
69. 00 06900 RESPIRATORY THERAPY 69. 00 06900 ELECTROCARDI OLOGY						69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY						70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS						73.00
13. 00 01300 DROUS CHARGED TO FATTENTS	1	/1	'			1 /3.00

0

0

91. 00 92. 00

200. 00

201. 00

202. 00

09100 EMERGENCY

91.00

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

OUTPATIENT SERVICE COST CENTERS

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017 Fo 12/31/2017	Part Date/Time Pre	pared:
					5/30/2018 4:1	6 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 289, 613	0	2, 289, 613	8, 520	268. 73	30.00
200.00 Total (lines 30 through 199)	2, 289, 613		2, 289, 613	8, 520		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 & PEDI ATRI CS	33	8, 868	3			30.00
200.00 Total (lines 30 through 199)	33	8, 868	8			200. 00

111-6-	Figure 1 Contrar	KENTUCKI ANA ME	DICAL CENTED		1 - 11 -	£ F CMC :	2552 10
	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	KENTUCKI ANA ME	Provider C	ON. 1E 0174	Period:	u of Form CMS-2 Worksheet D	2552-10
APPURI	TONWENT OF INPATTENT ANCILLARY SERVICE CAPITA	IL CU313	Provider Co		From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre	pared:
						5/30/2018 4:1	6 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		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	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATING ROOM	686, 595	9, 288, 229	0. 07392	1 23, 091	1, 707	50.00
53. 00	05300 ANESTHESI OLOGY	0	0	1	•	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	203, 674	9, 655, 676	•		326	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	•	0	55. 00
56. 00	05600 RADI 0I SOTOPE	0	0	0.00000		0	56.00
57.00	05700 CT SCAN	0	0	0. 00000	0 0	0	57. 00
58.00	05800 MRI	0	0	0.00000	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	173, 896	16, 465, 720	0. 01056	1 40, 390	427	59. 00
60.00	06000 LABORATORY	109, 711	16, 673, 976	0. 00658	0 42, 020	276	60.00
65.00	06500 RESPI RATORY THERAPY	43, 829	2, 813, 868	0. 01557	6 11, 166	174	65. 00
69. 00	06900 ELECTROCARDI OLOGY	39, 341	2, 275, 282	0. 01729	1 5, 679	98	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0.0000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 949	2, 691, 935	0. 03267	1 7, 606	248	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	150, 572				506	
73.00	07300 DRUGS CHARGED TO PATIENTS	87, 084	9, 859, 671	0. 00883	2 33, 445	295	73. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	09100 EMERGENCY	62, 983			•	37	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	135, 174				0	
200.00	Total (lines 50 through 199)	1, 780, 808	79, 358, 208	l	196, 888	4, 094	200. 00

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		narod:
				10 12/31/2017	5/30/2018 4: 1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	00.00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.		
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)	/ 00	7.00	0.00	
INDATI ENT POUTINE CERVI OF COCT OFNITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0.50	0 00	22	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	8, 52			
200.00 Total (lines 30 through 199)	Inpati ent	U	8, 52	U	33	200. 00
Cost Center Description	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS		l .				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	KENTUCKIANA MEDIC	CAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 4:16 pm
		Title XIX	Hospi tal	PPS

						5/30/2018 4:1	6 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(o	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(o	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		o	0	56. 00
57.00	05700 CT SCAN	0	0		o	0	57. 00
58.00	05800 MRI	0	0		o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		o	0	59. 00
60.00	06000 LABORATORY	0	0		o	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		o	0	65. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		o	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		o	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		o	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	•			0	92.00
200.00		0	0		o	0	200. 00

Health Financial Systems	KENTUCKI ANA ME	EDI CAL	CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS					Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV	pared:
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other		tal Cost	Total		Ratio of Cost	
	Medi cal		of col 1		(from Wkst. C,		
	Education Cost	thro	ough col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	(8	7)	
				4)			
	4.00		5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	_	.1		T			
50. 00 05000 OPERATI NG ROOM	0		0		0 9, 288, 229		
53. 00 05300 ANESTHESI OLOGY	0		0		0	0. 000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0		0		0 9, 655, 676		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0		0	0. 000000	
56. 00 05600 RADI 01 SOTOPE	0)	0		0	0. 000000	
57. 00 05700 CT SCAN	0		0		0 0	0. 000000	
58. 00 05800 MRI	0		0		0	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0		0 16, 465, 720		
60. 00 06000 LABORATORY	0		0		0 16, 673, 976		
65. 00 06500 RESPI RATORY THERAPY	0		0		0 2, 813, 868		
69. 00 06900 ELECTROCARDI OLOGY	0		0		0 2, 275, 282		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0		0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0 2, 691, 935		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0 4, 609, 309		
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0		0		0 9, 859, 671	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS							
91. 00 09100 EMERGENCY	0		0		0 4, 314, 038		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 710, 504		
200.00 Total (lines 50 through 199)	0)	0		0 79, 358, 208		200. 00

	5' ' 1 6 1	KENTHOKI ANA MED	LOAL OFNITED			C.E. OHC.	2550 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	KENTUCKI ANA MED	Provider CO	CN. 1E 0174	eri od:	eu of Form CMS-2 Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCIELARY SER SH COSTS	WICE UTHER PASS	Provider CC		From 01/01/2017	Part IV	
I HKUUC	on CO313				Γο 12/31/2017	Date/Time Pre	
						5/30/2018 4: 1	6 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0.000000	23, 091			0	50.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	23, 091	}		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 472)			54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0.000000	13, 472)		0	55.00
56. 00	05600 RADI OLOGY - THERAPEUTI C	0. 000000	0)		0	56.00
57. 00	05700 CT SCAN	0. 000000	0)		0	57.00
58. 00	05800 MRI	0. 000000	0)			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	40, 390)		0	59.00
60.00	06000 LABORATORY	0. 000000	42, 020				60.00
65. 00	06500 RESPIRATORY THERAPY	0.000000	11, 166				65.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	5, 679			0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 0, 7	ì		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	7, 606	ì		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	15, 490			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	33, 445			0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0.000000	33, 443	L	<u> </u>	0	, 73.00
91. 00	09100 EMERGENCY	0. 000000	2, 529	(0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	2, 327	1		0	•
200.00	,	0.000000	196, 888	ì		_	200.00
200.00	1.2.2. (1	. , 5, 666	'	-1	,	

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0176	Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/30/2018 4:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

