payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0176 Worksheet S Parts I-III From 01/01/2018 AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared:

						5/22/2019 3:	.09 pm
PART I - COST	REPORT	STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 5/22/20	19 Time:	3: 09 pi
use only	2. [] Manually submitted co	st report				
			report enter the number of Enter "F" for full or "L'		r resubmitted this co	ost report	
Contractor use only	(1) (2) (3) (4)]Cost Report Status As Submitted Settled without Audit Settled with Audit Reopened Amended		1 r this Provider CCN 1.	O. NPR Date: 1. Contractor's Vendo 2. [O]If line 5, co number of tim	lumn 1 is 4:	

PART II - CERTIFICATION

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 KENTUCKI ANA MEDICAL CENTER (15-0176) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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)
Ti tl e	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	83, 471	62, 945	0	13, 357	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	83, 471	62, 945	0	13, 357	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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 3:09 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 2.00 Zip Code: 47129 County: CLARK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 KENTUCKIANA MEDICAL 150176 31140 1 09/18/2009 Ν 0 3.00 CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate 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 22.01 22.01 cost reporting 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)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N 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 on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result 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 Ν 23.00 below? In column 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 Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d days paid days el i gi bl e Medi cai d Medi cai d paid days unpai d eligible days unpai d 1.00 3. 00 4. 00 5. 00 6.00 2.00

24.00	If this provider is an IPPS hospital, enter the	70	223	122	0	532	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.							

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	N: 15-0176		01/01	1/2018	Part		
			1 01 1		То		1/2018	5/22	2/2019 3	3:09 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-o Stat Medica eligil unpai	e aid ble id	Medica HMO da	ays	Other Medicai days	
. 00	If this provider is an IDC enter the in state	1.00	2. 00	3. 00	4. 00	0 0	5. 00	0	6. 00	25
5. 00	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 days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	U	Hek		ıral ¢		of Geo	25.
					OI L	1. 0		Date	2. 00	,gi
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. age) status "2" for r cation in	at the end ural. If ap column 2.	of the cos plicable,	it		1 1 0			26. 27. 35.
	effect in the cost reporting period.				B	egi nn	i na·	F	ndi ng:	
						1. 0			2. 00	
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	er					36.
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	s MDH statu	ıs		C			37.
. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37.
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.
						Y/I			Y/N	
. 00	Does this facility qualify for the inpatient hospital	navment a	diustment f	or low volu	ıme	1. 0 N			2. 00 N	39.
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	n					
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			Υ			Υ	40.
							1. 00	_	00 3.0	
	Prospective Payment System (PPS)-Capital									
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ry circumst	ances		N N		N N	
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	II and Wkst	. L-1, Pt.	I thro	ugh				
00	Is this a new hospital under 42 CFR §412.300(b) PPS of	•		,		Ο.	N		N N	
00	Is the facility electing full federal capital payment Teaching Hospitals	:/ Enter "	r ror yes	or "N" for	no.		N		<u> </u>	48.
00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for	yes	N			56.
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or "N" th of this of ", complete	" for no in cost report e Worksheet	column 1. ing period?	If col	umn 1 r "Y"				57
00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	oursement f	or physicia	ns' service	s as		N			58.
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I			N			59.
00	ALC COSES CHAINED OF THE 100 OF HOLKSHEET A: 11 Jes	s, comprete	WKSt. D Z,	NAHE 413. 8 Y/N	35 Wo	orkshe Li ne	eet A	Qual	s-Through ificati erion C	gh on
. 00									3110110	ouc
	Are you claiming nursing and allied health education			1. 00		2. C	00		3. 00	60

		DICAL CENTER			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	F	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prep 5/22/2019 3:09	pared:
	Y/N	IME	Direct GME	IME	Direct GME	у ріп
	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 column 1. (see instructions) 61.01 Enter the average number of unweighted primary care				0.00	0.00	61. 00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Dec	agram Nama	Drogram Code	House abt ad IME	Housi abt ad	61. 06
	PF	ogram Name			Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00		61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						/0.0-
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	ti ons) Teachi	ng Health Cent	ter (THC) into			62. 00 62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63. 00
			Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	nnrovi	der Settings-	1.00 This base year	2.00	3.00	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ry train n-priman all non n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 0			64. 00

11031 TTAL 1	AND HUSPITAL HEALTH CARE COMPL	LA IDENTITICATION DA	Trovider c	F	From 01/01/2018 o 12/31/2018		
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4.00	5. 00	
is tra yea ass FTE pro res the col unw res rot non col unw res you 5,	yes, or your facility index residents in the base in period, the program name cociated with primary care is for each primary care is for each primary care is for each primary care gram in which you trained is idents. Enter in column 2, in program code. Enter in umn 3, the number of veighted primary care FTE is idents attributable to cations occurring in all in-provider settings. Enter in umn 4, the number of veighted primary care is ident FTEs that trained in ir hospital. Enter in column the ratio of (column 3 vided by (column 3 + column			0.00	0.00	0. 000000	65. 00
(4))	. (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3. 00	
	tion 5504 of the ACA Current		Nonprovider Settinç	gsEffective f	or cost reporti	ng peri ods	
66. 00 Ent FTE Ent FTE	pinning on or after July 1, 20 cer in column 1 the number of uses is attributable to rotations of cer in column 2 the number of uses is that trained in your hospita olumn 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	0.00	0.00	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67. 00 Ent	er in column 1, the program	1. 00	2. 00	3. 00	4.00	5. 00 0. 000000	/ 7 00
nam you whi Ent cod num car to non col unw res you 5, di v	he associated with each of ar primary care programs in ch you trained residents. Her in column 2, the program le. Enter in column 3, the observed in the program le. Enter in column 3, the observed in the program le. Enter in column 3 and le provider settings. Enter in le provider settings. Enter in le provider settings. Enter in le provider primary care sident FTEs that trained in le provider le provider le provider le provider le primary care sident enter la column le provider le provider le provider le provider le primary care sident enter la column 3 dided by (column 3 + column 3 dided by (column 3 + column 3 (see instructions)						
					1.0	0 2.00 3.00	
I np	patient Psychiatric Facility Pl	PS			1.0	0 2.00 3.00	
70.00 Is	this facility an Inpatient Psy	ychiatric Facility (I	PF), or does it cont	ain an IPF sub	provi der? N		70. 00
71.00 If rec 42 pro Col (se	er "Y" for yes or "N" for no. line 70 is yes: Column 1: Did cent cost report filed on or bo CFR 412.424(d)(1)(iii)(c)) Col gram in accordance with 42 CFI umn 3: If column 2 is Y, indicate te instructions) patient Rehabilitation Facility	the facility have an efore November 15, 20 umn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	O4? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ves or "N" for o s in a new teac ves or "N" for o	no. (see hi ng no.	0	71. 00
	this facility an Inpatient Ref		(IRF), or does it o	contain an IRF	N		75. 00
76.00 sub If rec no. CFR	pprovider? Enter "Y" for yes a line 75 is yes: Column 1: Did tent cost reporting period endi Column 2: Did this facility 2 412.424 (d)(1)(iii)(D)? Enter licate which program year began	and "N" for no. the facility have an ng on or before Nove train residents in a "Y" for yes or "N"	approved GME teachi mber 15, 2004? Enter new teaching program for no. Column 3: If	ng program in "Y" for yes on in accordance column 2 is Y	the most r "N" for with 42	0	76. 00

ealth Financial Systems KENTUCKIANA MED OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0176	Period: From 01/01/2018 To 12/31/2018	Worksheet S- Part I Date/Time Pr 5/22/2019 3:	epared:	
				1.00	+	
Long Term Care Hospital PPS						
D.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 1.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no. TEFRA Providers			ng period? Enter	N N	80. 0	
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0	
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under section	า	N	87. 0	
[1660(d)(1)(b)(v1)? Effect 1 for yes of N for no.			V	XI X		
			1. 00	2.00		
Title V and XIX Services		. ""		.,		
Does this facility have title V and/or XIX inpatient hospitally yes or "N" for no in the applicable column.	I services? E	nter "Y" for	N	Y	90.0	
1.00 Is this hospital reimbursed for title V and/or XIX through t	he cost repor	t either in	N	N	91.0	
full or in part? Enter "Y" for yes or "N" for no in the appl						
2.00 Are title XIX NF patients occupying title XVIII SNF beds (du- instructions) Enter "Y" for yes or "N" for no in the applica		ion)? (see		N	92. 0	
3.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 0	
"Y" for yes or "N" for no in the applicable column.					0.4.0	
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. 0	
5.00 If line 94 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	95. 0	
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	or "N" for n	o in the	N	N	96. 0	
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	n	0. 00	0.00	97. 0	
8.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for						
8.01 Does title V or XIX follow Medicare (title XVIII) for the re	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					
B. 02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 0	
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 0	
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N d	N	98. 0	
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0	
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 0	
Rural Providers						
O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payme	nt N		105. 0 106. 0	
for outpatient services? (see instructions) 07.00 f this facility qualifies as a CAH, is it eligible for cost	rei mbursemen	t for I&R	N		107. 0	
training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.						
08.00 s this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 4:	2 N		108. 0	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupation	al Speech	Respi ratory		
	1.00	2.00	3.00	4. 00		
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 0	
				1.00		
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no.	If yes,	1. 00 N	110. 0	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-0176	Peri od: From 01/01/20 To 12/31/20		repared:
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addifor tele-health services.	t reporting period? Enter umn 1 is Y, enter the icipating in column 2.	N		111.00
			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 'is yes, enter the method used (A, B, or E only) in column 2. Is a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or 'is yes, enter "Y" for	If column 2 is "E", enter for long term care (incl) based on the definition	rin column udes	N O	115. 00
17.00 s this facility legally-required to carry malpractice insurar		"N" for	Y	117. 00
18.00 s the malpractice insurance a claims-made or occurrence policities claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the policy	y is	1	118. 00
	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	126, 3	315	0	0 118. 0
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE		N		118. 0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in a "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes or Lifies for the Outpatien		N	120. 0
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged to	Y		121. 0
22.00 Does the cost report contain healthcare related taxes as defined for a column 1. If column 1 is the Worksheet A line number where these taxes are included.				122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certification date	e		126. 0
27.00 f this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification date			127. 0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification date			128. 0
29.00 f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		n		129. 0
30.00 f this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in colum	mn 2.			130. 0
31.00 f this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2.00 f this is a Medicare certified in the transplant center, and the column in	mn 2.			131. 0
32.00 f this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2. 33.00 f this is a Medicare certified other transplant center, enter				132. 0
in column 1 and termination date, if applicable, in column 2. 34.00 f this is an organ procurement organization (OPO), enter the				134. 0
and termination date, if applicable, in column 2. All Providers				
40.00 Are there any related organization or home office costs as def		Y		140. 0

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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: To 5/22/2019 3:09 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 Ν 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 Ν N 155.00 156.00 Subprovi der - 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 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

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	l"), enter the	9. 9	169. 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	01/01/2018	12/31/2018	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)			

0168.00

	Financial Systems KENTUCKIANA ME		CN. 1E 017/		u of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	epared:
				Y/N	5/22/2019 3:0 Date)9 pm
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter M	N for all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			T	I	
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	instructions)	N		1.00
	preporting period: IT yes, enter the date of the change ITI	201 dilii1 2. (3ee	Y/N	Date	V/I	
			1.00	2. 00	3. 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.		N			2. 00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical 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
	(see matruetrons)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 60	Financial Data and Reports					
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	erent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.				
				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?	If yes, is th	ne provider is	S 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.		I during the	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.	I & R in an App	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3.00	4. 00	
	PS&R Data					
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	04/10/2019	Y	04/10/2019	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 01/01/2018 To 12/31/2018	Worksheet S- Part II Date/Time Pr 5/22/2019 3:	epared:
		Descri	pti on	Y/N	Y/N	O / Dill
		(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	Date 2.00	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 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	Capital Related Cost	a I matruati ana			N	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	23. 00
24. 00	Were new leases and/or amendments to existing leases entered 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 thinstructions.	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	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	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, 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 exi physicians 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	
24 00	Home Office Costs			NI NI		24 00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	N N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			· N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end 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.	00	
	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	respectively. Enter the employer/company name of the cost report	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	DCO. COM	43. 00

Heal th	Financial Systems KENTL	JCKIANA MED	I CAL CENTER			In Lie	u of Form C	MS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE	Provi der		Peri From To	od: 1 01/01/2018 12/31/2018		Prep	pared:
		-	3	. 00					
	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.		SENI OR MANAGE	R					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.	he cost							43. 00

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0176

				T	o 12/31/2018	Date/Time Prep 5/22/2019 3:09	
						I/P Days / 0/P	<i>y</i> piii
						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
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13. 00
14. 00	Total (see instructions)		46	16, 790	0. 00	o	14. 00
15. 00	CAH visits		40	10, 790	0.00	0	15. 00
16. 00	SUBPROVIDER - IPF			•		U	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	,			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			1			33. 01

Health Financial Systems KENTUCKI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0176

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

				'	0 12/31/2010	5/22/2019 3:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	, p
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	I II II C XVIII	II ti c Xi X	Patients	& Residents	Payrol I	
		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, 315	70	7, 445			1.00
2.00	HMO and other (see instructions)	950	877				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	O	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 315	70	7, 445			7. 00
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)	4, 315	70	7, 445	0. 00	244. 44	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			36			24. 10
25. 00	CMHC - CMHC			30			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)		, and the second	· ·	0.00		1
28. 00	Observation Bed Days		0	679			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Health Financial Systems KENTUCKI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0176

					To	12/31/2018	Date/Time Pre 5/22/2019 3:0	
		Full Time Equivalents	<u> </u>		Di scha	arges	, , , ==, =, , , , , , ,	
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	-	13. 00	14. 00	Pati ents 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	0	765	14.00	1, 332	1. 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)				700		1, 002	1. 00
2.00	HMO and other (see instructions)				137	139		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO IRF Subprovider					0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
7. 00	Total Adults and Peds. (exclude observation							7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)	0. 00		o	765	9	1, 332	14. 00
15. 00	CAH visits							15. 00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC							24. 10 25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
27. 00	Total (sum of lines 14-26)	0.00						27. 00
28. 00	Observation Bed Days	0.00						28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0176

					To	12/31/2018	Date/Time Prep 5/22/2019 3:09	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	11, 505, 101	C	11, 505, 101	508, 414. 00	22. 63	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	C	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	C	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	О	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0		0. 00 0. 00	l .	4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital -based RHC and FOHC services		0	C	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	O	О	0. 00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	О	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 67, 551	0		0. 00 2, 356. 00		9. 00 10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		750, 309		750, 309	5, 938. 00	126. 36	11. 00
12. 00	Care Contract labor: Top level		750, 307			0.00		12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		66, 740	C	66, 740	373. 00	178. 93	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	C	0	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		0	0	0	0. 00 0. 00	l .	14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	ő	0. 00		
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	О	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 711, 933		2, 711, 933			17. 00
18. 00	instructions) Wage-related costs (other)		7, 057					18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		5, 848 0	0	-,			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	С	0			21. 00
22. 00	Physician Part A - Administrative		0	d	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0		0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		0					25. 50
25. 51	(core) Related organization		0	C	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	C	0			25. 52
25 53	- Administrative - wage-related (core) Home office & Contract		0	C	0			25. 53
20.00	Physicians Part A - Teaching - wage-related (core)							20.00
26 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	S 4. 00	173, 977	C	173, 977	5, 788. 00	30.06	26. 00
	Administrative & General	5. 00	1, 200, 437			45, 818. 00		27. 00

							5/22/2019 3:0	9 pm
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d 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		8, 802, 391	0	8, 802, 391	69, 575. 00	126. 52	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	137, 102	2 0	137, 102	6, 903. 00	19. 86	29. 00
30.00	Operation of Plant	7. 00	C	0	0	0.00	0. 00	30. 00
31. 00	Laundry & Linen Service	8. 00	C	0	0	0.00	0. 00	31. 00
32.00	Housekeepi ng	9. 00	C	0	0	0.00	0.00	32. 00
33.00	Housekeeping under contract		316, 200	0	316, 200	12, 240. 00	25. 83	33.00
	(see instructions)							
34.00	Di etary	10. 00	273, 928	-135, 496	138, 432	12, 164. 00	11. 38	34.00
35.00	Di etary under contract (see		C	0	0	0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	C	135, 496	135, 496	11, 907. 00	11. 38	36. 00
37.00	Maintenance of Personnel	12. 00	C	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	376, 894	. 0	376, 894	8, 587. 00	43. 89	38. 00
39.00	Central Services and Supply	14. 00	C	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	248, 387	0	248, 387	11, 114. 00	22. 35	40. 00
41.00	Medical Records & Medical	16. 00	190, 560	0	190, 560	9, 287. 00	20. 52	41.00
	Records Library							
42.00	Social Service	17. 00	C	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	C	0	0	0.00	0. 00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | Part | Part

					'	0 12/31/2010	5/22/2019 3:0	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		20, 623, 692	0	20, 623, 692	590, 229. 00	34. 94	1. 00
	instructions)							
2.00	Excluded area salaries (see		67, 551	0	67, 551	2, 356. 00	28. 67	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		20, 556, 141	0	20, 556, 141	587, 873. 00	34. 97	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		817, 049	0	817, 049	6, 311. 00	129. 46	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		2, 718, 990	0	2, 718, 990	0.00	13. 23	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		24, 092, 180	0	24, 092, 180	594, 184. 00	40. 55	6. 00
7.00	Total overhead cost (see		11, 719, 876	0	11, 719, 876	193, 383. 00	60. 60	7. 00
	instructions)							

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0176	Period: Worksheet S-3
		From 01/01/2018 Part IV

	To 12/31/2018	Date/Time Prep 5/22/2019 3:09	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	171, 323	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)	0	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)	1, 639, 872	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	-72, 327	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	14, 204	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	125, 040	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	156, 776	16. 00
	Non cumul ative portion)		
	TAXES		
	FICA-Employers Portion Only	668, 134	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	14, 760	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0	
24.00	Total Wage Related cost (Sum of lines 1 -23)	2, 717, 782	24. 00
	Part B - Other than Core Related Cost		
25. 00	MISC EMPLOYEE BENEFITS	7, 057	25. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Pre 5/22/2019 3:00	pared:
Cost Center Description	· ·	Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identifi	ication:			

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	859, 436	2, 932, 449	1.00
2.00	Hospi tal	859, 436	2, 932, 449	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

	TAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	vider CCN: 15-0176	Peri od:	Worksheet S-1	0
			From 01/01/2018 To 12/31/2018		nare
			10 12/01/2010	5/22/2019 3:0	
				1.00	
	Uncompensated and indigent care cost computation				
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	d by line 202 colu	mn 8)	0. 404530	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid			1, 428, 011	2.
00	Did you receive DSH or supplemental payments from Medicaid?			N N	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?	N	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d		0	
00 00	Medicaid charges Medicaid cost (line 1 times line 6)			9, 897, 409 4, 003, 799	
00	Difference between net revenue and costs for Medicaid program (lin	e 7 minus sum of L	ines 2 and 5: if	2, 575, 788	1
	< zero then enter zero)				
	Children's Health Insurance Program (CHIP) (see instructions for e	ach line)			
00	Net revenue from stand-al one CHIP			0 0	
. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0	10. 11.
. 00	Difference between net revenue and costs for stand-alone CHIP (lin	e 11 minus line 9;	if < zero then	0	1
	enter zero)				
00	Other state or local government indigent care program (see instruc				1 12
. 00	Net revenue from state or local indigent care program (Not include Charges for patients covered under state or local indigent care pr			0	13.
00	10)	ogram (Not Therade	u 111 111103 0 01		' -
00	State or local indigent care program cost (line 1 times line 14)			0	15
. 00		nt care program (I	ine 15 minus line	0	16
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP a	nd state/Local ind	igent care progra	ms (see	
		na stato, rodai rna	. go oa. o p. og. a.		l .
	instructions for each line)				
	Private grants, donations, or endowment income restricted to fundi	9		1	
3. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ital operations	ms (sum of lines	0	18.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ital operations	ms (sum of lines	1	18.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in	oital operations digent care progra	d Insured	0 2, 575, 788 Total (col. 1	18.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in	oital operations digent care progra Uninsured patients	d Insured patients	0 2,575,788 Total (col. 1 + col. 2)	18.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16)	oital operations digent care progra	d Insured	0 2, 575, 788 Total (col. 1	18.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	oital operations digent care progra Uninsuree patients 1.00	d Insured patients	0 2, 575, 788 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 0. 00 0. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions)	unital operations digent care progra Uninsured patients 1.00	d Insured patients 2.00	0 2, 575, 788 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 0. 00 0. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts	unital operations digent care progra Uninsured patients 1.00	I nsured patients 2.00	0 2, 575, 788 Total (col. 1 + col. 2) 3.00	18. 19.
0.00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	Uni nsured pati ents Uni nsured pati ents 1.00	d Insured patients 2.00	0 2, 575, 788 Total (col. 1 + col. 2) 3.00	18. 19. 20. 21.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	Uni nsured pati ents Uni nsured pati ents 1.00	I nsured patients 2.00 0 0 0 0 0	0 2,575,788 Total (col. 1 + col. 2) 3.00	18. 19. 20. 21.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	Uni nsured pati ents Uni nsured pati ents 1.00	I nsured patients 2.00 0 0 0	0 2,575,788 Total (col. 1 + col. 2) 3.00	18. 19. 20. 21.
. 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	Uni nsured pati ents Uni nsured pati ents 1.00	I nsured patients 2.00 0 0 0 0 0	0 2,575,788 Total (col. 1 + col. 2) 3.00	18. 19. 20. 21.
00 00 00 00 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	uital operations digent care progra Uni nsured patients 1.00 ty (see	I nsured patients 2.00 0 0 0 0 0 0 0	0 2,575,788 Total (col. 1 + col. 2) 3.00	20. 21. 22.
. 00 . 00 . 00 . 00 . 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro	Uni nsured pati ents 1.00 ty (see ays beyond a lengt gram?	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit	0 2,575,788 Total (col. 1 + col. 2) 3.00 0 0 0 0	20. 21. 22. 23.
. 00 . 00 . 00 . 00 . 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i	Uni nsured pati ents 1.00 ty (see ays beyond a lengt gram?	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit	0 2,575,788 Total (col. 1 + col. 2) 3.00 0 0	20. 21. 22. 23.
. 00 . 00 . 00 . 00 . 00 . 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit	Uni nsured pati ents 1.00 ty (see as as ays beyond a lengt gram? ndi gent care progra	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit	0 2,575,788 Total (col. 1 + col. 2) 3.00 0 0 0 0 1.00 N	20. 21. 22. 23.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit	Uni nsured pati ents Uni nsured pati ents 1.00 ty (see as lays beyond a lengt gram? ndi gent care program actions)	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit	0 2,575,788 Total (col. 1 + col. 2) 3.00 0 0 0 0	20. 21. 22. 23. 24. 25.
	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instru Medicare allowable bad debts for the entire hospital complex (see	ty (see lays beyond a lengt gram? ndigent care progra	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit	0 2, 575, 788 Total (col. 1 + col. 2) 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 21. 22. 23. 24. 25. 26. 27. 27.
3. 00 0. 00 0. 00 0. 00 0. 00 1.	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instrumedicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	digent care progra Uninsured patients 1.00 ty (see as ays beyond a length gram? ndigent care program etions) instructions)	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit am's length of	0 2, 575, 788 Total (col. 1 + col. 2) 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
	Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	digent care progra Uninsured patients 1.00 ty (see as ays beyond a length gram? ndigent care program etions) instructions)	I Insured patients 2.00 0 0 0 0 0 0 0 h of stay limit am's length of	0 2, 575, 788 Total (col. 1 + col. 2) 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th	Financial Systems	KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-10		
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	CN: 15-0176	Peri od:	Worksheet A	
					From 01/01/2018	5 . (7) 5	
					To 12/31/2018	Date/Time Pre 5/22/2019 3:0	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati		7 pili
	oust deliter beschiptron	Sur ur r cs	Other	+ 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						
1.00	00100 CAP REL COSTS-BLDG & FLXT		4, 189, 203				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 488, 228				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	173, 977	2, 849, 895			3, 023, 872	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 200, 437	11, 801, 330				5. 00
6.00	00600 MAI NTENANCE & REPAI RS	137, 102	1, 481, 840			1, 618, 942	6. 00
8. 00 9. 00	OO800 LAUNDRY & LI NEN SERVI CE OO900 HOUSEKEEPI NG	U	744, 599			744, 599	8. 00
	1 1	272 020	385, 102			385, 102	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	273, 928	456, 790 0		8 -361, 443 0 361, 443		
13. 00	01300 NURSI NG ADMI NI STRATI ON	376, 894	5, 372			382, 266	
14. 00	01400 CENTRAL SERVICES & SUPPLY	370, 874	6, 790, 446			6, 790, 446	
15. 00	01500 PHARMACY	248, 387	1, 476, 653			1, 725, 040	
16. 00	01600 MEDICAL RECORDS & LIBRARY	190, 560	183, 043				
10.00	I NPATIENT ROUTINE SERVICE COST CENTERS	170, 300	100, 040	373,00	<u> </u>	373,003	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 873, 194	658, 860	4, 532, 05	4 0	4, 532, 054	30. 00
	ANCILLARY SERVICE COST CENTERS			., .,	.,	., .,	
50.00	05000 OPERATI NG ROOM	1, 303, 235	1, 322, 293	2, 625, 52	8 0	2, 625, 528	50. 00
53.00	05300 ANESTHESI OLOGY	o	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	794, 913	334, 590	1, 129, 50	3 0	1, 129, 503	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0		0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	720, 263	245, 679	· ·		965, 942	
60.00	06000 LABORATORY	395, 032	1, 479, 267			1, 874, 299	60. 00
65. 00	06500 RESPI RATORY THERAPY	536, 285	83, 616			619, 901	65. 00
69. 00	06900 ELECTROCARDI OLOGY	431, 312	7, 309	1		438, 621	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	•	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	<u> </u>	0		0 0	0	73. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	782, 031	881, 332	1, 663, 36	3 0	1, 663, 363	91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	702,031	001, 332	1, 003, 30	3	1, 003, 303	91.00
92.00	SPECIAL PURPOSE COST CENTERS						72.00
113 00	11300 INTEREST EXPENSE		4, 998, 132	4, 998, 13	2 -4, 998, 132	0	113. 00
118.00		11, 437, 550	42, 863, 579				
110.00	NONREI MBURSABLE COST CENTERS	11, 437, 330	42,000,017	34, 301, 12	7 0	34, 301, 127	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		0 0	0	190. 00
	19100 RESEARCH	ا	0				191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0		0 0	l	192. 00
	07951 MARKETING/ ADVERTISING	10, 088	22, 337	32, 42	5 0	32, 425	
	07950 HI LLVI EW	57, 463	163, 125			220, 588	194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	11, 505, 101	43, 049, 041	54, 554, 14	2 0	54, 554, 142	200. 00