NAME Cast Center Description 1.00			Title XVIII	Hospi tal	5/30/2018 4: 1 PPS	6 pm
		Cost Center Description	II the Aviii	nospi tai	113	
		·			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding swing-bed and newborn days) 1.7 you have not yet vate room days (sectuding swing-bed and observation bed days.) 1.7 you have only private room days. 3.0 on the complete this line. 3.0 on the complete	1 00		excluding newborn)		8 520	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this is foculding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) 100 (and in the private room days) after becember 31 of the cost reporting period (credenday sear, enter 0 on this line) 101 (and swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 102 (and swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 103 (and swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 104 (and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and enterior) 105 (and swing-bed NF type inpatient days applicable to the program (excluding swing-bed and enterior) 106 (and swing-bed NF type inpatient days applicable to the program (excluding private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 105 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 107 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 108 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 109 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 109 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 100 (and swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 101 (and swing-bed becember 31 of the cost reporting period (including xviii) 108 (and xviii) 109 (and					· ·	
Semi-private room days (excluding sating-bed And observation bed days) Semi-private room days (excluding sating-bed And observation bed days) Total saing-bed SRF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Popular of Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Popular of Total inpatient days (including private room days) after December 31 of the cost Popular of Total inpatient days (including private room days) after December 31 of the cost Popular of Total inpatient days (including private room days) after December 31 of the cost Popular of Total inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting period (including private room days) December 31 of the cost reporting p				vate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost capering period in the cost period in the cost period in period in period in the cost period in period in the cost period in period in the cost period in period (if calendar year, enter 0 on this line) 10. Suring-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to the period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to tillex Virial period (if calendar year, enter 0 on this line) 13.00 Swing-bed SNF type inpatient days applicable to tillex Virial period (if calendar year, enter 0 on this line) 14.00 All type inpatient days applicable to tillex Virial period (if calendar year, enter 0 on this line) 15.00 Swing-bed SNF type inpatient days applicable to tillex Virial period (if calendar year, enter 0 on this line) 16.00 Number year, days (tillex Virial Virial year) 17.00 Number year, days (tillex Virial Virial year) 18.00 Number year, days (tillex Virial Yirial year) 18.00 Number year, days (tillex Virial Yirial year) 18.00 Number year				-		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 14.00 Modically necessary private room days applicable to title XVIII only (including private room days) 15.00 Intell nursery days (title V or XXX only) 16.00 November 31 of the cost reporting period (see instructions) 17.00 Intell nursery days (title V or XXX only) 18.00 November 31 of the cost reporting period (see instructions) 18.00 Modical rate for saing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions) 18.00 Modical rate for saing-bed SNF services applicable to services through December 31 of the cost reporting period (line S XIIII period cost applicable to SNF type services after December 31 of the cost reporting period (line S XIIIII period cost applicable to SNF type se				- 21 -6		
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7	5.00		olli days) through becelliber	31 OF the Cost	U	5.00
reporting period (if calendar year, either 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 1.00 total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 1.00 total inpatient days including private room days aprivate room days are period (including private room days) after December 31 of the cost 1.00 total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 1.00 becember 31 of the cost reporting period (including private room days) after 1.00 becember 31 of the cost reporting period (including private room days) after 1.00 becember 31 of the cost reporting period (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NFT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NFT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed	6.00		om days) after December 3	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed Swit ye inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed Swit type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (is cell natural into its line) 12. 00 Swing-bed Swit Type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (is cell natural into its line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 16. 00 International value of the cost reporting period (if calendar year, enter 0 on this line) 15. 00 Medical inverse days (title V or XIX only) 15. 00 Medical rorate for swing-bed SNF services applicable to services through December 31 of the cost cost (including private room days) 16. 00 Program (excluding swing-bed SNF services applicable to services after December 31 of the cost cost (including private room days) 16. 00 17. 00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost cost (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 x X III no 17) 17. 00 Medical of rate for swing-bed SNF services after December 31 of the cost reporting period (line 6		reporting period (if calendar year, enter 0 on this line)				
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7. 00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 con this line) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 con this line) 13.00 Swing-bed SMF type inpatient days applicable to title V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SMF type inpatient days applicable to title V or XIX only (including private room days) 0 13.00 Swing-bed SMF type inpatient days applicable to title V or XIX only (including private room days) 0 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Narsery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 16.00 Narsery day	8 00		m days) after December 3	1 of the cost	<u></u>	8 00
10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 1	0.00		ii days) ai tei beceiibei 5	i or the cost		0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line S x line 19) 19.00 Medical drate for swing-bed NF services after December 31 of	9.00		the Program (excluding	swing-bed and	4, 310	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.10 Nedically incessary private room days applicable to the Program (excluding swing-bed days) 1.11 On Nedically incessary private room days applicable to the Program (excluding swing-bed days) 1.12 On Nedically incessary private room days applicable to the Program (excluding swing-bed days) 1.12 On Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incessary) 1.13 On Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (incessary) 1.14 On Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (incessary) 1.15 On Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incessary) 1.15 On Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incessary) 1.16 On Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incessary) 1.16 On Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 on 20 on reporting period (incessary) 1.17 On Nedicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 on 20	40.00					40.00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	10. 00			oom days)	0	10.00
December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 12.00 12.00 13.00 13.00 14.00 14.00 15.00	11 00			nom davs) after	0	11 00
through December 31 of the cost reporting period 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Novery days (title V or XIX only) 17. 00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 19. 00 Modicare rate for swing-bed cost sapplicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17) 19. 00 Modicare rate for swing-bed cost sapplicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 19. 00 Modicare rate for swing-bed cost sapplicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 19. 00 Modicare rate for swing-bed cost sapplicable to NF type service safter December 31 of the cost reporting period (line 7 x	00			Join day Joy at tol		
3. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) a free December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 14. 00 15. 00 15. 00 16. 00 17. 00 16. 00 18. 00 16. 00 18. 00 16. 00 18. 00	12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	Konly (including private	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14,00 15,00 16 to 10 16	12 00		/ anly (including private	a maam daya)		12 00
14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 16.00 16.00 Nursery days (title V or XIX only) 16.00 16.00 Nursery days (title V or XIX only) 16.00 17.00 17.00 18.00 18.00 18.00 18.00 18.00 19.00	13.00				U	13.00
16.00 Nursery days (title V or XIX only) 16.00 17.00 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 18.00 18.00 19.00	14. 00				0	14. 00
SWING BED ADJUSTNENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period services applicable to services through December 31 of the cost reporting period services applicable to services through December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to SNF type services through December 31 of the cost reporting period services after 12, 872, 859 services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting beriod services after December 31 of the cost reporting beriod services after December 31 of the co	15. 00				-	
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 18.00 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 19.0	16. 00				0	16. 00
reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room condering edien charge (line 29 + line 3) 30. 00 Average periden minus earlied minus applicable to the Private room cost differential (line 3 x line 4) 31. 00 Average periden minus earlied minus applicable to the Program (line 14 x line 35) 32. 00 Average periden private room cost differential (l	17 00		os through Docombor 21 o	f the cost	0.00	17 00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 29.00 Average private room per diem charge (line 30 + line 3) 29.00 Average per diem private room charges (fine 29 + line 3) 29.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 General inpatient routine service cost period (line 3 x line 31) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem	17.00	1	es till odgir becellber 31 o	the cost	0.00	17.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 20	18.00		es after December 31 of	the cost	0.00	18. 00
reporting period 20.00 Reductaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line period (line social policible) to SNF type services through December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) to SNF type services after December 31 of the cost reporting period (line social policible) social policible) to SNF type services after December 31 of the cost reporting period (line social policible) social policible) social policible to NF type services after December 31 of the cost reporting period (line social policible) social policible) social policible to NF type services after December 31 of the cost reporting period (line social policible) social policible) social policible social policible social policible social policible) social policible social polic						
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10 12,872,859 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 18) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 12,872,859 27.00 Private room charges (excluding swing-bed charges) 27.00 Private room charges (excluding swing-bed charges) 27.00 Private room charges (excluding swing-bed charges) 27.00 Average private room per diem charge (line 29 + line 3) 28.00 Average per diem private room charge differential (line 27 + line 28) 27.00 27.00 Average per diem private room charge differential (line 27 + line 28) 27.00 27.00 27.00 27.00 Average per diem private room charge differential (line 27 + line 28) 27.00	19. 00		s through December 31 of	the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17) Total general inpatient routine services after December 31 of the cost reporting period (line 6 x line 18) Total swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) To	20. 00		s after December 31 of th	ne cost	0.00	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perivate room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 3 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
5 x line 17) 23.00 24.00 25.00 26.00 27. x line 19) 25.00 28. line 20) 29. line 20) 29. line 20) 20. line 20) 21. line 20) 22. line 20) 23. line 20) 24. line 20) 25. line 20) 26. line 20 line 21 minus line 26) 27. line 20) 28. line 20) 29. line 20 line 21 minus line 26) 29. line 21 minus line 28) 20. line 21 minus line 28) 20. line 21 minus line 30 line 21 minus line 33 (see instructions) 20. line 21 minus line 36) 20. line 21 minus line 36) 20. line 21 minus line 36) 20. line 22 minus line 36) 20. line 34 x line 31) 20. line 34 x line 31 x line 35) 31. line 36) 32. line 34 x line 35 x line 35 x line						
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average period method private room charge (line 29 ± line 3) 33.00 Average per diem private room charge (line 29 ± line 3) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential djustment (line 3 x line 35) 27 minus line 36) 28.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost dapplicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		er 31 of the cost reporti	ng period (line	0	22. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 12.872,859 Total swing-bed cost (see instructions) 12.872,859 Total swing-bed cost (see instructions) 12.872,859 Total swing-bed charges) 12.872,859 Total swing-bed charges) 12.872,859 Total swing-bed charges) 12.872,859 Total swing-bed charges) 12.872,859 Total swing-bed charges (excluding swing-bed charges) 12.872,859 Total swing-bed charges) 12.872,859 Total swing-bed charges (see instructions) 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room cost differential (line 12.872,859 Total swing-bed cost and private room co	23. 00	,	31 of the cost reporting	period (line 6	0	23. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 40.00						
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Private ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average inpatient routine service cost net of swing-bed cost and private room cost differential (line 12,872,859) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 50.00 Aucumentation (line 14 x line 35) 50.00 Aucumentation (line 14 x line 35) 50.00 Aucumentation (line 15 x line 26) 50.00 Aucumentation (line 16 x line 37 x line 38) 50.00 Aucumentation (line 17 x line 28) 50.00 Aucumentation (line 18 x line 31) 50.00 Aucumentation (line 18 x line 31) 50.00 Aucumentation (line 19 x line 30) 50.00 Aucumentation (line 19 x line 30) 50.00 Aucumentation (line 19 x line 30) 50.00 Aucumentation (line	24. 00		1 31 of the cost reportion	ng period (line	0	24. 00
x line 20) 26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 Private room charges (excluding swing-bed and observation bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS Average per diem private room cost differential (line 34 x line 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line	25 00		31 of the cost reporting	period (line 8	0	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average p	23.00		or the cost reporting	perroa (Trie o		23.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 36. 00 Pri vate room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 20. 00	26. 00	1				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.01 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00		(line 21 minus line 26)		12, 872, 859	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 30.00 30.00 0.00 32.00 0.00 33.00 0.00 0.00 33.00 0.00 0.00 33.00 0.00 0.00 33.00 0	29 00		d and observation had sh	argos)		20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12,872,859) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.000 0.00 0.00 0.00 0.00 0.00 0.00			a and observation bed cha	ar ges)		
32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 872, 859) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31. 00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 37.00 35.00 37.00 12,872,859 37.00 12,872,859 37.00 12,872,859 38.00 12,872,859 38.00 12,872,859 38.00 14,510,90 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 35.00 36.00 37			nuc lino 22)(coo inctruo	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 12,872,859 37.00		, , ,		ti ons)		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,510.90 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	10 01)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,510.90 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 6,511,979 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	12, 872, 859	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,510.90 38.00 Program general inpatient routine service cost (line 9 x line 38) 6,511,979 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,510.90 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 6,511,979 39.00 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 6,511,979 39.00 40.00	38 00				1 510 90	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 6,511,979 41.00	40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		6, 511, 979	41. 00