Heal th	Financial Systems	KENTUCKI ANA MEI	DICAL CENTER		In Lieu	u of Form CMS-	-2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CC	CN: 15-0176	Peri od:	Worksheet A	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pro 5/22/2019 3:0	
	Cost Center Description	Adjustments	Net Expenses			3/22/2019 3.1	D9 DIII
	oost denter beserretten		For Allocation				
		6.00	7. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT	-3, 089, 155	1, 630, 187				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	2, 502, 936				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	3, 023, 872				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-6, 444, 795	11, 010, 257				5. 00
6.00	00600 MAINTENANCE & REPAIRS	-24, 691	1, 594, 251				6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	744, 599				8. 00
9. 00	00900 HOUSEKEEPI NG	l ol	385, 102				9. 00
10. 00	01000 DI ETARY	ا	369, 275				10.00
11. 00	01100 CAFETERI A	-153, 330	208, 113				11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	382, 266				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		6, 790, 446				14.00
15. 00	01500 PHARMACY		1, 725, 040				15. 00
16. 00		1					•
16.00	01600 MEDI CAL RECORDS & LI BRARY	-334	373, 269				16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 522 054				1 20 00
30. 00	03000 ADULTS & PEDIATRICS	0	4, 532, 054				30.00
F0 00	ANCILLARY SERVICE COST CENTERS	040 000	4 045 500				
50. 00	05000 OPERATING ROOM	-810, 000	1, 815, 528				50.00
53. 00	05300 ANESTHESI OLOGY	0	0				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-168, 236	961, 267				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	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	965, 942				59. 00
60. 00	06000 LABORATORY	0	1, 874, 299				60.00
65. 00	06500 RESPI RATORY THERAPY	0	619, 901				65. 00
69. 00	06900 ELECTROCARDI OLOGY	0	438, 621				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	-879, 516	783, 847				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
113.0	11300 INTEREST EXPENSE	0	0				113. 00
118.0	SUBTOTALS (SUM OF LINES 1 through 117)	-11, 570, 057	42, 731, 072				118. 00
	NONREI MBURSABLE COST CENTERS						
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19100 RESEARCH	0	0				191.00
	19200 PHYSICIANS' PRIVATE OFFICES	l ol	0				192. 00
	07951 MARKETI NG/ ADVERTI SI NG	o	32, 425				194. 00
	1 07950 HI LLVI EW		220, 588				194. 01
200. 0	1	-11, 570, 057	42, 984, 085				200. 00
_55.0	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	, 5, 5, 507	, , , , , , , , , , , , , , , , , , ,	1			,

Heal th	Financial Systems		KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provider 0	CCN: 15-0176	Period: From 01/01/2018 To 12/31/2018	Worksheet A- Date/Time Pr 5/22/2019 3:	epared:
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	A - CAFETERIA COSTS							
1.00	CAFETERI A	11. 00	135, 496	225, 947				1. 00
	0 = = = = =		135, 496	225, 947				
	B - CAPITAL COSTS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	530, 139				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	14, 708				2. 00
3.00	ADMINISTRATIVE & GENERAL	5.00	O	4, 998, 132				3. 00
	0 — — — — —		<u> </u>	5, 542, 979				
500.00	Grand Total: Increases		135, 496	5, 768, 926				500.00

	Financial Systems		KENTUCKIANA ME				u of Form CMS-	
RECLASS	SI FI CATI ONS			Provi der		Peri od: From 01/01/2018	Worksheet A-6	5
							Date/Time Pro 5/22/2019 3:0	
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7.00	8. 00	9. 00	10.00			
	A - CAFETERIA COSTS							
1.00	DI ETARY	10.00	135, 496	225, 947	7	0		1. 00
	<u> </u>		135, 496	225, 947	7	7		
	B - CAPITAL COSTS							1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	544, 847	7 1	1		1. 00
2.00	INTEREST EXPENSE	113.00	o	4, 998, 132	2 1	1		2. 00

3. 00 500. 00

5/22/2019 3	
Acqui si ti ons	
Beginning Purchases Donation Total Disposals a	d
Ball ances Retirements	
1.00 2.00 3.00 4.00 5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1. 00 Land 0 0 0 0	0 1.00
2.00 Land Improvements 0 0 0 0	0 2.00
3.00 Buildings and Fixtures 0 0 0 0	0 3.00
4.00 Building Improvements 1,645,888 0 0 0	0 4.00
5. 00 Fi xed Equipment 993, 892 147, 731 0 147, 731	0 5.00
6. 00 Movable Equipment 15, 387, 352 1, 699, 625 0 1, 699, 625 1, 389, 9	
7.00 HIT designated Assets 0 0 0 0	0 7.00
8.00 Subtotal (sum of lines 1-7) 18,027,132 1,847,356 0 1,847,356 1,389,9	
9.00 Reconciling Items 0 0 0 0	0 9.00
10.00 Total (line 8 minus line 9) 18,027,132 1,847,356 0 1,847,356 1,389,9	06 10.00
Ending Balance Fully	
Depreci ated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	1 00
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 1,645,888 0	4. 00
5. 00 Fi xed Equi pment	5. 00
6. 00 Movable Equipment 15, 697, 071 0	6. 00
7.00 HIT designated Assets 0 0	7. 00
8.00 Subtotal (sum of lines 1-7) 18,484,582 0	8. 00
9.00 Reconciling Items 0 0	9.00
10.00 Total (line 8 minus line 9) 18,484,582 0	10.00

Hoal th	Financial Systems	KENTUCKIANA ME	DICAL CENTER		In lie	eu of Form CMS-2	2552_10
	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	TAL	072272017 0.0) piii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2	<u> </u>		
1.00	CAP REL COSTS-BLDG & FIXT	202, 533	3, 986, 670		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 488, 228	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 690, 761	3, 986, 670		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 189, 203				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 488, 228				2. 00
	1	1	, , , , , , , , ,	I .			

0 0

4, 189, 203 2, 488, 228 6, 677, 431

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018		
		COM	PUTATION OF RA	TIOS	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 CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	4, 532, 531	C	4, 532, 53			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 744, 316	C	2, 744, 31			2.00
3.00	Total (sum of lines 1-2)	7, 276, 847		7, 276, 84			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	f 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 CI		-	1			
1.00	CAP REL COSTS-BLDG & FIXT	0	})	0 -2, 886, 622		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1)	0 2, 488, 228	l .	2. 00
3.00	Total (sum of lines 1-2)	0)	0 -398, 394	3, 986, 670	3. 00
				JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1. 00	CAP REL COSTS-BLDG & FLXT	530, 139)	ol o	1, 630, 187	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 708		1	0 0		2. 00
3.00	Total (sum of lines 1-2)	544, 847		l .	0 0		3. 00
5.00	1.000. (00 0	011,017	1	TI .	٥,	1 ., 100, 120	0.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0176

				To	0 12/31/2018	Date/Time Prep 5/22/2019 3:09	
				Expense Classification on		0,22,201, 0.0	<i>y</i> piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00	1. 00
	COSTS-BLDG & FLXT (chapter 2)					Ĭ	
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0. 00	О	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	di scounts (chapter 8)		9				
5. 00	Refunds and rebates of expenses (chapter 8)	В	-31, 933	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	O	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service	A	-24, 691	MAINTENANCE & REPAIRS	6. 00	10	8. 00
0.00	(chapter 21)				0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 857, 752		0. 00	0	9. 00 10. 00
11 00	adjustment				0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-8, 043, 692			О	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		-153, 330	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		U		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-334	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	o	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vendi ng machi nes		0		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty	В	-37, 002	ADMINISTRATIVE & GENERAL	5. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments		_				
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24.00	limitation (chapter 14)	A-8-3	0	*** Coot Conton Doloted ***	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-0-3	Ü	*** Cost Center Deleted ***	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		0	cost denter bereted	114.00		23.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of						
30. 99	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
300	pathology costs in excess of		0	3000 00com Bollotou	55. 00		500
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	o	32. 00
	Depreciation and Interest MISC INCOME	В	11 750	ADMINISTRATIVE & CENERAL	5. 00		33. 00
	INI SO I NOOME	ן ט	-11, /30	ADMINISTRATIVE & GENERAL	5.00	્	

Health Financial Systems		KENTUCKIANA ME	DICAL CENTER	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2018 To 12/31/2018		
			Expense Classification or			
			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	
35.00 NON-ALLOWABLE EXPENSES	A	-35, 803	ADMINISTRATIVE & GENERAL	5. 00	9	35. 00
40. 00 HAF	A	-1, 373, 770	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
40.01 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40. 01
(3)						
50.00 TOTAL (sum of lines 1 thru 49)		-11, 570, 057				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

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

 B. Amount Received if cost cannot be determined.

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

Heal th	Financial Systems	KENTUCKIANA M	EDICAL CENTER	In Li€	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period: From 01/01/2018	Worksheet A-8	8-1
OFFI CE	COSTS			To 12/31/2018		
	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 HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
1.00		CAP REL COSTS-BLDG & FIXT	FACILITY LEASE	0	3, 986, 670	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	4, 954, 537	3.00
4.00	0.00			O	o	4.00
5.00	TOTALS (sum of lines 1-4).			897, 515	8, 941, 207	5.00
	Transfer column 6, line 5 to					

* 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.

 as not been pested to not kenest in detailed I and of El the amount arronage ended a service out of any in or time parti							
			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:

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-2552-10			2552-10	
		SERVICES FROM	RELATED OF	RGANIZATIONS AND H	IOME	Provi der	CCN: 15-0176		ri od:	Worksheet	A-8-	-1
OFFICE	COSTS							To	om 01/01/2018 12/31/2018	Date/Ti me 5/22/2019		
	Net	Wkst. A-7 Ref.								3/22/2017	3.09	z pili
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCURI	RED AND ADJUSTI	MENTS REQUI	RED AS A RESULT (OF TRAI	NSACTI ONS	WITH RELATED	D ORGA	NIZATIONS OR (CLAI MED		
	HOME OFFICE CO											
1.00	-3, 986, 670	9										1. 00
2.00	897, 515	9										2.00
3.00	-4, 954, 537	0										3.00
4.00	0	0										4.00
5.00	-8, 043, 692											5. 00
* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as												

* 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.

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0176

						To 12/31/2018	B Date/Time Pro 5/22/2019 3:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		OPERATING ROOM	810, 000					
2.00		RADI OLOGY-DI AGNOSTI C	168, 236			2, 1, , 00	1	
3.00		EMERGENCY	879, 516	1		211, 500	1	
4.00	0. 00		0	(1	0	0	1
5.00	0. 00		0	(0	0	0	0.00
6.00	0. 00		0	(0	0	0	6. 00
7. 00	0. 00		0	(0	0	0	7. 00
8.00	0. 00		0		0	0	0	0.00
9.00	0. 00		0		0	0	0	9. 00
10. 00	0. 00		0	(0	0	
200.00		0 1 0 1 (8)	1, 857, 752				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Limit	Memberships &	Component	of Mal practice Insurance	
				LIIIII	Continuing Education	Share of col.	Trisurance	
	1. 00	2.00	8. 00	9, 00	12. 00	13. 00	14.00	
1.00		OPERATI NG ROOM	0.00					1.00
2. 00		RADI OLOGY-DI AGNOSTI C	0	1	-			1
3.00		EMERGENCY	0				0	1
4. 00	0.00	4	0				0	i
5.00	0. 00		0			0	0	i
6.00	0. 00		0			0	O	6. 00
7.00	0.00		0			0	0	7. 00
8.00	0.00		0			0	0	8. 00
9.00	0. 00		0		0	0	0	9. 00
10.00	0. 00		0	(0	0	0	10.00
200.00			0	(0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18.00		
1 00		OPERATI NG ROOM	15.00					1. 00
1. 00 2. 00		RADI OLOGY-DI AGNOSTI C		1	-	1	1	2.00
3.00		EMERGENCY		1	1	879, 516		3.00
4. 00	0.00					0/9, 310		4.00
5.00	0.00							5.00
6. 00	0.00							6.00
7. 00	0.00							7.00
8. 00	0.00							8.00
9. 00	0.00							9. 00
10. 00	0.00		1					10.00
200.00			l ő	l è		1		200.00
	1	I control of the cont			1	, , , , , , , , , , , , , , , , , , , ,		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 3:09 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 00 1, 630, 187 1, 630, 187 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 502, 936 2, 502, 936 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 023, 872 22, 958 35, 248 3, 082, 078 4.00 00500 ADMINISTRATIVE & GENERAL 11, 010, 257 226. 738 5.00 5 00 147, 677 326, 520 11, 711, 192 710, 983 1, 594, 251 6.00 00600 MAINTENANCE & REPAIRS 463,070 37, 292 2, 805, 596 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 744, 599 24, 939 38, 291 807, 829 8.00 00900 HOUSEKEEPI NG 55, 419 9.00 385, 102 36, 095 0 476, 616 9.00 01000 DI ETARY 369, 275 93. 984 562, 126 10.00 61, 213 10 00 37.654 11.00 01100 CAFETERI A 208, 113 33, 468 51, 385 36, 855 329, 821 11.00 01300 NURSING ADMINISTRATION 382, 266 11, 579 17, 778 102, 516 514, 139 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 6, 790, 446 44, 356 68, 103 6, 902, 905 14.00 14.00 11, 490 1, 821, 733 01500 PHARMACY 17, 641 67, 562 15.00 15.00 1, 725, 040 16.00 01600 MEDICAL RECORDS & LIBRARY 373, 269 30, 261 46, 462 51, 833 501,825 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 532, 054 724, 899 6, 782, 597 30.00 472, 131 1, 053, 513 30.00 ANCILLARY SERVICE COST CENTERS 1, 815, 528 50.00 05000 OPERATING ROOM 252, 071 354, 481 50.00 164, 177 2, 586, 257 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 961, 267 44, 980 69,061 1, 291, 525 54.00 216, 217 05500 RADI OLOGY-THERAPEUTI C 55.00 r Λ 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 05900 CARDIAC CATHETERIZATION 59.00 965, 942 32, 466 49, 847 195, 912 1, 244, 167 59.00 06000 LABORATORY 1, 874, 299 12, 292 18, 872 107, 449 2, 012, 912 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 619, 901 4, 053 6, 222 145, 870 776, 046 65.00 06900 ELECTROCARDI OLOGY 69.00 438, 621 5, 411 8, 308 117, 317 569, 657 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 Ω 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 783, 847 7, 571 1, 015, 755 91.00 11.624 212, 713 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) 42, 731, 072 1, 630, 187 2, 502, 936 3, 063, 704 42, 712, 698 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 194. 00 07951 MARKETING/ ADVERTISING 32, 425 0 0 2, 744 35, 169 194. 00 194. 01 07950 HI LLVI EW 220, 588 0 15, 630 236, 218 194. 01 C 200.00 Cross Foot Adjustments 0 200.00 201 00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 42, 984, 085 1, 630, 187 2, 502, 936 3, 082, 078 42, 984, 085 202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/22/2019 3:09 pm	

				'		5/22/2019 3:0	9 pm
	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	11, 711, 192					5. 00
6.00	00600 MAINTENANCE & REPAIRS	1, 050, 651	3, 856, 247	·			6. 00
8.00	00800 LAUNDRY & LINEN SERVICE	302, 519	96, 512				8.00
9.00	00900 HOUSEKEEPI NG	178, 485			794, 785		9.00
10.00	01000 DI ETARY	210, 507	236, 885		52, 008	1, 061, 526	10.00
11. 00	01100 CAFETERI A	123, 513	129, 515		28, 435	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	192, 537	44, 809		9, 838	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 585, 022	171, 653		37, 687	0	14. 00
15. 00	01500 PHARMACY	682, 210		III	9, 762	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	187, 925	117, 107		25, 711	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	107, 723	117, 107		25, 711		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 539, 974	1, 827, 087	1, 206, 860	401, 140	1, 061, 526	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	2, 337, 774	1,027,007	1, 200, 000	401, 140	1,001,320	30.00
50. 00	05000 OPERATI NG ROOM	968, 512	635, 340	0	139, 489	0	50.00
53. 00	05300 ANESTHESI OLOGY	700, 312	033, 340	1	137, 407	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	483, 655	174, 066	1	38, 216	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	463, 655	174,000	1	36, 210	0	55.00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0	0		0	0	56.00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	465, 921	125, 638		27, 584	0	59.00
60.00	06000 LABORATORY	753, 803	47, 566	•	10, 443	0	60.00
65. 00	l l	1		1		0	
69. 00	06500 RESPIRATORY THERAPY	290, 617	15, 683	1	3, 443	0	65. 00
	06900 ELECTROCARDI OLOGY	213, 327	20, 940		4, 597	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0) 0	0	0	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS	200 204	20, 200	1 0	(422	0	01 00
91.00	09100 EMERGENCY	380, 384	29, 298	0	6, 432	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.00	SPECIAL PURPOSE COST CENTERS						440.00
	11300 I NTEREST EXPENSE	44 (00 5(0	0 05/ 0/3		704 705	4 0/4 50/	113. 00
118.00	3 /	11, 609, 562	3, 856, 247	1, 206, 860	794, 785	1, 061, 526	1118.00
	NONREI MBURSABLE COST CENTERS				a		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	07951 MARKETI NG/ ADVERTI SI NG	13, 170	0	0	0		194. 00
	07950 HI LLVI EW	88, 460	0	0 ار	0	0	194. 01
200.00	1 1						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	11, 711, 192	3, 856, 247	1, 206, 860	794, 785	1, 061, 526	202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I
To 1/21/2019 Part II
To 1/21/2019 Part II Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176

				To	12/31/2018	Date/Time Pre 5/22/2019 3:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<i>y</i> p
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11 00	10.00	SUPPLY	45.00	LI BRARY	
	CENEDAL CEDVICE COCT CENTEDO	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-BLDG & FIXT						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	611, 284	i i				11. 00
13. 00	01300 NURSING ADMINISTRATION	8, 939	1				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	ol	9, 697, 267			14. 00
15.00	01500 PHARMACY	18, 496	ol ol	0	2, 576, 665		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	12, 710	o	0	0	845, 278	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	257, 096	462, 593	0	0	97, 487	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	77, 690	1	0	0	71, 844	50. 00
53. 00	05300 ANESTHESI OLOGY		Ί "Ι	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	31, 661	0	0	0	111, 450	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE			0	0	0	56. 00
57. 00	05700 CT SCAN			0	0	0	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	57, 666	51, 882	0	0	0 188, 093	58. 00 59. 00
60.00	06000 LABORATORY	26, 590		0	0	136, 651	60.00
65. 00	06500 RESPIRATORY THERAPY	36, 797		0	0	25, 354	65. 00
69. 00	06900 ELECTROCARDI OLOGY	27, 663		0	0	17, 138	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	27,000		0	0	17, 130	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		ol ol	3, 526, 074	0	25, 241	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1	6, 171, 193	Ö	44, 176	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1	0, 171, 170	2, 576, 665	91, 314	73. 00
	OUTPATIENT SERVICE COST CENTERS	_	-1	-1		,	
91.00	09100 EMERGENCY	55, 976	0	0	0	36, 530	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	, , , , , , , , , , , , , , , , , , , ,	611, 284	770, 262	9, 697, 267	2, 576, 665	845, 278	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1	0	0		190. 00
	19100 RESEARCH	C	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	이	0	0		192. 00
	07951 MARKETING/ ADVERTISING	C	0	0	0		194. 00
	1 07950 HI LLVI EW	C	기 이	0	이	0	194. 01
200.00						_	200. 00
201.00		(11 204	770 2/2	0 (07 2/7	0 57/ //5		201. 00
202.00	TOTAL (sum lines 118 through 201)	611, 284	770, 262	9, 697, 267	2, 576, 665	845, 278	202.00

Heal th Financial Systems KENTUCKI ANA MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION CENERAL SERVICE COSTS

| Provider CON: 15 0176 | Portion: | Workshoot P.

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0176 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/22/2019 3:09 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 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 01100 CAFETERI A 11.00 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 14, 636, 360 0 14, 636, 360 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 618, 898 4, 618, 898 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 130, 573 0 2, 130, 573 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 2, 160, 951 2, 160, 951 59 00 60.00 06000 LABORATORY 2, 987, 965 2, 987, 965 60.00 06500 RESPIRATORY THERAPY 1, 214, 163 1, 214, 163 65.00 65.00 06900 ELECTROCARDI OLOGY 903, 120 69.00 69.00 903, 120 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 551, 315 0 3, 551, 315 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 6, 215, 369 6, 215, 369 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 73.00 <u>2, 667, 97</u>9 73.00 2,667,979 91.00 09100 EMERGENCY 1, 524, 375 1, 524, 375 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 42, 611, 068 0 42, 611, 068 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 \cap 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 194. 00 07951 MARKETING/ ADVERTISING 194. 00 0 48.339 48, 339 194. 01 07950 HI LLVI EW 0 324, 678 324, 678 194. 01 200.00 Cross Foot Adjustments 200. 00

42, 984, 085

0

42, 984, 085

201.00

202.00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

				To	12/31/2018	Date/Time Prep 5/22/2019 3:0	
			CAPI TAL REI	ATED COSTS		3/22/2019 3.0	7 DIII
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Assigned New Capital				DEPARTMENT	
		Related Costs				DEI ARTIMENT	
		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		00.050	05.040	F0 00/	F0 00/	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	22, 958		58, 206 374, 415	58, 206	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	147, 677 463, 070	226, 738 710, 983	1, 174, 053	6, 167 704	6.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	24, 939	· ·	63, 230	704	8.00
9. 00	00900 HOUSEKEEPING	0	36, 095		91, 514	0	9. 00
10.00	01000 DI ETARY	0	61, 213		155, 197	711	10.00
11. 00	01100 CAFETERI A	l o	33, 468	·	84, 853	696	
13. 00	01300 NURSING ADMINISTRATION	0	11, 579		29, 357	1, 936	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	44, 356		112, 459	0	14. 00
15.00	01500 PHARMACY	0	11, 490	17, 641	29, 131	1, 276	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	30, 261	46, 462	76, 723	979	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	472, 131	724, 899	1, 197, 030	19, 895	30. 00
FO 00	ANCILLARY SERVICE COST CENTERS	0	1/4 177	252 074	417 240	/ /05	
50. 00 53. 00	O5000 OPERATI NG ROOM O5300 ANESTHESI OLOGY	0	164, 177 0		416, 248 0	6, 695 0	50. 00 53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	44, 980	-	114, 041	4, 083	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	44, 700	07,001	114, 041	4, 003	55.00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	o	0	57. 00
58.00	05800 MRI	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	32, 466	49, 847	82, 313	3, 700	59. 00
60.00	06000 LABORATORY	0	12, 292		31, 164	2, 029	60.00
65. 00	06500 RESPI RATORY THERAPY	0	4, 053		10, 275	2, 755	
69. 00	06900 ELECTROCARDI OLOGY	0	5, 411	8, 308	13, 719	2, 216	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	· -1	0	0	70.00
71. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	U	0	U U	<u> </u>	U	73.00
91. 00	09100 EMERGENCY	0	7, 571	11, 624	19, 195	4, 017	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,, ,, ,	, 52 .	0	1, 017	92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	0	1, 630, 187	2, 502, 936	4, 133, 123	57, 859	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1			ما		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES		0	0	0		191. 00 192. 00
	07951 MARKETING/ ADVERTISING		0		0		194. 00
	07950 HILLVIEW		0		0		194. 00
200.00	1				ol	273	200.00
201.00	1 1		0	o	ol	0	201. 00
202.00		0	1, 630, 187	2, 502, 936	4, 133, 123	58, 206	202. 00
		· ·					