COMPLIA	Financial Systems	KENTUCKI ANA MEI		CN, 15 017/		u of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der C	UN: 15-U1/6	Peri od: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/30/2018 4:1	pared: 6 pm
	Coat Contan Dagonintian	Total	_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	3	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	5					
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	4						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48.00	Program inpatient ancillary service cost (WI Total Program inpatient costs (sum of lines			nne)		8, 247, 684 14, 759, 663	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 40) (.	see mstructro) (15 <i>)</i>		14, 757, 003	49.00
50. 00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sur	n of Parts I and	1, 158, 226	50. 00
51. 00		patient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	539, 266	51.00
	and IV)		,				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-phy	sician anesth	netist and	1, 697, 492 13, 062, 171	
00.00	medical education costs (line 49 minus line				Totrot, and	10,002,171] 55. 55
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00	,				50)	_	56. 00
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	pdated and co	ompounded by the	_	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the m	arket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	Thisti uctions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost reporti	ing period (See	0	64. 00
/ F . O O	instructions)(title XVIII only)		04 6 11				45.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decemb	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ine costs (line	64 plus line 6	5)(title XVII	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 o	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	o de la companya de					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	: 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				<u> </u>		70.00
71. 00	Adjusted general inpatient routine service)	-	71.00
72.00	,		/l: 14 l:	25)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73.00
75. 00	Capital-related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	,		rovi dor rocord	lc)			78.00
	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	i tati on		•	,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs						82. 00 83. 00
JJ. JU	Program inpatient ancillary services (see in	•	-,				84. 00
84. 00	Utilization review - physician compensation						85. 00
84. 00 85. 00	Total Drogram inpationt assette as south /						
84. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86. 00
84. 00 85. 00		SS THROUGH COST S)	-			503 1, 510. 90	87. 00

Health Financial Systems	KENTUCKI ANA MED	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0176		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 4:10	
		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	2, 289, 613	12, 872, 859	0. 17786	4 759, 983	135, 174	90.00
91.00 Nursing School cost	0	12, 872, 859	0.00000	0 759, 983	0	91.00
92.00 Allied health cost	0	12, 872, 859	0.00000	0 759, 983	0	92.00
93.00 All other Medical Education	0	12, 872, 859	0.00000	0 759, 983	0	93. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0176	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Pre 5/30/2018 4:1	pared: 6 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			8, 520	1. 00
2.00	Inpatient days (including private room days, excluding swing-			8, 520	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	ed days)		8, 017	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		31 of the cost	0, 017	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		24 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	m davs) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	33	9. 00
10.00	newborn days)	alv. (i palveli pa priveta pa	am daya)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc		olli days)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		om days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	V only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar y			U	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	ays)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	oo through Docombon 21 of	the east	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
20.00	reporting period	3 ai tei becember 31 of th	le cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		12, 872, 859	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	poriod (line 4	0	23. 00
23.00	x line 18)	31 of the cost reporting	perrou (Trile o	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reportin	g period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 872, 859	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(.=/ 0.=/ 00.	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	Fille 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruct	i ons)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x li			0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	terential (line	12, 872, 859	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 510. 90	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		49, 860	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)		49, 860	41.00

	27 militus filie 30)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 510. 90	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	49, 860	39.0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	49, 860	41.0

Provider CRN. 15-0176 Serious (Provider Description Provider D	<u>Heal</u> th	Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	eu of Form CMS-2	<u>255</u> 2-10
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0176		Worksheet D-1	
Title NT								
Total				Ti +I	e XIX	Hosni tal		6 pm
Col.		Cost Center Description	Total					
1.00		·	Inpatient Cost	Inpatient Days		÷		
			1.00	2 00		4.00		
	42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42. 00
44.00 CORONARY CARE UNIT		Intensive Care Type Inpatient Hospital Units						
45.00 SURCIAL INTENSIVE CARE UNIT 45.00								
According Acco								
Cost Center Description								
1.00	47. 00							47. 00
Program Inpatient and Illary service cost (West. D-3, col. 3, line 200) 63,125 48.00 112,986 49.00 Intel Program Inpatient costs (sum of lines 4, lithrough 4B) (see Instructions) 112,986 49.00 Poss through costs applicable to Program Inpatient routine services (from West. D, sum of Parts I and B, 868 50.00 Pass through costs applicable to Program Inpatient and Illary services (from West. D, sum of Parts I and B, 868 50.00 Pass through costs applicable to Program Inpatient and Illary services (from West. D, sum of Parts II and III) 40.00 40.00 10.00 12.90 10.00 1		Cost Center Description					1 00	
49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 112,985 50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 1.8,868 50.00 111) 111 112,985 111 112,985 1	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)				48. 00
5.0 to Pass through costs applicable to Program inpatient routine services (from West. D., sum of Parts I and I 1.0 pass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 4,094 51.00 51.0	49. 00	Total Program inpatient costs (sum of lines			ons)			
111 51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wikst. D., sum of Parts II and IV) 51.00 Total Program excludable cost (sum of lines 50 and 51) 12,962 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 100,023 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 100,023 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 100,023 53.00 Total Program discharges 0.54.00 54.00 55.00 Target amount (line 54 x line 55) 0.56.00 Target amount (line 54 x line 55) 0.56.00 Target amount (line 54 x line 55) 0.57.00 Discharger amount (line 54 x line 55) 0.57.00 Discharger of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00 Discharger of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00 Discharger of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 69.00	F0 00		-+!++!		. WI+ D	£ Dt- II	0.0/0	F0 00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and Program excludable cost (sum of lines 50 and 51) 12,962 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 100,023 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 100,023 53.00 Total Program discharges 0.00 55.00 100,023	50.00		arrent routine	services (Tron	ıı WKSt. D, SUİ	ıı oı Partsı and	8, 868	50.00
12,962 52.00 Total Program excludable cost (sum of lines 50 and 51) 12,962 52.00 1000	51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	4, 094	51.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION TARGET AMOUNT AND LIMIT COMPUTATION 55.00 Program discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines \$3.754 or 55 from prior year cost reporting period ending 1996, updated and compounded by the 10.00 S8.00 Bonus payment (see Instructions) 60.00 Lesser of lines \$3.754 or 55 from prior year cost reporting period ending 1996, updated and compounded by the 10.00 S8.00 Lesser of lines \$3.754 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of lines \$3.754 or 55 from prior year cost reporting period ending 1996, updated and compounded by the 10.00 S8.00 Lesser of lines \$3.754 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of lines \$3.754 or 55 from prior year cost report, updated by the market basket 60.02 Lesser of lines \$3.754 or 55 from prior year cost report, updated by the market basket 60.02 Lesser of lines \$3.754 or 55 from prior year cost report, updated by the market basket 60.02 Lesser of lines \$3.754 or 55 from prior year cost report the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 60.00 Relication from the market basket 60.00 Relication from	E2 00	1 ,	50 and E1)				12.042	F2 00
medical education costs (line 4° sinus line 52)* TARGET AMUNIT AMD LINT COMPUTATION 54.00 55.00 55.00 7 55.00 7 7 55.00 7 7 7 7 7 7 7 7 7				elated, non-phy	ysician anestl	netist, and		
54.00 Program discharges 0.6 4.00		medical education costs (line 49 minus line						
1 1 2 2 3 3 3 3 3 3 3 3	F4 00							- A 00
56.00 Target amount (line 54 x line 55) 0.56.00 55.00								
58.00 Bonus payment (see Instructions) 58.00 by 00 Lesser of Filnes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of Filnes 53/54 is 1ess than the lower of Filnes 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relicef payment (see instructions) 63.00 All lowable Inpatient cost plus incentive payment (see instructions) 64.00 Relicef payment (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (111 EXVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (111 EXVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See Instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY. ONE RUISING FACILITY. ONE OF A title OF A + line 68) 69.00 PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY. OTHER SERVICE Cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to	56.00	Target amount (line 54 x line 55)						
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 5% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see Instructions) 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 64.00 Wedicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Wedicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled oursing facility/often roursing facility/often rour		, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (I	ine 56 minus	line 53)		
market basket 0.00 (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c			norting period	ending 1996 ı	indated and co	omnounded by the		
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 62.00	37.00		por tring period	charing 1770, c	apaatea ana e	siipourided by the	0.00	37.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0. 8elief payment (see instructions) 0. 63.00 0. 80.00 0								
amount (Iline 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Relief payment (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 70.00 Adjusted general inpatient routine service cost (cost per diem (line 70 + line 2) 71.00 Adjusted general inpatient routine service costs (from Worksheet B, Part II, column 22, line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Define encapital-related costs (line 75 + line 2) 76.00 Porgram coutine service cost (line 74 minus line 77) 78.00 Porgram coutine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficia	61.00							61.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROCRAM INPATIENT ROUITINE SWING BEB COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND CEPTID ONLY 70.00 Skilled nursing facility/Cother nursing facility/CF/IID routine service cost (line 37) 71.00 Algusted general inpatient routine service costs (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 2, line 45) 75.00 Per diem capital-related costs (line 9 x line 76) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Per diem capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (see instructions) 88.00 Measonable inpatient routine service costs (see instructions) 88.00 Total Program inpatient ancillary services (see instructions) 88.00 Utilization review - physician compensation (see instructions) 88.00 Total Program inpatient routine service cost per diem (line 27 + line 2) 88.00 Total Program inpatient potenting costs (see instructions) 88.00 A								
RECORRAM INPATIENT ROUTINE SWING BED COST							-	
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	63.00		ent (see instru	uctions)			0	63.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 70 70 70 70 70 70 70	64. 00		ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Program capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost (see instructions) 82. 00 Inpatient routine service costs (see instructions) 83. 00 Villization review - physician compensation (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient routine service cost see instructions) 76. 00 Total Program inpatient routine service cost (see instructions) 87. 00 Total Program inpatient operat		instructions)(title XVIII only)						
Total Medicare swing-bed SNF Inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)	65.00		its after Decemb	per 31 of the d	cost reporting	g period (See	0	65.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Agd usted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjus	66. 00		ne costs (line	64 plus line 6	55)(title XVI	I only). For	0	66. 00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/OF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 70.00 Program routine service cost (line 9 x line 71) 70.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 70.00 Total Program general inpatient routine service costs (line 72 + line 73) 70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 70.00 Per diem capital-related costs (line 75 ÷ line 2) 70.00 Rabinatine routine service cost (line 74 minus line 77) 70.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program inpatient service costs (see instructions) 80.00 Total Program inpatient ancillary services (see instructions) 80.00 Total Program inpatient operating costs (sum of lines 83 through 85) 80.00 Total observation bed days (see instructions)	/ -	,						
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 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 NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 72.00 Program routine service cost (line 9 x line 71) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital-related costs (line 75 + line 2) 76.00 Program capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 74 minus line 77) 77.00 Rood Total Program routine service cost (line 74 minus line 77) 77.00 Rood Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Rood Total Program routine service cost (see instructions) 81.00 Reasonable inpatient routine service (see instructions) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 503 87.00 Rood Adjusted general inpatient routine cost per diem (line 27 + line 2) 1,510.90 88.00	67.00		ie costs through	n December 31 d	of the cost re	eporting period	0	67.00
69.00 Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 73.00 73.00 73.00 74.00 75.00	68. 00	1 `	e costs after [December 31 of	the cost repo	orting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 26, line 45) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 76.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 Total Observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 78.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 79.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	(0.00	1 '		/l: /7 :	- (0)			(0.00
70.00 71.00 71.00 72.00 72.00 73.00 73.00 74.00 75.00 75.00 76.00 76.00 77.00 77.00 77.00 78.00 79.00 79.00 79.00 79.00 79.00 79.00 70.00	69.00						<u> </u>	69.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost per diem limitation 10.10 Inpatient routine service cost limitation (line 9 x line 81) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service s(see instructions) 83.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 83.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00				•)		1
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 73.00 74.00 74.00 74.00 74.00 75.00 74.00 75.		,		ine 70 ÷ line	2)			
Total Program general inpatient routine service costs (line 72 + line 73) Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) Program capital -related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Reasonable inpatient ancillary services (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 82.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 74.00 75.00 76.00 76.00 77.00 76.00 77.00				n (line 14 x li	ne 35)			
26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76) Response to beneficiaries for excess costs (from provider records) Response to line 1 Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Reasonable inpatient routine service cost per diem limitation Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine service see instructions) Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine service cost (line 74 minus line 79) Reasonable records Reasonable inpatient routine service cost (line 74 minus line 79) Reasonable records Reasonable rec								1
Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Root program capital related costs (line 9 x line 76) Root program capital related costs (line 9 x line 76) Root program capital related costs (line 9 x line 77) Root program capital related costs (line 74 minus line 77) Root program capital related costs (line 74 minus line 77) Root program capital related costs (line 9 x line 76) Root program routine service costs (from provider records) Root program routine service costs for comparison to the cost limitation (line 78 minus line 79) Root program routine service cost limitation Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine service costs (see instructions) Root program inpatient ancillary services (see instructions) Root Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Root program inpatient routine cost per diem (line 27 ÷ line 2) Root program inpatient routine cost per diem (line 27 ÷ line 2) Root program inpatient routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2) Root program routine cost per diem (line 27 ÷ line 2)	75. 00	'	routine service	e costs (from V	Vorksheet B, I	Part II, column		75. 00
77. 00 78. 00 78. 00 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 82. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 83. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 84. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 85. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 87. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 88. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 89. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 89. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 89. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Roggregate charges for excess costs (from provider records) 82. 00 Roggregate charges	76. 00		ne 2)					76. 00
Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00		1	. *					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00		1 '	•	arovi dan z	46)			
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00						nus line 79)		
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Bas on					. (, ,		
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1		* .				
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1		ns)				1
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00		, , , , , , , , , , , , , , , , , , , ,		ons)				
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 503 87.00 1,510.90 88.00		Total Program inpatient operating costs (sum	of lines 83 th					
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,510.90 88.00	87 00						EUS	87 00
		1	•	: line 2)				
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions))			759, 983	89. 00