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

ADMINISTRATIVE MAINTENANCE & LAUNDRY & HOUSEKEEPING DIETARY EGNERAL SERVICE COST CENTERS 5.00 6.00 8.00 9.00 10.00					To	12/31/2018	Date/Time Pre 5/22/2019 3:0	
SENERAL SERVICE COST CENTERS		Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG		7 DIII
S.00 6.00 8.00 9.00 10.00		dost denter beserver on				HOUSEKEELLING	DILIANI	
CENERAL SERVICE COST CENTERS						9. 00	10.00	
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		GENERAL SERVICE COST CENTERS						
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 380, 582 5. 00 00500 ADMIN INSTRATI VE & GENERAL 380, 582 5. 00 00600 ADMIN INSTRATI VE & GENERAL 380, 582 5. 00 00600 ADMIN INSTRATI VE & GENERAL 380, 582 5. 00 00600 ADMIN INSTRATI VE & GENERAL 380, 582 6. 00 00600 ADMIN INSTRATI VE & GENERAL 380, 580 00600 ADMIN INSTRATI ON 4, 014 40, 602 00600 4, 504 00600 ADMIN INSTRATI ON 6, 257 14, 047 00600 1, 747 00600 14, 00600 14, 00600 00600 ADMIN INSTRATI ON 6, 257 14, 047 00600 1, 747 00600 14, 00600 1	1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5. 00 00500 ADMINISTRATIVE & GENERAL 380, 582	4.00							4.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9, 831 30, 256 103, 317 8. 00 9. 00 00900 HOUSEKEEPING 5, 800 43, 790 0 141, 104 9. 00 10000 IETARY 6, 841 74, 261 0 9, 233 246, 243 10. 00 11. 00 11. 00 01100 CAFETERI A 4, 014 40, 602 0 5, 048 0 11. 00 13. 00 01300 NURSI NG ADMINI STRATI ON 6, 257 14, 047 0 1, 747 0 13. 00 01500 PHARMACY 22, 170 13, 939 0 1, 733 0 15. 00 01600 MEDI CAL RECORDS & LI BRARY 6, 107 36, 712 0 4, 565 0 16. 00 16. 00 INPATI ENT ROUTI NE SERVI CE COST CENTERS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 3000 ADULTS & PEDI ATRI CS 30. 00 3000 ADULTS & PEDI ATRI CS 30. 00	5.00		380, 582					5. 00
9. 00 00900 HOUSEKEEPING 5,800 43,790 0 141,104 9. 00 10 00 10 ETARY 6,841 74,261 0 9.233 246,243 10.00 11.00 01 100 CAFETERIA 4,014 40,602 0 5.048 0 11.00 11.00 01 00 UNESING ADMINISTRATION 6,257 14,047 0 1,747 0 13.00 13.00 01 00 01 00 CENTRAL SERVICES & SUPPLY 84,000 53,812 0 6,691 0 14.00 15.00 01 00 PHARMACY 22,170 13,939 0 1,733 0 15.00 16.00 PHARMACY 22,170 13,939 0 1,733 0 15.00 16.00 MEDICAL RECORDS & LIBRARY 6,107 36,712 0 4,565 0 16.00 NEDICAL RECORDS & LIBRARY 6,107 36,712 0 4,565 0 16.00 NEDICAL RECORDS & LIBRARY 6,107 36,712 0 4,565 0 16.00 NEDICAL RECORDS & LIBRARY 6,107 36,712 0 4,565 0 16.00 NEDICAL RECORDS & LIBRARY 6,107 36,712 0 50.00 NEDICAL RECORDS & LI	6.00	00600 MAINTENANCE & REPAIRS	34, 144	1, 208, 901				6.00
9. 00 00900 HOUSEKEEPING 5,800 43,790 0 141,104 9,00 10. 00 10000 DI ETARY 6,841 74,261 0 9,233 246,243 10.00 11. 00 01100 CAFETERIA 4,014 40,602 0 5,048 0 11.00 13. 00 01300 NURSING ADMINISTRATION 6,257 14,047 0 1,747 0 13.00 14. 00 01400 CENTRAL SERVICES & SUPPLY 84,000 53,812 0 6,691 0 14.00 15. 00 01500 PHARMACY 22,170 13,939 0 1,733 0 15.00 16. 00 01600 MEDICAL RECORDS & LIBRARY 6,107 36,712 0 4,565 0 15.00 18. 00 01500 ADULTS & PEDIATRICS 82,544 572,776 103,317 71,217 246,243 30. 00 03000 ADULTS & PEDIATRICS 82,544 572,776 103,317 71,217 246,243 30. 00 05300 ANESTHESI OLOGY 0 0 0 24,765 0 53.00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15,718 54,568 0 6,785 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55.00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 55.00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57.00 58. 00 05800 MRI 0 0 0 0 0 0 0 0 57.00 58. 00 05800 MRI 0 0 0 0 0 0 0 0 57.00 59. 00 05900 CARDI AC CATHETEI ZATI ON 15,142 39,386 0 4,897 0 59.00 60. 00 06000 LABORATORY 24,497 14,912 0 1,854 0 0.00 65. 00 06500 RESPIRATORY THERAPY	8.00	00800 LAUNDRY & LINEN SERVICE	9, 831	30, 256	103, 317			8. 00
11. 00	9.00	00900 HOUSEKEEPI NG	5, 800	43, 790		141, 104		9.00
11. 00	10.00	01000 DI ETARY	6, 841	74, 261	O	9, 233	246, 243	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 6, 257 14, 047 0 1, 747 0 13. 00 14. 00 01400 CENTRAL SERVI CES & SUPPLY 84, 000 53, 812 0 6, 691 0 14. 00 15. 00 01500 PHARMACY 22, 170 13, 939 0 1, 733 0 15. 00 16. 00 01600 MEDI CAL RECORDS & LI BRARY 6, 107 36, 712 0 4, 565 0	11. 00			1				•
14. 00				l			0	•
15. 00				l			0	l
16. 00 01600 MEDI CAL RECORDS & LI BRARY 6, 107 36, 712 0 4, 565 0 16. 00 NPATI ENT ROUTI NE SERVI CE COST CENTERS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 ANCI LLARY SERVI CE COST CENTERS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 53. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 718 54, 568 0 6, 785 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00				l				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 82,544 572,776 103,317 71,217 246,243 30.00 3000 ADULTS & PEDI ATRI CS 82,544 572,776 103,317 71,217 246,243 30.00 ANCI LLARY SERVI CE COST CENTERS			1			•	0	
30. 00 03000 ADULTS & PEDI ATRI CS 82, 544 572, 776 103, 317 71, 217 246, 243 30. 00 ANCI LLARY SERVI CE COST CENTERS 31, 475 199, 174 0 24, 765 0 50. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 718 54, 568 0 6, 785 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05700 CT SCAN 0 0 0 0 0 0 0 56. 00 57. 00 05800 MRI 0 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00 065. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00 065. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00 065. 00 0.00					-	.,		
ANCI LLARY SERVI CE COST CENTERS	30.00		82.544	572, 776	103, 317	71, 217	246, 243	30.00
50. 00 05000 OPERATI NG ROOM 31, 475 199, 174 0 24, 765 0 50. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 718 54, 568 0 6, 785 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0						, = ,		
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 15, 718 54, 568 0 6, 785 0 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 0 0 0 0 0 0 55. 00 57. 00 0 0 0 0 0 0 0 0 <	50.00		31, 475	199, 174	0	24, 765	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 718 54, 568 0 6, 785 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00	53. 00	l l	0	l .		•	0	•
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00			15, 718	54, 568	0	6. 785	0	•
56. 00 056.00 RADI OI SOTOPE 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00			0	0			0	•
58. 00 05800 MRI 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00			0	0	0	0	0	•
58. 00 05800 MRI 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 15, 142 39, 386 0 4, 897 0 59. 00 60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00	57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00	58. 00		0	0	0	0	0	58. 00
60. 00 06000 LABORATORY 24, 497 14, 912 0 1, 854 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 444 4, 917 0 611 0 65. 00	59. 00	05900 CARDI AC CATHETERI ZATI ON	15, 142	39, 386	0	4. 897	0	59.00
65. 00 06500 RESPIRATORY THERAPY 9, 444 4, 917 0 611 0 65. 00	60.00		1				0	60.00
	65. 00		1				0	65. 00
							0	ł
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00			0	1			0	ł
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00			0	0	0	0	0	ł
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00			0	0	0	0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00	73. 00		0	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS		OUTPATIENT SERVICE COST CENTERS		•				
91. 00 09100 EMERGENCY 12, 362 9, 185 0 1, 142 0 91. 00	91.00	09100 EMERGENCY	12, 362	9, 185	0	1, 142	0	91. 00
92.00 OBSERVATION BEDS (NON-DISTINCT PART 92.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS		SPECIAL PURPOSE COST CENTERS			•			
113. 00 11300 I NTEREST EXPENSE 113. 00	113.00	11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 377, 279 1, 208, 901 103, 317 141, 104 246, 243 118.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	377, 279	1, 208, 901	103, 317	141, 104	246, 243	118. 00
NONREI MBURSABLE COST CENTERS		NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH 0 0 0 191. 00	191.00	19100 RESEARCH	0	0	0	0	0	191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00	192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194. 00 07951 MARKETI NG/ ADVERTI SI NG 428 0 0 0 0 194. 00	194.00	07951 MARKETING/ ADVERTISING	428	0	o	0	0	194. 00
194. 01 07950 HI LLVI EW 2, 875 0 0 0 194. 01	194. 01	07950 HI LLVI EW	2, 875	0	0	0	0	194. 01
200.00 Cross Foot Adjustments 200.00	200.00	Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers 0 0 0 0 201.00	201.00	1 1	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201) 380,582 1,208,901 103,317 141,104 246,243 202.00	202.00	TOTAL (sum lines 118 through 201)	380, 582	1, 208, 901	103, 317	141, 104	246, 243	202. 00

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176

				To	12/31/2018	Date/Time Pre 5/22/2019 3:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		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	405.040					10.00
11. 00	01100 CAFETERI A	135, 213					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 977	55, 321	05/ 0/0			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	256, 962	70.040		14.00
15. 00	01500 PHARMACY	4, 091	0	-	72, 340	407.007	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 811	0	0	0	127, 897	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F/ 0/0	22.224		٥	14 740	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	56, 868	33, 224	0	0	14, 748	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	17 105	10, 038	O	o	10, 868	50.00
53. 00	05300 ANESTHESI OLOGY	17, 185 0	10,038	1	0	10, 868	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7,003	1		0	16, 860	
55. 00	05500 RADI OLOGY-THERAPEUTI C	7,003	0		0	16, 860	1
56. 00	05600 RADI OI SOTOPE	0	0		0	0	1
57. 00	05700 CT SCAN	0	0	-	0	0	
58. 00	05800 MRI	0	0		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 756	3, 726	-	0	28, 479	
60.00	06000 LABORATORY	5, 882	3, 720		0	20, 479	1
65. 00	06500 RESPIRATORY THERAPY	8, 139	1	·	0	3, 836	1
69. 00	06900 ELECTROCARDI OLOGY	6, 119			0	2, 593	1
70. 00	07000 ELECTROCARD OLOGI 07000 ELECTROENCEPHALOGRAPHY	0,117	3, 377		0	2, 373	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	I - 1	0	3, 818	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l o		0	6, 683	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		72, 340	13, 814	1
70.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	72,010	10,011	70.00
91. 00	09100 EMERGENCY	12, 382	0	0	0	5, 526	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	12,002			Ĭ	0,020	92.00
	SPECIAL PURPOSE COST CENTERS	I.		l. I.			1
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		135, 213	55, 321	256, 962	72, 340	127, 897	118.00
	NONREI MBURSABLE COST CENTERS				,		
190.00	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	0	0	0	o	0	194. 00
194. 01	07950 HI LLVI EW	0	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	135, 213	55, 321	256, 962	72, 340	127, 897	202. 00
				,	,		

Heal th Financial Systems KENTUCKI ANA MEDICAL CENTER In Lieu of Form CMS-2552-10

ALLOCATION OF CARLTAI RELATED COSTS

| Provider CON: 15 0176 | Portion: | Workshoot P.

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/22/2019 3:09 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 2, 397, 862 0 2, 397, 862 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 716, 448 716, 448 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 219, 058 0 219,058 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 55 00 0 0 05600 RADI OI 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 59 00 190, 399 0 190, 399 59 00 60.00 06000 LABORATORY 101,010 0 101, 010 60.00 06500 RESPIRATORY THERAPY 44, 733 44, 733 65.00 65.00 06900 ELECTROCARDI OLOGY 69.00 69.00 42,537 42, 537 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 97, 252 0 97, 252 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 170, 211 170, 211 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 73.00 73.00 86, 154 86, 154 91.00 09100 EMERGENCY 63, 809 63, 809 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 4, 129, 473 0 4, 129, 473 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 Ω 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. 00 480 480 194. 01 07950 HI LLVI EW 0 3.170 3, 170 194. 01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 4, 133, 123 4, 133, 123 202.00 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0176 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/22/2019 3:09 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 73 210 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 73, 210 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,031 1,031 11, 331, 124 4.00 00500 ADMINISTRATIVE & GENERAL 1, 200, 437 5 00 6,632 6, 632 -11, 711, 192 31 272 893 5 00 6.00 00600 MAINTENANCE & REPAIRS 20, 796 20, 796 137, 102 2, 805, 596 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 120 1, 120 807, 829 8.00 0 9.00 00900 HOUSEKEEPI NG 1,621 1, 621 476, 616 9.00 0 01000 DI ETARY 10.00 2.749 138, 432 562, 126 2.749 10 00 11.00 01100 CAFETERI A 1,503 1,503 135, 496 0 329, 821 11.00 01300 NURSING ADMINISTRATION 520 520 376, 894 0 514, 139 13.00 13.00 0 01400 CENTRAL SERVICES & SUPPLY 1, 992 1, 992 6, 902, 905 14.00 14.00 01500 PHARMACY 15.00 516 516 248, 387 1, 821, 733 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 359 1, 359 190, 560 501,825 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 203 30.00 21, 203 3, 873, 194 0 6, 782, 597 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 373 1, 303, 235 50.00 7, 373 0 2, 586, 257 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 2,020 2,020 794, 913 1, 291, 525 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 Λ 55.00 0 56.00 05600 RADI 0I S0T0PE 0 0 56.00 0 0 57.00 05700 CT SCAN 0 0 57.00 0 0 58.00 05800 MRI 58.00 0 0 0 05900 CARDIAC CATHETERIZATION 1, 458 1, 458 59.00 720, 263 1, 244, 167 59.00 06000 LABORATORY 395, 032 2, 012, 912 60.00 552 552 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 182 182 536, 285 776, 046 65.00 06900 ELECTROCARDI OLOGY 69 00 243 243 431, 312 569, 657 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 C 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 Ω 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72 00 72 00 C Ω 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 340 340 782, 031 0 1, 015, 755 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 73.210 73, 210 11, 263, 573 -11, 711, 192 31, 001, 506 118. 00 118 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192 00 O Ω 194.00 07951 MARKETING/ ADVERTISING 0 10,088 0 35, 169 194. 00 194. 01 07950 HI LLVI EW 0 236, 218 194. 01 57, 463 200.00 Cross Foot Adjustments 200. 00 201 00 l201. 00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 1, 630, 187 2, 502, 936 3, 082, 078 11, 711, 192 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 22. 267272 34. 188444 0.272001 0. 374484 203. 00 380, 582 204. 00 204.00 Cost to be allocated (per Wkst. B, 58, 206 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.005137 0. 012170 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Heal th I	Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	<u> 2552-10</u>
COST AL	LOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 01/01/2018		
				T	o 12/31/2018		
						5/22/2019 3:0	9 pm
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAI RS	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(PATIENT DA				
			YS)				
		6.00	8.00	9.00	10.00	11. 00	
C	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	DO500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	44, 751					6.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 120	7, 445				8.00
	00900 HOUSEKEEPI NG	1, 621		1			9.00
	01000 DI ETARY	2,749	l .	2, 749			10.00
	D1100 CAFETERI A	1		1		10 005	
	•	1, 503	l .	1, 503		18, 805	1
	D1300 NURSING ADMINISTRATION	520	l .	520		275	1
	01400 CENTRAL SERVICES & SUPPLY	1, 992	0	1, 992	0	0	14. 00
15. 00	D1500 PHARMACY	516	0	516	0	569	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 359	0	1, 359	0	391	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	· ·					
	03000 ADULTS & PEDIATRICS	21, 203	7, 445	21, 203	22, 443	7, 909	30.00
	ANCILLARY SERVICE COST CENTERS	21, 203	7,443	21, 203	22, 443	7, 707	30.00
		7.070	1			0.000	
	O5000 OPERATING ROOM	7, 373		.,		2, 390	1
	D5300 ANESTHESI OLOGY	0	_	0	-	0	
54.00	D5400 RADI OLOGY-DI AGNOSTI C	2, 020	0	2, 020	0	974	54.00
55. 00	D5500 RADI OLOGY-THERAPEUTI C	0	0	ol c	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
	05700 CT SCAN	0]	0	0	
					0	0	
	05800 MRI	1	0	1	0		
	D5900 CARDI AC CATHETERI ZATI ON	1, 458	l .	1, 458		1, 774	1
60.00	D6000 LABORATORY	552	0	552	0	818	60.00
65.00	06500 RESPIRATORY THERAPY	182	0	182	0	1, 132	65.00
69. 00	06900 ELECTROCARDI OLOGY	243	0	243	o	851	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	l e			0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	_	l o	0	0	
	•		1	1	0	-	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	l .	C	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0) C	0	0	73. 00
C	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	340	0	340	0	1, 722	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	1	l .				
	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11 751	7, 445	12 010	22 442	10 005	118.00
		44, 751	7, 443	42, 010	22, 443	10, 003	1110.00
	NONREI MBURSABLE COST CENTERS		1	T	1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0) c	0		190. 00
191.00	19100 RESEARCH	0	0	(C	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	ol	0	192. 00
	D7951 MARKETING/ ADVERTISING	0	0		0		194. 00
	07950 HI LLVI EW	Ö	_	1	١		194. 01
200.00	Cross Foot Adjustments			Ī			200.00
	,						
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	3, 856, 247	1, 206, 860	794, 785	1, 061, 526	611, 284	202.00
	Part I)						1
203.00	Unit cost multiplier (Wkst. B, Part I)	86. 171192	162. 103425	18. 918948	47. 298757	32. 506461	203.00
204.00	Cost to be allocated (per Wkst. B,	1, 208, 901	l .			135, 213	1
	Part II)	1, 200, 701	.55,517		2.3,210	.55,216	50
205.00	Unit cost multiplier (Wkst. B, Part	27. 013944	13. 877367	3. 358819	10. 971929	7. 190269	205 00
203.00	· · · · · · · · · · · · · · · · · · ·	27.013944	13.0//30/	3. 330019	10. 97 1929	7. 190209	200.00
204 20	NAUE adjustment amount to be all control						20/ 22
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						1
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
		•	•	•			

Health Financial Systems	KENTUCKIANA MED	DICAL CENTER	In Lieu of Form CMS-2552-1			
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Prep 5/22/2019 3:09	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY		
	(DIRECT NRSING	(COSTED		(GROSS CHAR		
	HRS)	REOULS)		GES)		

				10) 12/31/2018	5/22/2019 3:09 pm	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	0,22,201, 010, 6	
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY		
		(DIRECT NRSING	(COSTED		(GROSS CHAR		
		HRS)	REQUIS.)		GES)		
0	ENEDAL CEDVICE COCT CENTEDO	13. 00	14. 00	15. 00	16. 00		_
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	1				1. 00	Ω
4	10200 CAP REL COSTS-BLDG & FIXT					2.00	
	10400 EMPLOYEE BENEFITS DEPARTMENT					4.00	
	0500 ADMINISTRATIVE & GENERAL					5. 00	
1	0600 MAI NTENANCE & REPAI RS	•				6. 00	
	10800 LAUNDRY & LINEN SERVICE	1				8. 00	
	10900 HOUSEKEEPI NG					9. 00	
	1000 DI ETARY					10.00	
	11100 CAFETERI A					11.00	
	1300 NURSING ADMINISTRATION	273, 918				13. 00	
	11400 CENTRAL SERVICES & SUPPLY	0	8, 650, 033			14.00	0
15.00 0	1500 PHARMACY	o	0			15. 00	0
16. 00 0	1600 MEDICAL RECORDS & LIBRARY	0	0	О	105, 334, 799	16.00	0
I	NPATIENT ROUTINE SERVICE COST CENTERS						
_	3000 ADULTS & PEDI ATRI CS	164, 506	0	0	12, 147, 861	30.00	0
_	NCI LLARY SERVI CE COST CENTERS						
	5000 OPERATING ROOM	49, 703	0		8, 952, 489	50.00	
	5300 ANESTHESI OLOGY	0	0		0	53.00	
	5400 RADI OLOGY-DI AGNOSTI C	0	0	0	13, 887, 856	54.00	
	15500 RADI OLOGY-THERAPEUTI C	0	0	0	0	55. 00	
	15600 RADI OI SOTOPE	0	0	0	0	56.00	
1	15700 CT SCAN 15800 MRI	0	0	0	U	57. 00	
	15900 CARDI AC CATHETERI ZATI ON	18, 450	0	0	22 442 422	58. 00 59. 00	
4	16000 LABORATORY	10, 430	0	0	23, 442, 633 17, 028, 137	60.00	
	16500 RESPI RATORY THERAPY	23, 550	0	0	3, 159, 421	65. 00	
4	16900 ELECTROCARDI OLOGY	17, 709	0	0	2, 135, 610	69.00	
	17000 ELECTROENCEPHALOGRAPHY	17,707	0	0	2, 133, 010	70.00	
	77100 MEDICAL SUPPLIES CHARGED TO PATIENT		3, 145, 284	ŭ	3, 145, 284	71.00	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 504, 749		5, 504, 749	72.00	
	7300 DRUGS CHARGED TO PATIENTS	o	0		11, 378, 726	73. 00	
0	UTPATIENT SERVICE COST CENTERS						
	9100 EMERGENCY	0	0	0	4, 552, 033	91.00	
	9200 OBSERVATION BEDS (NON-DISTINCT PART					92.00	0
	PECIAL PURPOSE COST CENTERS					440.00	
1	1300 INTEREST EXPENSE	272 010	0 (50 000	100	105 224 700	113. 00	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	273, 918	8, 650, 033	100	105, 334, 799	118. 00	U
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00	Ω
	9100 RESEARCH		0	-	o	191. 00	
	9200 PHYSI CI ANS' PRI VATE OFFI CES		0	0	0	192.00	
	17951 MARKETI NG/ ADVERTI SI NG	0	0	0	0	194. 00	
	77950 HI LLVI EW	0	0	Ö	ol	194. 01	
200.00	Cross Foot Adjustments	i j	ŭ	Ĭ	١	200. 00	
201. 00	Negative Cost Centers					201. 00	
202.00	Cost to be allocated (per Wkst. B,	770, 262	9, 697, 267	2, 576, 665	845, 278	202. 00	
	Part I)			, ,			
203. 00	Unit cost multiplier (Wkst. B, Part I)	2. 812017		25, 766. 650000	0. 008025	203. 00	
204. 00	Cost to be allocated (per Wkst. B,	55, 321	256, 962	72, 340	127, 897	204. 00	0
	Part II)						_
205. 00	Unit cost multiplier (Wkst. B, Part	0. 201962	0. 029706	723. 400000	0. 001214	205. 00	O
206. 00						206. 00	Ω
200.00	(per Wkst. B-2)					200.00	U
207. 00	NAHE unit cost multiplier (Wkst. D,	1				207. 00	0
	Parts III and IV)						
				. '	'	•	

	Financial Systems	KENTUCKI ANA ME				eu of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018		
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14, 636, 360		14, 636, 36	0 0	14, 636, 360	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	4, 618, 898		4, 618, 89	8 0	4, 618, 898	1
53. 00	05300 ANESTHESI OLOGY	0			0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 130, 573		2, 130, 57	3 0	2, 130, 573	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	00.00
56. 00	05600 RADI OI SOTOPE	0			0 0	0	56. 00
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MRI	0			0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	2, 160, 951		2, 160, 95		2, 160, 951	
	06000 LABORATORY	2, 987, 965		2, 987, 96		2, 987, 965	1
65. 00	06500 RESPI RATORY THERAPY	1, 214, 163	0	1, 214, 16		1, 214, 163	
69. 00	06900 ELECTROCARDI OLOGY	903, 120		903, 12	0	903, 120	
	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 551, 315		3, 551, 31		3, 551, 315	
	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 215, 369		6, 215, 36		6, 215, 369	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 667, 979		2, 667, 97	9 0	2, 667, 979	73. 00
	OUTPATIENT SERVICE COST CENTERS				_		
	09100 EMERGENCY	1, 524, 375		1, 524, 37		1,021,070	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 223, 300		1, 223, 30	ol	1, 223, 300	92.00

43, 834, 368 1, 223, 300

42, 611, 068

43, 834, 368 1, 223, 300

42, 611, 068

0

113. 00

43, 834, 368 200. 00 1, 223, 300 201. 00

42, 611, 068 202. 00

0

SPECIAL PURPOSE COST CENTERS

113.00 11300 INTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

Health Financial Systems	KENTUCKI ANA ME				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/22/2019 3:0	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11 100 010		44 400 04			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 188, 918		11, 188, 91	8		30. 00
ANCI LLARY SERVI CE COST CENTERS	5 005 (47	0.554.070	0.050.40	0 545005		
50. 00 05000 OPERATI NG ROOM	5, 395, 617	3, 556, 872	8, 952, 48			
53. 00 05300 ANESTHESI OLOGY	0	0		0.000000	0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 475, 272	9, 412, 584	13, 887, 85		0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0.000000	
56. 00 05600 RADI OI SOTOPE	0	0		0.000000	0.000000	
57. 00 05700 CT SCAN	0	0		0.000000	0.000000	
58. 00 05800 MRI	0	0		0.000000	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 912, 281	12, 530, 352	23, 442, 63		0. 000000	
60. 00 06000 LABORATORY	11, 923, 879	5, 104, 258	17, 028, 13		0. 000000	
65. 00 06500 RESPI RATORY THERAPY	3, 008, 304	151, 117			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 253, 372	882, 238	2, 135, 61		0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 103, 629	1, 041, 655	3, 145, 28		0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	4, 503, 803		5, 504, 74		0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 996, 416	2, 382, 310	11, 378, 72	0. 234471	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS	T					
91. 00 09100 EMERGENCY	723, 504	3, 828, 529				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	958, 943	958, 94	3 1. 275675	0. 000000	92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE		:	405 007 ==			113. 00
200.00 Subtotal (see instructions)	64, 484, 995	40, 849, 804	105, 334, 79	9		200.00
201.00 Less Observation Beds		:	405 007 ==			201. 00
202.00 Total (see instructions)	64. 484. 995	40, 849, 804	105, 334, 79	9		202.00

64, 484, 995

40, 849, 804

105, 334, 799

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

201. 00 202. 00

Total (see instructions)

Health Financial Systems	KENTUCKI ANA MEDI	CAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/22/2019 3:09 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			
50. 00 05000 OPERATING ROOM	0. 515935			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153413			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. 092180			59.00
60. 00 06000 LABORATORY	0. 175472			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 384299			65. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 422886			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 129092			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 129092			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 234471			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 334878			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 275675			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201 00 Less Observation Reds				201 00

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

Less Observation Beds Total (see instructions)

201.00 202.00

Health Financial Systems	KENTUCKI ANA ME				u of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre	
		T: 41	- VIV	11: 4-1	5/22/2019 3:0	9 pm
		1111	e XIX	Hospi tal Costs	Cost	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
5550 SSITESI 25551 PET SI	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	10141 00010	
	Part I, col.	,				
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	14, 636, 360		14, 636, 36	0 0	14, 636, 360	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 618, 898		4, 618, 89	8 0	4, 618, 898	
53. 00 05300 ANESTHESI OLOGY	0			0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 130, 573		2, 130, 57	3 0	2, 130, 573	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	00.00
56. 00 05600 RADI OI SOTOPE	0			0	0	56. 00
57. 00 05700 CT SCAN	0			0	0	57. 00
58. 00 05800 MRI	0			0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 160, 951		2, 160, 95		2, 160, 951	
60. 00 06000 LABORATORY	2, 987, 965		2, 987, 96		2, 987, 965	
65. 00 06500 RESPI RATORY THERAPY	1, 214, 163		1 ., ,		1, 214, 163	
69. 00 06900 ELECTROCARDI OLOGY	903, 120		903, 12	0	903, 120	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.554.04	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 551, 315		3, 551, 31		3, 551, 315	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 215, 369		6, 215, 36		6, 215, 369	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 667, 979		2, 667, 97	9 0	2, 667, 979	73. 00
OUTPATIENT SERVICE COST CENTERS	4 504 075	<u> </u>	4 504 07	-	4 504 075	04 00
91. 00 09100 EMERGENCY	1, 524, 375	l .	1, 524, 37		1,,	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 223, 300		1, 223, 30	U	1, 223, 300	92.00
SPECIAL PURPOSE COST CENTERS						110 00
113. 00 11300 I NTEREST EXPENSE	42 024 242	_	42 024 27		42 024 272	113. 00
200.00 Subtotal (see instructions)	43, 834, 368	1 0	43, 834, 36	8 0	43, 834, 368	12UU. UU