Health Financial Systems	KENTUCKI ANA MED	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0176			Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 4:10	
		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	2, 289, 613	12, 872, 859	0. 17786	4 759, 983	135, 174	90.00
91.00 Nursing School cost	0	12, 872, 859	0.00000	0 759, 983	0	91.00
92.00 Allied health cost	0	12, 872, 859	0.00000	0 759, 983	0	92.00
93.00 All other Medical Education	0	12, 872, 859	0.00000	0 759, 983	0	93. 00

Health Fina	ncial Systems	KENTUCKIANA MEDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 4:1	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS		1		1	
	O ADULTS & PEDI ATRI CS			6, 110, 446		30.00
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0. 44597	2, 999, 176	1, 337, 564	50.00
	O ANESTHESI OLOGY		0. 44397		1	53.00
	O RADI OLOGY-DI AGNOSTI C		0. 17243			
	O RADI OLOGY-THERAPEUTI C		0. 00000		0	
	O RADI OI SOTOPE		0. 00000		0	56.00
	O CT SCAN		0.00000		Ō	57. 00
58. 00 0580	O MRI		0.00000	00	0	58. 00
59. 00 0590	O CARDI AC CATHETERI ZATI ON		0. 09632	5, 537, 234	533, 374	59. 00
60. 00 0600	O LABORATORY		0. 21511	6 5, 978, 532	1, 286, 078	60.00
65. 00 0650	O RESPIRATORY THERAPY		0. 39512	1, 622, 689	641, 157	65. 00
	O ELECTROCARDI OLOGY		0. 28130		252, 095	
	O ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 91315			
	O IMPL. DEV. CHARGED TO PATIENTS		0. 91302			
	O DRUGS CHARGED TO PATIENTS		0. 27766	4, 552, 880	1, 264, 153	73. 00
	ATIENT SERVICE COST CENTERS					
	O EMERGENCY		0. 33426			
	O OBSERVATION BEDS (NON-DISTINCT PART		1. 06963		0	92. 00
200.00	Total (sum of lines 50 through 94 and			26, 780, 651		
201. 00	Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0 700 151	l	201. 00
202. 00	Net charges (line 200 minus line 201)		l	26, 780, 651		202. 00

Heal th F	Financial Systems KENTUCKIANA MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
I NPATI EI	NT ANCILLARY SERVICE COST APPORTIONMENT F	rovi der Co		Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 4:1	pared:
		Ti +I	e XIX	Hospi tal	PPS	o piii
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
					(col. 1 x col.	
				ŭ .	2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS			43, 039		30. 00
	NCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 44597		10, 298	
1	DESTREST OLOGY		0.00000		0	
	D5400 RADI OLOGY-DI AGNOSTI C		0. 17243		2, 668	
	05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	
	05600 RADI OI SOTOPE		0. 00000		0	56. 00
1	05700 CT SCAN		0.00000		0	57.00
	05800 MRI		0.00000		0	58.00
1	05900 CARDI AC CATHETERI ZATI ON		0. 09632			59.00
	06000 LABORATORY		0. 21511			1
	16500 RESPI RATORY THERAPY 16900 ELECTROCARDI OLOGY		0. 39512 0. 28130			
	17000 ELECTROCARDI OLOGY		0. 28130			1
1	77000 ELECTROENCEPHALOGRAPHY 17100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 91315		0 6, 945	
	17100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 91302	· ·		1
	17300 DRUGS CHARGED TO PATIENTS		0. 91302			
	UTPATIENT SERVICE COST CENTERS		0.27700	33, 443	7, 200	73.00
	9100 EMERGENCY		0. 33426	5 2, 529	845	91. 00
	19200 OBSERVATION BEDS (NON-DISTINCT PART		1. 06963		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1.00700	196, 888	-	
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		170,000		201.00
202.00	Net charges (line 200 minus line 201)			196, 888		202. 00
_02.00	1 2 3.3 (1.110 200 1.00 201)		1		1	1=32.00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	ICAL CENTER In Lieu		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 4:16 pm	