43, 834, 368 1, 223, 300

42, 611, 068

43, 834, 368 1, 223, 300

42, 611, 068

0

113.00 43,834,368 200.00 1,223,300 201.00

42, 611, 068 202. 00

0

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	KENTUCKI ANA ME				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/22/2019 3:0	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11 100 010		11 100 01	-I		
30. 00 03000 ADULTS & PEDI ATRI CS	11, 188, 918		11, 188, 918	3		30.00
ANCILLARY SERVICE COST CENTERS	5 005 (43	0.557.030	0.050.404	0 545005		
50. 00 05000 OPERATI NG ROOM	5, 395, 617	3, 556, 872	1		0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	1	0.00000	0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 475, 272	9, 412, 584	13, 887, 85		0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	9	0.000000	0.000000	
56. 00 05600 RADI 01 SOTOPE	0	0	9	0.000000	0. 000000	
57. 00 05700 CT SCAN	0	0	9	0.000000	0.000000	
58. 00 05800 MRI	0	0	(0.000000	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 912, 281	12, 530, 352			0. 000000	
60. 00 06000 LABORATORY	11, 923, 879	5, 104, 258			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	3, 008, 304	151, 117		I I	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 253, 372	882, 238			0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0.00000	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 103, 629	1, 041, 655		I .	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 503, 803	1, 000, 946		I	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 996, 416	2, 382, 310	11, 378, 72	0. 234471	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	723, 504	3, 828, 529		I	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	958, 943	958, 943	1. 275675	0. 000000	92. 00
SPECIAL PURPOSE COST CENTERS			T			
113. 00 11300 I NTEREST EXPENSE			405 004			113. 00
200.00 Subtotal (see instructions)	64, 484, 995	40, 849, 804	105, 334, 799	7		200.00
201.00 Less Observation Beds			105 004 704			201. 00
202.00 Total (see instructions)	64. 484. 995	40. 849. 804	105, 334, 799)		202.00

64, 484, 995

40, 849, 804

105, 334, 799

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

201. 00 202. 00

Total (see instructions)

		WENTHOW AND MED	OAL OFNITED		6.5. 0110	0550 40
	Financial Systems	KENTUCKI ANA MEDI			u of Form CMS-	2552-10
COMPU	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0176	Peri od: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre	epared:
				12, 71, 2010	5/22/2019 3:0	09 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	T	11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS					30. 00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
53. 00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY -DI AGNOSTI C	0. 000000				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000				56. 00
57. 00	05700 CT SCAN	0. 000000				57. 00
58. 00	05800 MRI	0. 000000				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0. 000000				60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70. 00		0. 000000				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
/3.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
04 00	OUTPATIENT SERVICE COST CENTERS	0.000000				- 04 00
	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92. 00
112 00	SPECIAL PURPOSE COST CENTERS					112 00
	11300 INTEREST EXPENSE					113. 00
200. 00 201. 00						200. 00 201. 00
201.00						201.00
202.00	p Total (See Tristi uctions)	1				1202.00

Health Financial Systems	KENTUCKI ANA ME	DICAL 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 01/01/2018 To 12/31/2018		nared:
				10 12/31/2010	5/22/2019 3:0	9 pm
		Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,				
30. 00 ADULTS & PEDIATRICS	2, 397, 862	0	2, 397, 86	2 8, 124	295. 16	30.00
200.00 Total (lines 30 through 199)	2, 397, 862		2, 397, 86	2 8, 124		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						4
30. 00 ADULTS & PEDIATRICS	4, 315					30. 00
200.00 Total (lines 30 through 199)	4, 315	1, 273, 615				200.00

Hool +b	Financial Systems	KENTUCKI ANA ME	DICAL CENTED		In Lie	u of Form CMS-2	neen 10
	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	°N: 15_0176	Peri od:	Worksheet D	2332-10
AL LOICE	TORMENT OF THE ATTENT ANOTEENED SERVICE GALLER	L 00313	Trovider o	SIV. 15 0170	From 01/01/2018	Part II	
					To 12/31/2018		
			Ti +Lo	: XVIII	Hospi tal	5/22/2019 3: 0 PPS	9 pm
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	. Onal gcs	COT dillit 4)	
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	716, 448	8, 952, 489	0. 08002	28 3, 154, 411	252, 441	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	00	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	219, 058	13, 887, 856	0. 01577	2, 409, 795	38, 010	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	00	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	57. 00
58. 00	05800 MRI	0	0	0. 00000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	190, 399					
60.00	06000 LABORATORY	101, 010					60.00
65. 00	06500 RESPI RATORY THERAPY	44, 733					65. 00
69. 00	06900 ELECTROCARDI OLOGY	42, 537	1				
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	ı	0.0000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	97, 252					1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	170, 211					
73. 00	07300 DRUGS CHARGED TO PATIENTS	86, 154	11, 378, 726	0. 00757	5, 066, 620	38, 359	73. 00
04.00	OUTPATIENT SERVICE COST CENTERS	/0.000	4 550 000	0.0140	200 200	4 75/	04.00
	09100 EMERGENCY	63, 809					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	200, 412		l .		0	
200.00	Total (lines 50 through 199)	1, 932, 023	94, 145, 881	I	30, 794, 351	590, 291	J∠UU. UÜ

Health Financial Systems	KENTUCKI ANA MEI	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0 0	0		0 0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	8, 12 8, 12			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems	KENTUCKIANA MEDIO	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 3:09 pm

						5/22/2019 3:0	9 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	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	C	0	0	56.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58. 00	05800 MRI	0	0	C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	l c	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	l c	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	l c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	l c	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	'					
91.00	09100 EMERGENCY	0	0	C	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92. 00
200.00	Total (lines 50 through 199)	0	0	C	0	0	200. 00

	Financial Systems	KENTUCKI ANA ME		ON 45 047/		eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THRUUG	SH COSTS				To 12/31/2018		pared:
						5/22/2019 3:0	9 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	· ·	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
	I	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_		T			
50.00	05000 OPERATI NG ROOM	0	0		0 8, 952, 489	l e	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 13, 887, 856	l	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0. 000000	
56. 00	05600 RADI 0I SOTOPE	0	0		0	0. 000000	
57. 00	05700 CT SCAN	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 23, 442, 633	l	
	06000 LABORATORY	0	0		0 17, 028, 137	l	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 3, 159, 421	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 2, 135, 610	l	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 3, 145, 284	l .	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 5, 504, 749	l	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 378, 726	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						1
	09100 EMERGENCY	0	0		0 4, 552, 033		
92 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	l n	1	0 958 943	0 000000	1 92 nr

0 0 0

0 0 0

4, 552, 033 958, 943 94, 145, 881

0. 000000 92. 00 200. 00

0 0 0

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Heal th	Financial Systems	KENTUCKI ANA MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS		Provi der CO		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre	pared:
			Ti +L o	XVIII	Hospi tal	5/22/2019 3: 0 PPS	9 pm
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	cost center bescriptron	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	3 - 1	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	3, 154, 411		0 877, 051	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, 409, 795		0 2, 041, 865	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	6, 746, 090		0 4, 177, 108	0	59. 00
60.00	06000 LABORATORY	0. 000000	6, 466, 790		0 874, 868	0	60. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 749, 533		0 21, 632	0	65. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 047, 946		0 440, 520	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 571, 728		0 1, 032, 357	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 242, 130		0 561, 199	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 066, 620		0 692, 830	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0. 000000	339, 308		0 642, 911	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 472, 795	0	92. 00
200.00	Total (lines 50 through 199)		30, 794, 351		0 11, 835, 136	0	200. 00

Health Financial Systems	KENTUCKIANA MEDI	CAL CENTED		In Lio	u of Form CMS-2	2552 10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVI		Provi der CC		Peri od: From 01/01/2018	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge PP	S Reimbursed	Cost	Cost	PPS Services	
	Ratio From Se	ervices (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	·	Subject To	Subject To		
			Ded & Coins	Ded & Coins		

			Charges			Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	1	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						1
	OPERATING ROOM	0. 515935		0	0	452, 501	
	O ANESTHESI OLOGY	0. 000000		0	0	0	53. 00
	O RADI OLOGY-DI AGNOSTI C	0. 153413		0	0	313, 249	1
	O RADI OLOGY-THERAPEUTI C	0. 000000	1	0	0	0	
56. 00 0560	O RADI OI SOTOPE	0. 000000	0	0	0	0	56. 00
	D CT SCAN	0. 000000	0	0	0	0	57. 00
58.00 0580		0. 000000		0	0	0	58. 00
	CARDIAC CATHETERIZATION	0. 092180	4, 177, 108	0	0	385, 046	59. 00
60.00 06000	DLABORATORY	0. 175472	874, 868	0	0	153, 515	60.00
65. 00 0650	RESPI RATORY THERAPY	0. 384299	21, 632	0	0	8, 313	65. 00
69. 00 0690	D ELECTROCARDI OLOGY	0. 422886	440, 520	0	0	186, 290	69. 00
70.00 0700	DELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70. 00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	1. 129092	1, 032, 357	0	0	1, 165, 626	71.00
72.00 0720	DIMPL. DEV. CHARGED TO PATIENTS	1. 129092	561, 199	0	0	633, 645	72. 00
73.00 0730	D DRUGS CHARGED TO PATIENTS	0. 234471	692, 830	0	0	162, 449	73. 00
	ATIENT SERVICE COST CENTERS						
91.00 0910	DEMERGENCY	0. 334878	642, 911	0	0	215, 297	91.00
92.00 0920	OBSERVATION BEDS (NON-DISTINCT PART	1. 275675	472, 795	0	0	603, 133	92.00
200.00	Subtotal (see instructions)		11, 835, 136	0	0	4, 279, 064	200.00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		11, 835, 136	0	0	4, 279, 064	202. 00

Health Financial Systems	KENTUCKI ANA ME	EDICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od: From 01/01/2018 To 12/31/2018	5/22/2019 3:0	epared: 09 pm
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM			1			50.00
53. 00 05300 OPERATTING ROOM 53. 00 05300 ANESTHESI OLOGY						53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C						55. 00
56. 00 05600 RADI 0I SOTOPE						56.00
57. 00 05700 CT SCAN						57. 00
58. 00 05800 MRI						58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
60. 00 06000 LABORATORY						60.00
65. 00 06500 RESPIRATORY THERAPY						65. 00
69. 00 06900 RESTRATORY THERAPY						69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY						70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS						73. 00
70. 00 OTOGO STANGED TO TATTENTO	1		1			1 , 5. 66

0 0 0

0

0

91. 00 92. 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

09100 EMERGENCY

91.00

200.00

201.00

202.00

Health Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narod:
				10 12/31/2010	5/22/2019 3:0	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description				Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments	_	Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	00.00
200.00 Total (lines 30 through 199)	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)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	8, 12			
200.00 Total (lines 30 through 199)		0	8, 12	4	70	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	_					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	KENTUCKIANA MEDIO	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 3:09 pm

				'	0 12/01/2010	5/22/2019 3:0	
			Ti tl	e XIX	Hospi tal	Cost	
	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	O5000 OPERATI NG 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	(0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57.00	05700 CT SCAN	0	0	(0	0	57.00
58.00	05800 MRI	0	0	(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			•			
91.00	09100 EMERGENCY	0	C	(0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00		0		(0	0	200. 00

Health Financial Systems	KENTUCKIANA ME				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	narod:
				10 12/31/2010	5/22/2019 3:0	pareu. 9 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0 8, 952, 489	l .	
53. 00 05300 ANESTHESI OLOGY	0	C)	0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	[C)	0 13, 887, 856	l .	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C)	0	0. 000000	
56. 00 05600 RADI 0I SOTOPE	0	C)	0	0. 000000	
57. 00 05700 CT SCAN	0	C)	0	0.000000	
58. 00 05800 MRI	0	C)	0	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C)	0 23, 442, 633		
60. 00 06000 LABORATORY	0	C)	0 17, 028, 137		
65. 00 06500 RESPIRATORY THERAPY	0	C)	0 3, 159, 421		
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 2, 135, 610	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 3, 145, 284	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 5, 504, 749	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 11, 378, 726	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	C		0 4, 552, 033	0.000000	91.00
92 OO 09200 OBSERVATION BEDS (NON-DISTINCT PART	1	1	ol .	n 958 943	0 000000	92 00

0 0 0

0 0

0. 000000 92. 00 200. 00

4, 552, 033 958, 943 94, 145, 881

0 0 0

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Heal th	Financial Systems	KENTUCKI ANA MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORT	TOMMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA CH COSTS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	pared:
			Ti tl	e XIX	Hospi tal	Cost	•
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10. 00	11.00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS	<u>'</u>		•	<u> </u>		
50.00	05000 OPERATING ROOM	0. 000000	13, 369		0 0	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	19, 652		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600 RADI 0I 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	44, 628		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	61, 182		0	0	60. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	31, 517		0	0	65. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 127		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	59, 356		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		0.050				
	09100 EMERGENCY	0. 000000	3, 253		0	1	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	227 224		0	0	
200.00	Total (lines 50 through 199)	1	237, 084	l	0 0	1 0	200. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0176	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/22/2019 3:0	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	5/22/2019 3: 0 PPS	9 pm
	Cost Center Description	THE AVIII	поэрг саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			8, 124	1
2.00	Inpatient days (including private room days, excluding swing-			8, 124	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 445	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	om davs) after December (31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber .	or or the cost		0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter beceiiber 5	i or the cost		0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 315	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (i neludi na privato re	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frict during private	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar ye			0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed of	uays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
47.00	SWING BED ADJUSTMENT				17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 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	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	14, 636, 360 0	21.00
22.00	5 x line 17)	or or the cost reports	riig perroa (irriic		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reportion	na period (line	0	24. 00
24.00	7 x line 19)	or the cost reportin	ig perrod (Triic		24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	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)		14, 636, 360	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line)			0.00	1
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 a	and private room cost di	fferential (line	14, 636, 360	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 801. 62	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	-		7, 773, 990 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			7, 773, 990	
		•			•