	Title XVIII Hospit.	al	5/30/2018 4: 10 PPS	6 pm
			1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1. 00	
1.00	DRG Amounts Other than Outlier Payments		0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5, 787, 743	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see linstructions)		2, 037, 178	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Oc 1 (see instructions)	tober	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	-	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		283, 745 0	2. 00 2. 01
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2. 01
3.00	Managed Care Simulated Payments		0	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment		44. 62	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period endior before 12/31/1996. (see instructions)	ng on	0. 00	5. 00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the c for new programs in accordance with 42 CFR 413.79(e)	ар	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If	the	0. 00	7. 01
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 120)	0.00	8. 00	
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the	cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0. 00	8. 02	
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see	0. 00	9. 00	
10. 00	instructions) FTE count for allopathic and osteopathic programs in the current year from your records		0. 00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.			11. 00
12.00	Current year allowable FTE (see instructions)			12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ended on or after September 30,	1997	0. 00 0. 00	
14.00	otherwise enter zero.	1777,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.		0. 00	15. 00
	Adjustment for residents in initial years of the program			16. 00
	Adjustment for residents displaced by program or hospital closure			17. 00
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).		0.00000	18. 00 19. 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
	IME payment adjustment - Managed Care (see instructions)		0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$.		0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)		0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7. 45	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	İ	10. 29	31.00
32.00	Sum of lines 30 and 31		17. 74	
33. 00	Allowable disproportionate share percentage (see instructions)		4. 28	
34. 00	Disproportionate share adjustment (see instructions)		83, 727	34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prep 5/30/2018 4:16	pared: 6 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	I language and the second of t		1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35. 00
35. 00	Factor 3 (see instructions)		0. 00000000	0. 000000000	35. 00
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	r zero on this line) (se		187, 655	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount of the state of th	3)	114, 023 161, 322	47, 299	35. 03 36. 00
40.00	Additional payment for high percentage of ESRD beneficiary dis		gh 46)		40.00
40. 00 41. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	J	0		40. 00
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-I				41. 01
	an 685. (see instructions)				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 683 instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided I days)	by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.	. 01)	0 252 745		46.00
47. 00 48. 00	Subtotal (see instructions)	mall rural bosnitals	8, 353, 715 0		47. 00 48. 00
48.00	Hospital specific payments (to be completed by SCH and MDH, si only. (see instructions)	maii rurai nospitais	0		48.00
				Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instructions)			8, 353, 715	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			693, 623 0	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			ő	52. 00
53.00	Nursing and Allied Health Managed Care payment	,		0	53. 00
54. 00	Special add-on payments for new technologies			1, 036	•
54. 01	Islet isolation add-on payment	->		0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55.00
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see intro Routine service other pass through costs (from Wkst. D, Pt. I		brough 35)	0	56. 00 57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. 1		ili odgir 33).	0	58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	,		9, 048, 374	
60.00	Primary payer payments			15, 322	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		9, 033, 052	
62. 00	Deductibles billed to program beneficiaries			694, 447	
63.00	Coinsurance billed to program beneficiaries			21, 385	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			164, 723 107, 070	
65. 00 66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		96, 643	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	i de ti ons,		8, 424, 290	
68. 00	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (s	ee instructions)	0, 424, 270	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			o	69. 00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)	rusti ana)		0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see insti	ructions)			70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
	Bundled Model 1 discount amount (see instructions)			0	•
				U	, , , , , , , , , , ,
70. 92 70. 93	· · · · · · · · · · · · · · · · · · ·			-18, 512	70. 93
70. 92	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-18, 512 -234, 779	

Heal th	Financial Systems KENTUCKIANA MEDIC	CAL CENTER		In Lie	u of Form CMS-2	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0176	Peri od: From 01/01/2017 To 12/31/2017		pared: 6 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 90
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70. 9 ⁻
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				87, 951	70. 9
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			8, 083, 048	71.00
71. 01	Sequestration adjustment (see instructions)				161, 661	71.0
71. 02	Demonstration payment adjustment amount after sequestration				0	71.02
72. 00	Interim payments				7, 829, 611	72.0
73.00	Tentative settlement (for contractor use only)				0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			91, 776	74.00

73)		· · · · · ·	
75.00 Protested amounts (nonallowable cost report items) in accordance with		200, 189	75. C
CMS Pub. 15-2, chapter 1, §115.2			
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	J 90. 0
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	91.0
22.00 Operating outlier reconciliation adjustment amount (see instructions)		Ō	
93.00 (Capital outlier reconciliation adjustment amount (see instructions)		Ö	
94.00 The rate used to calculate the time value of money (see instructions)		0.00	
55.00 Time value of money for operating expenses (see instructions)		0.00	1
66.00 Time value of money for capital related expenses (see instructions)		o o	
10.00 Time varies of money for capital related expenses (see first detrois)	Prior to 10/1	_	70.
	1. 00	2.00	
HSP Bonus Payment Amount			
00.00 HSP bonus amount (see instructions)	0	0	100. 0
HVBP Adjustment for HSP Bonus Payment			
01.00 HVBP adjustment factor (see instructions)	1. 0000000000	1.0000000000	آ101. ر
02.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	l	102.
HRR Adjustment for HSP Bonus Payment			1.02.
03. 00 HRR adjustment factor (see instructions)	0. 9700	0. 9700	103
04.00 HRR adjustment amount for HSP bonus payment (see instructions)	0.7700		104.
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment			1.0
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 0
Century Cures Act? Enter "Y" for yes or "N" for no.			200. (
Cost Reimbursement			
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. (
02. 00 Medicare discharges (see instructions)			202.
03.00 Case-mix adjustment factor (see instructions)			203.
Computation of Demonstration Target Amount Limitation (N/A in first year of the currer	at 5 year demonst	tration	1203. 1
period)	it 5-year demons	.i a ti oii	
04.00 Medicare target amount			204.
05.00 Case-mix adjusted target amount (line 203 times line 204)			205.
06.00 Medicare inpatient routine cost cap (line 202 times line 205)			206.
Adjustment to Medicare Part A Inpatient Reimbursement			1200. 1
07.00 Program reimbursement under the §410A Demonstration (see instructions)			207.
08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			207.
			200.
09.00 Adjustment to Medicare IPPS payments (see instructions)			210.
10.00 Reserved for future use			
11.00 Total adjustment to Medicare IPPS payments (see instructions)			211.
Comparision of PPS versus Cost Reimbursement			4
12.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212.
:13.00 Low-volume adjustment (see instructions)			213.
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. (
(line 212 minus line 213) (see instructions)		ĺ	

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0176

				T: +1 o	VVIII	Haani tal	5/30/2018 4:10	6 pm
		W/S F Part A	Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1.00	Inno.	0	1.00	2.00	3.00	4. 00	5. 00	1 00
1. 00	DRG amounts other than outlier payments	1. 00	0	0	C	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	5, 787, 743	0	5, 787, 743		5, 787, 743	1. 01
1.02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 037, 178	0		2, 037, 178	2, 037, 178	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	283, 745	0	201, 855	81, 891	283, 746	2. 00
2. 01	Outlier payments for	2. 02	0	0	С	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	O	0	C	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	С	0	0	4. 00
	Indirect Medical Education Adju							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	С	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	o	0	С	O	0	6. 01
	Indirect Medical Education Adju	ustment for the	Add-on for Sec	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	С	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	С	О	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	C	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	С	0	0	9. 01
	8. 01)							
10.00	Di sproporti onate Share Adjustme	33. 00	0. 0428	0.0420	0.0420	0.0428		10.00
10. 00	Allowable disproportionate share percentage (see	33.00	0.0428	0. 0428	0. 0428	0.0428		10. 00
11. 00	instructions) Disproportionate share	34. 00	83, 727	0	61, 929	21, 798	83, 727	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	161, 322	0	114, 023	47, 299	161, 322	11. 01
	Additional payment for high per	centage of ESF	D beneficiary o	di scharges	,			
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	C	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	8, 353, 715 0	0	6, 165, 549 C	2, 188, 166 0	8, 353, 715 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	8, 353, 715	0	6, 165, 549	2, 188, 166	8, 353, 715	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	693, 623	0	496, 905	196, 718	693, 623	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	1, 036	0	1, 036	0	1, 036	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 01 17. 02

Health Financial Systems		KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 4:1	pared:
			Title	: XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4. 00	5. 00	
18.00 Capital outlier reconciliation adjustment amount (see	93. 00	0	0		0	0	18. 00

Fine Fine			W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
18.00 Capital Duftier reconciliation 93.00 0 0 0 0 0 0 18.00									
19.00 SUBTOTAL W/S L, 11 ne CAMOUNTS From D, 0 0 0 0 0 0 0 0 0			-	1.00	2.00	3. 00	4. 00		
19.00 SUBTOTAL	18. 00		93. 00	0	0	0	0	0	18. 00
19.00 SUBTOTAL									
W/S L, line (Amounts from L) 0 1.00 3.00 4.00 5.00	40.00					, ,,,			40.00
Capital DRG other than outlier 1.00	19.00	SUBTOTAL	W (O I I I	(1)	Ü	6, 663, 490	2, 384, 884	9, 048, 374	19.00
0			W/S L, line	`					
20.00 Capital DRG other than outlier 1.00 631,482 0 467,412 164,070 631,482 20.00 20.01 Model 4 BPCl Capital DRG other than outlier 1.01 0 0 0 0 0 0 0 20.01 1.01 0 0 0 0 0 0 0 0 0			0		2.00	2.00	4.00	F 00	
20. 01 Model 4 BPCI Capital DRG other than outlier 1. 01	20.00	Conital DDC ather than suttion	-						20.00
than outlier				031, 482	0	407, 412	164, 070		
21.00	20. 01		1.01	U	U	0	0	U	20.01
21. 01 Model 4 BPCI Capital DRG outlier payments 2. 01 0 0 0 0 0 0 0 21. 01	21 00		2 00	62 1/11	0	20 403	32 649	62 1/1	21 00
22.00 Indirect medical education percentage (see instructions) 10.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.00000000				02, 141	0	27, 479	32, 040 0		
22.00 Indirect medical education percentage (see instructions) 23.00 10 10 10 10 10 10 10	21.01		2.01		0		0		21.01
23. 00 Indirect medical education adjustment (see instructions) 6. 00 0 0 0 0 0 0 0 23. 00	22 00	1 3	5 00	0 0000	0 0000	0 0000	0 0000		22 00
23.00 Indirect medical education adjustment (see instructions) 10.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000	22.00		0.00	0.0000	0.0000	0.000	0.0000		22.00
24. 00	23. 00		6. 00	0	0	0	0	0	23. 00
Share percentage (see instructions) 25.00 Disproportionate share adjustment (see instructions) 11.00 0 0 0 0 0 0 0 0 25.00		adjustment (see instructions)							
25.00 Disproportionate share adjustment (see instructions) 11.00 0 0 0 0 0 0 0 25.00	24.00	Allowable disproportionate	10. 00	0. 0000	0.0000	0. 0000	0.0000		24. 00
25. 00 Disproportionate share adjustment (see instructions) 26. 00 Total prospective capital payments (see instructions) V/S E, Part A (Amounts to E, Part A) 0 0 0 0 0 0 0 0 0		share percentage (see							
26. 00 Total prospective capital payments (see instructions) 12. 00 693, 623 0 496, 905 196, 718 693, 623 26. 00		instructions)							
26. 00 Total prospective capital payments (see instructions) V/S E, Part A (Amounts to E, Part A) 0 1.00 2.00 3.00 4.00 5.00	25. 00		11. 00	0	0	0	0	0	25. 00
Payments (see instructions) W/S E, Part A (Amounts to E, Part A)									
W/S E, Part A (Amounts to E, Part A)	26. 00		12. 00	693, 623	0	496, 905	196, 718	693, 623	26. 00
Second S		payments (see instructions)							
27.00 Low volume adjustment factor 28.00 Low volume adjustment 27.00 Low volume adjustment 27.00 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 238,915 238,915 29.00 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume Y 100.00									
27. 00 Low volume adjustment factor 0.087857 0.100179 27. 00 28. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 70. 96 585, 434 585, 434 28. 00 29. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 70. 97 238, 915 238, 915 29. 00 100. 00 Transfer low volume Y 100. 00 100. 00					2.00	2.00	4.00	Г 00	
28. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 29. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 29. 00 Transfer amount to Wkst. E, Pt. A, line) 100. 00 Transfer low volume Y	27.00	II	0	1.00	2.00			5.00	27.00
(transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume (transfer low volume Y			70.0/					FOF 424	
Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume Y	28.00		70.96			585, 434		585, 434	28.00
29. 00 Low volume adjustment 70. 97 (transfer amount to Wkst. E, Pt. A, line) 100. 00 Transfer low volume 70. 97									
(transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume Y	20.00		70.07				220 015	220 015	20 00
Pt. A, line) 100.00 Transfer low volume Y	29.00		70. 77				230, 913	230, 913	29.00
100.00 Transfer Low volume Y 100.00									
	100 00			Y					100 00
ladiustments to Wkst. F. Pt. A.I	100.00	adjustments to Wkst. E, Pt. A.		'					100.00

From 01/01/2017 Part A Exhibit 5 Date/Time Prepared: 12/31/2017 5/30/2018 4:16 pm Title XVIII Hospi tal PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 5, 787, 743 1.01 1.01 5, 787, 743 5, 787, 743 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2.037.178 2. 037. 178 2, 037, 178 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October 1.04 DRG for Federal specific operating payment 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 283, 745 201, 855 81, 890 283, 745 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 0 Operating outlier reconciliation 3 00 2 01 O 0 Ω 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 22.01 0 0 6.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0428 0.0428 0.0428 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34 00 83, 727 61, 929 21.798 83.727 11.00 instructions) 161, 322 161, 322 11.01 Uncompensated care payments 36.00 114, 023 47, 299 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 0 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 8, 353, 715 6, 165, 550 2, 188, 165 8, 353, 715 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 8, 353, 715 6, 165, 550 2, 188, 165 8, 353, 715 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 693, 623 496, 905 196, 718 693, 623 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 1,036 1,036 1,036 17.00 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0

6, 663, 491

2, 384, 883

9, 048, 374 19. 00

19.00 SUBTOTAL

amount (see instructions)

Health Financial Systems	KENTUCKI ANA MEI	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION	TION EXHIBIT 5	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 4:1	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	631, 482	467, 41	2 164, 070	631, 482	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		o o	0	20. 01

		Wkst. L, line	(Amt. from				
		0	Wkst. L) 1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	631, 482		164, 070	631, 482	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	001,102	0	0	0	1
21. 00	Capital DRG outlier payments	2. 00	62, 141	29, 493	32, 648	62, 141	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 0
22. 00	Indirect medical education percentage (see	5. 00	0. 0000	0. 0000	0.0000		22. 00
23. 00	<pre>instructions) Indirect medical education adjustment (see instructions)</pre>	6. 00	0	0	0	0	23. 00
24. 00		10.00	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	693, 623	496, 905	196, 718	693, 623	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0		0	28.00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-18, 512	0	-18, 512	-18, 512	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-234, 779	-173, 664	-61, 115	-234, 779	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		64, 898	23, 053	87, 951	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 4:16 pm	

			10 12/31/201/	5/30/2018 4:10	pared:
		Title XVIII	Hospi tal	PPS	о рііі
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1 0
	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		0 3, 379, 063	
	OPPS payments	ti ons)		2, 382, 339	
	Outlier payment (see instructions)			19, 187	
1	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 0
	Line 2 times line 5			0	
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
	Transitional corridor payment (see instructions)	IV ool 12 line 200		0	
	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	rv, cor. 13, rrne 200			
	Total cost (sum of lines 1 and 10) (see instructions)				1
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges				1
2. 00	Ancillary service charges			0	12. 0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			0	14.0
	Customary charges Aggregate amount actually collected from patients liable for p	naymont for sorvices on	a chargo basis	0	15. 0
	Amounts that would have been realized from patients liable for				
	had such payment been made in accordance with 42 CFR §413.13(e		ii a chargebasi's		10.0
	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0.000000	17. 0
	Total customary charges (see instructions)			0	18. 0
	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	0	19. 0
	instructions)	l : 6 ! == 11	10) (20.0
	Excess of reasonable cost over customary charges (complete onlinstructions)	ry if line il exceeds il	ne 18) (See	0	20.0
	Lesser of cost or charges (see instructions)			0	21.0
1	Interns and residents (see instructions)			0	1
3. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2, 401, 526	24.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 25 0
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	r CAH see instructions)		0 441, 857	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		and 231 (see	1, 959, 669	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, Ii	ine 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.0
	Subtotal (sum of lines 27 through 29)			1, 959, 669	1
	Primary payer payments Subtotal (line 30 minus line 31)			2, 852 1, 956, 817	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		1, 730, 017	32.0
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.0
4. 00	Allowable bad debts (see instructions)			110, 595	
	Adjusted reimbursable bad debts (see instructions)			71, 887	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		79, 761	
	Subtotal (see instructions)			2, 028, 704	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			186	1
	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 5
1	Demonstration payment adjustment amount before sequestration	,		0	1
	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	Ō	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 9
1	Subtotal (see instructions)			2, 028, 518	
	Sequestration adjustment (see instructions)			40, 570	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractors use only)			1, 917, 496 0	
	Balance due provider/program (see instructions)			70, 452	
- 1	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2.	chapter 1.	70, 432	1
	§115. 2]
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
0. 00	· · · · · · · · · · · · · · · · · · ·				91.0
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)			0	1
90. 00 91. 00 92. 00	· · · · · · · · · · · · · · · · · · ·			0.00	92. 0

Health Financial Systems KENT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0176

					5/30/2018 4: 16	5 pm
			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		7, 829, 61	1	1, 917, 496	1. 00
2.00	Interim payments payable on individual bills, either			0	0	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)					
0.01	Program to Provider					0.04
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				-	0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADJUSTINIENTS TO FROGRAM			0		3. 51
3. 52				0		3. 52
3. 53				0		3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
0. , ,	3, 50-3, 98)					0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 829, 61	1	1, 917, 496	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)					
E 04	Program to Provider		I			E 04
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.03	Provider to Program			U	0	5. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51	TEMPORAL TO TROOKING			0		5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			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		91, 77	6	70, 452	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		7, 921, 38	7	1, 987, 948	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractors)	1. 00	2. 00	0.00
8.00	Name of Contractor				1	8. 00

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu					
			Worksheet E-	1	
		From 01/01/2017 To 12/31/2017		enared.	
		10 12/01/2017	5/30/2018 4:		
	Title XVIII	Hospi tal	PPS		
			1. 00		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION				1.00	
, , , , , , , , , , , , , , , , , , ,					
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				
5.00 Total hospital charges from Wkst C, Pt. I, o				5. 00 6. 00	
	.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20				
	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				
line 168					
8.00 Calculation of the HIT incentive payment (se				8. 00 9. 00	
9.00 Sequestration adjustment amount (see instru	0 Sequestration adjustment amount (see instructions)				
0.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	30.00 Initial/interim HIT payment adjustment (see instructions)				
31.00 Other Adjustment (specify)				31.00	
32.00 Balance due provider (line 8 (or line 10) mi	line 30 and line 31) (see instruction	ons)		32. 00	

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176		Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 4:16 pm

			Γο 12/31/2017	Date/Time Pre 5/30/2018 4:1	
		Title XIX	Hospi tal	PPS	<u> </u>
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		1		
8.00	Routi ne servi ce charges		43, 039		8. 00
9. 00	Ancillary service charges		196, 888	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		239, 927	0	12. 00
13. 00	CUSTOMARY CHARGES	. comil coo on a charge	0	0	13.00
13.00	Amount actually collected from patients liable for payment for basis	services on a charge		U	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 4			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 0110 3110. 10(0)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		239, 927	0	1
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	239, 927	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
	Other than outlier payments		97, 697	0	
23. 00	Outlier payments		0	0	
24. 00 25. 00	Program capital payments Capital exception payments (see instructions)		0		24. 00 25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		97, 697	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		97, 097	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		97, 697	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		,,,,,,,,		27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		97, 697	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34. 00
35.00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	l 33)	97, 697	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		97, 697	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		97, 697	0	
41. 00	Interim payments		97, 697	0	
42.00	Balance due provider/program (line 40 minus line 41)	uco with CMS Dub 15 2	0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	ICE WI LII CWS PUD 15-2,	0	Ü	43. 00
	Chapter 1, 3110.2		1		I

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10

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

Provider CCN: 15-0176

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared:

onl y)				0 12/31/201/	5/30/2018 4:1	
		General Fund	Speci fi c	Endowment Fund	•	<u> </u>
		1. 00	Purpose Fund 2.00	3.00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	2, 621, 967	' (0	0	
2.00	Temporary investments	0			0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	2 527 005		0	0	
5. 00	Other receivable	2, 537, 905 n			0	
6. 00	Allowances for uncollectible notes and accounts receivable		ól ö		0	
7.00	Inventory	509, 028	3	0	0	
8.00	Prepai d expenses	334, 602		0	0	
9.00	Other current assets	1, 839, 079		0	0	
10.00	Due from other funds	7 042 501			0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	7, 842, 581		0	0	11. 00
12. 00	Land	0		0	0	12. 00
13. 00	Land improvements	O		-	0	
14.00	Accumulated depreciation	O		0	0	14. 00
15. 00	Bui I di ngs	0		-	0	1
16.00	Accumulated depreciation	0		0	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation			0	0	
19. 00	Fi xed equi pment	0			0	
20. 00	Accumul ated depreciation	Ö		o o	0	
21.00	Automobiles and trucks	0		0	0	
22. 00	Accumul ated depreciation	0		0	0	
23. 00	Major movable equipment	9, 451, 912		-	0	
24. 00	Accumulated depreciation	0		0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation				0	
27. 00	HIT desi gnated Assets				0	
28. 00	Accumul ated depreciation	Ö		o o	0	
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	9, 451, 912	2 (0	0	30.00
04 00	OTHER ASSETS				_	04.00
31. 00 32. 00	Investments Deposits on Leases			-	0	
33. 00	Due from owners/officers	0		-	0	
34. 00	Other assets	4, 327, 622		0	0	
35.00	Total other assets (sum of lines 31-34)	4, 327, 622	2 (0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	21, 622, 115	5 (0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	4 007 454			_	07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	4, 806, 454 13, 862, 274	1	0	0	
39. 00	Payroll taxes payable	167, 970			0	
40. 00	Notes and Loans payable (short term)	7, 930, 342	1	o o	0	
41.00	Deferred income	0		0	0	41.00
42. 00	Accel erated payments	0				42. 00
43.00	Due to other funds	0		0	0	
44. 00 45. 00		26, 767, 040			0	
43.00	LONG TERM LIABILITIES	20, 707, 040	ή)	0	45.00
46. 00	Mortgage payable	О		0	0	46. 00
47.00	Notes payable	1, 422, 517	' (0	0	
48. 00	Unsecured Loans	0		0	0	1
49. 00	Other long term liabilities	57, 197, 929	1		0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	58, 620, 446	1	-	0	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	85, 387, 486		0	0	51.00
52. 00	General fund balance	-63, 765, 371				52.00
53. 00	Specific purpose fund	00,700,07.				53.00
54.00	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	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-63, 765, 371		o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	21, 622, 115	1	o	0	
	[59]					

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0176

Peri od: Worksheet G-1 From 01/01/2017

12/31/2017 Date/Time Prepared: 5/30/2018 4:16 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -40, 313, 175 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -23, 452, 196 2.00 3.00 Total (sum of line 1 and line 2) -63, 765, 371 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 11.00 -63, 765, 371 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -63, 765, 371 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00

Health Financial Systems K STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0176

		1	o 12/31/2017	Date/Time Prep 5/30/2018 4:10	
	Cost Center Description	I npati ent	Outpati ent	Total	J Pill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	10, 452, 189		10, 452, 189	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)	0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	40 450 404		10 150 100	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	10, 452, 189	<u>'</u>	10, 452, 189	10. 00
11 00	Intensive Care Type Inpatient Hospital Services	T			11 00
11. 00 12. 00	INTENSIVE CARE UNIT				11. 00 12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
10.00	11-15)	`		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	10, 452, 189		10, 452, 189	17. 00
18. 00	Ancillary services	47, 200, 883		74, 333, 664	18. 00
19. 00	Outpatient services	614, 25		5, 024, 543	19. 00
20. 00	RURAL HEALTH CLINIC	(0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24. 00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	58, 267, 323	31, 543, 073	89, 810, 396	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		47, 000, 045		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		46, 099, 915		29. 00
30. 00 31. 00	ADD (SPECIFY)				30. 00 31. 00
31.00					31.00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	ì	Ó		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40.00					40.00
41.00)		41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		46, 099, 915		43.00
	to Wkst. G-3, line 4)				

		MEDI CAL CENTER		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0176	Peri od: From 01/01/2017	Worksheet G-3	
			To 12/31/2017	Date/Time Pre	nared.
			10 12/01/201/	5/30/2018 4: 10	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			89, 810, 396	1.00
2.00	Less contractual allowances and discounts on patients' acc	counts		67, 671, 347	2. 00
3.00	Net patient revenues (line 1 minus line 2)			22, 139, 049	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		46, 099, 915	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-23, 960, 866	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 communicat	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	1
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other	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
24. 00	OTHER REVENUE			508, 670	24.00
25. 00	Total other income (sum of lines 6-24)			508, 670	25.00
26. 00	Total (line 5 plus line 25)			-23, 452, 196	26.00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28	3)		-23, 452, 196	29.00

Provider COX: 15-0176	Heal th	Financial Systems KENTUCKIANA MEDI	ICAL CENTER	Inlie	u of Form CMS-2	2552_10
PART FULLY PROSPECTIVE METHOD 1.00				Period: From 01/01/2017	Worksheet L Parts I-III Date/Time Pre 5/30/2018 4:1	pared:
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL ADMONT			Title XVIII	Hospi tal	PPS	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AUROUNT Capital DRG other than outlier 0.1.01 Model 4 BPCI Capital DRG other than outlier 0.1.01 Model 4 BPCI Capital DRG outlier payments 0.2.01 Model 4 BPCI Capital DRG outlier payments 0.0.01 4.00 Mumber of interns & residents (see instructions) 0.00 4.00 Mumber of interns & residents (see instructions) 0.00 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0.6.00 Columns 1 columns 1 and 0.6.00 Mindrect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0.6.00 Columns 1 and						
CAPITAL FEDERAL MIQUIT 1.00 Capital DRG other than outlier 6.1		DADT I SWILL BROODESTIVE HETUR			1. 00	
1.00						
1.01 Model 4 BPC Capital DRG outlier payments	1 00				(21, 402	1 00
2.00 Capit tal DRG outlier payments 62,141 2.00 1.00						
2.01 Model 4 BPCI Capital DRG outlier payments 0 2.01					-	
Total inpatient days divided by number of days in the cost reporting period (see instructions) 0.00 4.00						
Number of interns & residents (see instructions) 0.00 4.00 5.00 1.00			operting period (see inst	ructions)		
5.00			eporting period (see inst	i uctions)		
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)		,				
1.01)(see instructions) 1.00 Procretage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 1.00 Procretage of Medicaid patient days to total days (see instructions) 1.00 Sum of lines 7 and 8 1.00 Procretage of Medicaid patient days to total days (see instructions) 1.00 Sum of lines 7 and 8 1.00 Program inpatient context share aprications (see instructions) 1.00 Disproportionate share adjustment (see instructions) 1.00 Disproportionate share adjustment (see instructions) 1.00 Total prospective capital payments (see instructions) 1.00 Program inpatient routine capital cost (see instructions) 1.00 Program inpatient routine capital cost (see instructions) 1.00 Total inpatient program capital cost (see instructions) 1.00 Total inpatient program capital cost (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) 1.00 Total inpatient program capital cost (line 3 x line 4) 1.00 Program inpatient capital cost (see instructions) 1.00 Program inpatient capital costs (line 3 x line 4) 1.00 Program inpatient capital costs (see instructions) 1.00 Program inpatient capital costs (line 1 mus line 2) 1.00 Program inpatient and patient capital costs (see instructions) 1.00 Program inpatient capital costs (line 1 mus line 2) 1.00 Program inpatient capital costs (line 1 mus line 2) 1.00 Program inpatient capital costs (see instructions) 1.00 Applicable exception percentage (see instructions) 1.00 Applicable exception percentage (see instructions) 1.00 Applicable exception percentage (see instructions) 1.00 Program inpatient capital costs (see instructions) 1.00 Capital minimum payment level for extraordinary circumstances (see instructions) 1.00 Capital minimum payment level (see cataordinary circumstances (see instructions) 1.00 Capital minimum payment level to capital payments (line 8 less line 9) 1.00 Carrent year comparison of capital minimum payment level over capital payment from prior year 1.10 Not comparison of capital minimum payment le			a sum of lines 1 and 1 01	columns 1 and		
Part II - Computation of Exception axions (see instructions) Part II - Computation of Exception Payments (line 3 x line 4) Part III - Computation of Exception Payments (see instructions) Part III - Computation of Exception Payments (see instructions) Part III - Computation of Exception Payments (see instructions) Part III - Computation of Exception payments (see instructions) Part III - Computation of Exception payments (see instructions) Part III - Computation of Exception payments (see instructions) Part III - Payment program capital cost (see instructions) Part III - Payment under the payment of the paymen	0.00		e sum of fiftes f and f. of	, corumns r and	O	0.00
8.00 Percentage of Medicaid patient days to total days (see instructions) 0.00 8.00 0.00 1	7. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	, part A line	0.00	7. 00
9.00 Sum of lines 7 and 8 0.00 9.00 10.00 Allowable disproportionate share percentage (see instructions) 0.00 10.00 11.00 Disproportionate share adjustment (see instructions) 0.00 11.00 11.00 11.00 Total prospective capital payments (see instructions) 693,623 12.00 11.0	8 00		uctions)		0.00	8 00
10.00 Allowable disproportionate share percentage (see instructions) 0.00 10.0			detrons)			
11.00 Total prospective capital payments (see instructions) 11.00 693,623 12.00 12.00 12.00 12.00 13.00 14.0			(2)			
PART III - PAYMENT UNDER REASONABLE COST 1.00			3)			
PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient program capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 PART line capital costs (see instructions) 0 1.00 A populable exception percentage (see instructions) 0 2.00 Applicable exception percentage (see instructions) 0 3.00 A papicable exception percentage (see instructions) 0 0.00 Copital cost for comparison to payments (line 3 x line 4) 0 0 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 0 5.00 Capital cost payment level (line 5 plus line 7) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
PART III - PAYMENT UNDER REASONABLE COST 1.00 Program Inpatient routine capit al cost (see instructions) 2.00 Program Inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (see instructions) 3.00 Applicable exception percentage (see instructions) 3.00 Applicable exception percentage (see instructions) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) 11.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12.00 Net comparison of capital minimum payment level over capital payments for the following period (if line 12 is negative, enter the amount on this line) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 Current year operating and capital costs (see instructions) 14.00 Current year operating and capital costs (see instructions) 15.00 Current year operating and capital costs (see instructions) 16.00 Current year operating and capital costs (see in	12.00	prospective capital payments (see thisti detroils)			070, 020	12.00
1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (From Part I, line 12, as applicable) 11.00 Carryover of accumulated capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payments (from prior year 0 11.00 Carryover of accumulated capital minimum payment level over capital payments (line 10 plus line 11) 12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 15.00 Current year perating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 16.00 Current year operating and capital costs (see instructions) 0 16.00 Current year operating and capital costs (see instructions)					1. 00	
1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (From Part I, line 12, as applicable) 11.00 Carryover of accumulated capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payments (from prior year 0 11.00 Carryover of accumulated capital minimum payment level over capital payments (line 10 plus line 11) 12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 15.00 Current year perating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 16.00 Current year operating and capital costs (see instructions) 0 16.00 Current year operating and capital costs (see instructions)		PART II - PAYMENT UNDER REASONABLE COST				
3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Not program inpatient capital costs for extraordinary circumstances (see instructions) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payments (line 10 plus line 11) 12.00 Net comparison of capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payment (from prior year One of accumulated capital minimum payment level over capital payment (fine 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 15.00 Current year operating and capital costs (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year operating and capital costs (see instruct	1.00				0	1.00
A. 00 Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1. 00 Program inpatient capital costs (see instructions) 2. 00 Program inpatient capital costs (see instructions) 3. 00 Net program inpatient capital costs (line 1 minus line 2) 4. 00 Applicable exception percentage (see instructions) 5. 00 Capital cost for comparison to payments (line 3 x line 4) 6. 00 Percentage adjustment for extraordinary circumstances (see instructions) 7. 01 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8. 00 Capital minimum payment level (line 5 plus line 7) 9. 00 Current year capital payments (from Part I, line 12, as applicable) 10. 00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11. 00 Current year comparison of capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) 12. 00 Net comparison of capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) 12. 00 Net comparison of capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) 12. 00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13. 00 Current year allowable operating and capital payment (see instructions) 14. 00 Current year operating and capital payment (see instructions) 15. 00 Current year operating and capital payment (see instructions) 1 5. 00 Current year operating and capital payment (see instructions) 1 6. 00 Current year operating and capital costs (see instructions)	2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level to capital payments (from prior year Olicon Vorksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 18.00 Current year operating and capital payment (see instructions) 19.00 Current year operating and capital payment (see instructions) 19.00 Current year operating and capital payment (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions)	3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year operating and capital costs (see instructions) 18.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions) 19.00 Current year operating and capital costs (see instructions)	4.00	Capital cost payment factor (see instructions)			0	4. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 12.00 Net comparison of capital minimum payment level to capital payment (from prior year 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 17.00 Current year operating and capital payment (see instructions) 18.00 Current year operating and capital payment (see instructions) 19.00 Current year operating and capital costs (see instructions)	5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 16.00 Current year operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year operating and capital costs (see instructions) 18.00 Current year operating and capital costs (see instructions)						
Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 0 15.00 Current year operating and capital costs (see instructions)					1.00	
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 16.00 Current year operating and capital payment (see instructions) 0 16.00						
3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level over capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 16.00 Current year operating and capital payment (see instructions) 0 16.00						
4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level over capital payment (from prior year 12.00 Carryover of accumulated capital minimum payment level over capital payment (line 10 plus line 11) 13.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 15.00 Current year allowable operating and capital payment (see instructions) 15.00 Current year operating and capital costs (see instructions) 16.00 Current year operating and capital costs (see instructions)			ces (see instructions)		-	
5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 5.00 0 6.00 7.00 8.00 7.00 9.00 10.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00					•	0.00
6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0.00 6.00 0.00 7.00 0.00 8.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 1.00 1.00 1.00 0.00 1.00 1.00 1						
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 7.00 8.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				
8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 0 8.00 9.00 10.00 9.00 11.00 12.00 11.00 12.00 15.00			,			
9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 12.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 9.00 10.00 11.00 12.00 12.00 13.00 14.00 15.00 16.00 16.00		, ,	y circumstances (line 2 x	: line 6)	-	
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 12.00 Worksheet L, Part III, line 14) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 10.00 11.00 11.00 12.00 12.00 12.00 13.00 14.00 15.00 16.00					-	
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year operating and capital costs (see instructions) 18.00 Current year operating and capital costs (see instructions)						
Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year operating and capital costs (see instructions) 18.00 Current year operating and capital costs (see instructions)						
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 13.00 14.00 15.00 16.00	11.00	Worksheet L, Part III, line 14)		,		11.00
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 14.00 15.00 Current year operating and capital costs (see instructions) 0 16.00					-	
(if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 16.00 Current year operating and capital costs (see instructions)					-	
15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 16.00 Current year operating and capital costs (see instructions) 0 15.00	14.00		capital payment for the f	following period	0	14. 00
16.00 Current year operating and capital costs (see instructions) 0 16.00		(if line 12 is negative, enter the amount on this line)				
			structions)			
17.00 Current year exception offset amount (see instructions) 0 17.00						
	17. 00	Current year exception offset amount (see instructions)			0	17. 00