Heal th	Financial Systems	KENTUCKIANA MED	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0176	Period: From 01/01/2018	Worksheet D-1	
					To 12/31/2018		
			Ti tl e	e XVIII	Hospi tal	5/22/2019 3: 0 ^o PPS	9 рііі
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	col. 2)	÷	(col. 3 x col. 4)	
	I	1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`		10, 477, 066	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ons)		18, 251, 056	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sum	of Parts I and	1, 273, 615	50. 00
51. 00	<pre> Pass through costs applicable to Program ing</pre>	natient ancillar	v services (fr	om Wkst D s	sum of Parts II	590, 291	51. 00
31.00	and IV)	atrent anerriar	y services (ii	OIII WKSt. D, S	diii or rarts rr	370, 271	31.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nh	sician anosth	otist and	1, 863, 906	
55.00	medical education costs (line 49 minus line	9 1	rated, non-pny	isi ci ali aliesti	letist, and	16, 387, 150	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						E4 00
55.00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)				>	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, ເ	updated and co	ompounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the m	narket hasket		0.00	60. 00
61.00					the amount by	0.00	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	ŕ				0	
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00		sts through Decem	mber 31 of the	e cost reporti	ng period (See	0	64. 00
4E 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts ofter December	or 21 of the c	oct roporting	noried (See	0	65. 00
65. 00	instructions) (title XVIII only)	sts after beceilibe	er si or the c	ost reporting	perrou (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	1 '	ne costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	na costs aftar No	ecember 31 of	the cost reno	orting period	0	68. 00
00.00	(line 13 x line 20)	ie costs after De	ecember 31 of	the cost repo	iting period		08.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	•					70. 00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	vice costs (line	72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	Worksheet B, F	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p		,			79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	n (line 78 mir	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem rimi)				82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ir Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					679	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 801. 62	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	ee instructions)				1, 223, 300	89.00

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 397, 862	14, 636, 360	0. 16382	9 1, 223, 300	200, 412	90.00
91.00 Nursing School cost	o	14, 636, 360	0.00000	1, 223, 300	0	91.00
92.00 Allied health cost	o	14, 636, 360	0.00000	1, 223, 300	0	92. 00
93.00 All other Medical Education	0	14, 636, 360	0.00000	1, 223, 300	0	93. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	u of Form CMS-:	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0176	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/22/2019 3:0	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Title XIX	Hospi tal	Cost	, piii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			0.104	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			8, 124 8, 124	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	0, 121	3. 00
	do not complete this line.		-		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	7, 445 0	4. 00 5. 00
3.00	reporting period	iii days) tiii ougii beceiibei	31 Of the Cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	days) through becember	31 Of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluding	awing had and	70	9. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	Swing-bed and	70	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		om dovo) ofter	0	11 00
11. 00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
13. 00	through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			Ü	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17. 00
10.00	reporting period				40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)		14, 636, 360	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ng period (line	14, 030, 300	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		14, 636, 360	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3,	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 00)		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)	line 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	us line 33)(see instruct	i ons)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	ı
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	0 14, 636, 360	36. 00 37. 00
57.00	27 minus line 36)			, 555, 566] 55
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTHENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 801. 62	38.00
39. 00	Program general inpatient routine service cost (line 9 x line			126, 113	
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 40)	l	126, 113	41.00

Heal th	Financial Systems	KENTUCKIANA MEI	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0176	Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre 5/22/2019 3:0	
			_	e XIX	Hospi tal	Cost	9 piii
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		impatrent costi	inpatrent bays	col . 2)	Ŧ	4)	
42.00	MUDCEDY (+: +1 o V o VIV only)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>					42. 00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nc)		53, 626	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46) (see mstructro) (S)		179, 739	49.00
50.00	Pass through costs applicable to Program inp	patient routine	services (from	n Wkst. D, sum	of Parts I and	0	50. 00
51. 00	<pre> Pass through costs applicable to Program ing</pre>	oatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51. 00
F0 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	etist and	0	52. 00 53. 00
00.00	medical education costs (line 49 minus line		. a toa, p				00.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	rger amourt (i	THE 30 III Hus	11 He 33)	ő	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	0.00	59. 00				
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60. 00
61. 00						0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		S (TINES 54 X	60), OF 1% OF	the target		
62.00	Relief payment (see instructions)		-+:>			0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mstru	ctrons)			<u> </u>	63. 00
64. 00	9 '	sts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)	 (1:	/				// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Trie	64 prus rine d	os)(title xvii	i oniy). For	0	66. 00
67. 00	3	ne costs through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir</pre>	ne costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
40.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (lina (7 . lina	(0)		0	40.00
69.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	•					70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ line	۷)			71. 00 72. 00
73.00	Medically necessary private room cost applic						73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,		art II. column		74. 00 75. 00
	26, line 45)				,		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	ıs line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		,	us line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		. (11110 70 11111	ac 11110 ///		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	•	<i>.,</i>				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sun PART IV - COMPUTATION OF OBSERVATION BED PAS		i ougii 85)			<u> </u>	86. 00
87. 00	Total observation bed days (see instructions	5)	Line 2)			679	•
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	rine 2)			1, 801. 62 1, 223, 300	
	,	ŕ				•	

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/22/2019 3:0	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 397, 862	14, 636, 360	0. 16382	9 1, 223, 300	200, 412	90. 00
91.00 Nursing School cost	0	14, 636, 360	0.00000	0 1, 223, 300	0	91. 00
92.00 Allied health cost	0	14, 636, 360	0.00000	0 1, 223, 300	0	92. 00
93.00 All other Medical Education	0	14, 636, 360	0.00000	0 1, 223, 300	0	93. 00

Health Fina	ncial Systems	KENTUCKIANA MEDICAL CENTER		In Li∈	eu of Form CMS-:	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CC	Provider CCN: 15-0176		Worksheet D-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 3:0	
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 0300	O ADULTS & PEDIATRICS			6, 571, 432		30.00
ANCI	LLARY SERVICE COST CENTERS				<u>'</u>	1
	O OPERATING ROOM		0. 51593	3, 154, 411	1, 627, 471	50. 00
53.00 0530	O ANESTHESI OLOGY		0.00000	00	0	53. 00
	O RADI OLOGY-DI AGNOSTI C		0. 15341	, , , , , , ,	369, 694	
	O RADI OLOGY-THERAPEUTI C		0. 00000		0	
	0 RADI OI SOTOPE		0. 00000		0	
	O CT SCAN		0. 00000		0	57. 00
58. 00 0580			0. 00000		0	58. 00
	O CARDI AC CATHETERI ZATI ON		0. 09218			1
	O LABORATORY		0. 17547			1
	O RESPI RATORY THERAPY		0. 38429			1
	O ELECTROCARDI OLOGY		0. 42288			1
	O ELECTROENCEPHALOGRAPHY		0.00000		0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT		1. 12909			
	O I MPL. DEV. CHARGED TO PATIENTS		1. 12909			1
	ODRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS		0. 23447	71 5, 066, 620	1, 187, 975	73. 00
91. 00 0910			0. 33487	78 339, 308	113, 627	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART		1. 27567			1
200.00	Total (sum of lines 50 through 94 and	96 through 98)	1.2/30	30, 794, 351	1	
201.00	Less PBP Clinic Laboratory Services-P			30, 774, 331	10, 477, 000	201.00
202.00	Net charges (line 200 minus line 201)	rogram only charges (Title Ot)		30, 794, 351		202. 00
_32.00	, 2 goo (200 1 201)		1	00, , 001	ı	1=32.00

Heal th Financia	al Systems KENTUCKIANA MEDIC LLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15_0176	Peri od:	eu of Form CMS-2 Worksheet D-3	
INFAILLNI ANCI	ELAKT SERVICE COST AFFORTIONWENT	riovidei C	CIV. 15-0170	From 01/01/2018		
				To 12/31/2018	Date/Time Pre	pared:
					5/22/2019 3:0	19 pm
	<u> </u>	Ti tl	e XIX	Hospi tal	Cost	
Co	ost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	NT ROUTINE SERVICE COST CENTERS		1		1	
	DULTS & PEDI ATRI CS			223, 754		30.00
	RY SERVICE COST CENTERS		1			
	PERATING ROOM		0. 51593			
	NESTHESI OLOGY		0.00000		0	
	ADI OLOGY-DI AGNOSTI C		0. 15341			
	ADI OLOGY-THERAPEUTI C		0.00000		0	
	ADI OI SOTOPE		0.00000		0	
57. 00 05700 CT			0.00000		0	
58. 00 05800 MF			0.00000		0	
	ARDIAC CATHETERIZATION		0. 09218			
	ABORATORY		0. 17547			
	ESPI RATORY THERAPY		0. 38429			
	LECTROCARDI OLOGY		0. 42288			
	LECTROENCEPHALOGRAPHY		0.00000		0	
	EDICAL SUPPLIES CHARGED TO PATIENT		1. 12909		0	
	MPL. DEV. CHARGED TO PATIENTS		1. 12909		0	
	RUGS CHARGED TO PATIENTS		0. 23447	71 59, 356	13, 917	73. 00
	ENT SERVICE COST CENTERS					
91.00 09100 EN			0. 33487			
	BSERVATION BEDS (NON-DISTINCT PART		1. 27567	75 0	0	
	otal (sum of lines 50 through 94 and 96 through 98)			237, 084		200.00
	ess PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00 Ne	et charges (line 200 minus line 201)		[237, 084		202.00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Fo			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 3:09 pm		

	Title XVIII Hospital	5/22/2019 3: 0 PPS	9 pm
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1.00	DRG Amounts Other than Outlier Payments	C	
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6, 814, 988	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see linstructions)	2, 271, 663	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octo 1 (see instructions)	ober 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)	C	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	575, 251	1
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	C	
3.00	Managed Care Simulated Payments	C	
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	44.04	
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or before 12/31/1996. (see instructions)		
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap new programs in accordance with 42 CFR 413.79(e)	for 0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If t		1
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,	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 contract that the contract the state of 2014 is the contract that the co	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 strategies of \$200 (cap instructions).	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		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	l l	11.00
13. 00	Total allowable FTE count for the prior year.	0.00	1
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 19 otherwise enter zero.	997, 0.00	14. 00
15. 00		0.00	15. 00
	Adjustment for residents in initial years of the program	l l	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).	0.000000	
	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)	c	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	C	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>	0.00	24. 00
	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	1
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)		28. 00
28. 01			28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	c	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 83	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	12. 72	31.00
32.00	Sum of lines 30 and 31	18. 55	
33. 00	Allowable disproportionate share percentage (see instructions)	4. 81	
34. 00	Disproportionate share adjustment (see instructions)	109, 267	34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prep 5/22/2019 3:00	pared: 9 pm	
		Title XVIII	Hospi tal	PPS		
			Prior to 10/1			
	Uncompensated Care Adjustment		1. 00	2. 00		
35. 00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35. 00	
35. 01	Factor 3 (see instructions)		0. 000027732	0. 000030630	35. 01	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enteinstructions)	er zero on this line) (se	e 187, 655	253, 395	35. 02	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0	03)	140, 356 204, 225	63, 869	35. 03 36. 00	
40.00	Additional payment for high percentage of ESRD beneficiary di: Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40. 00	
40. 00	652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40.00	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	83, 684 an 685. (see	0		41. 00	
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-an 685. (see instructions)				41. 01	
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00		42. 00 43. 00	
44. 00	Ratio of average length of stay to one week (line 43 divided 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 47. 00	Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)	. 01)	9, 975, 394		46. 00 47. 00	
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	9, 973, 394		48. 00	
	only. (see instructions)			Amount		
				1. 00		
49. 00	Total payment for inpatient operating costs (see instructions	5)		9, 975, 394		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			887, 533		
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	51. 00 52. 00	
53. 00	Nursing and Allied Health Managed Care payment	THE 49 SEE THISTI UCTIONS).		0	53. 00	
54. 00	Special add-on payments for new technologies			ő	54. 00	
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	Cost of physicians' services in a teaching hospital (see intr	•	1 05)	0	56.00	
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		nrougn 35).	0	57. 00 58. 00	
59. 00	Total (sum of amounts on lines 49 through 58)	1V, Col. 11 111le 200)		10, 862, 927	59. 00	
60.00	Primary payer payments			42, 428	60.00	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		10, 820, 499	61. 00	
62.00	Deductibles billed to program beneficiaries			680, 456	62. 00	
63.00	1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			20, 770		
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			66, 848 43, 451		
65. 00 66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		6, 735	65. 00 66. 00	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	i de ti ons)		10, 162, 724	67. 00	
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68. 00	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	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	
	Demonstration payment adjustment amount before sequestration			0	70. 87	
70. 87	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 88 70. 89	
70. 88		i deti diis)		0	70. 89	
70. 88 70. 89	THSP bonus payment HVRP addustment amount (see instructions)			0	70. 90	
70. 88 70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)					
70. 88 70. 89	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 92	
70. 88 70. 89 70. 90 70. 91	1					
70. 88 70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 -86, 339 -272, 600	70. 92 70. 93	

Health Financial Systems	KENTUCKIANA MEDICAL CENTER		In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/22/2019 3:0		
	Ti tl d	e XVIII	Hospi tal	PPS	7 μιι	
		EEV	(1000)	Amount		

				To 12/31/2018	Date/Time Pre 5/22/2019 3:0	
		Ti tl e	e XVIII	Hospi tal	PPS	7 PIII
		11 61 6		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0		70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or aft	er 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				105, 040	•
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			9, 698, 745	
71. 01	Sequestration adjustment (see instructions)				193, 975	•
71. 02	Demonstration payment adjustment amount after sequestration				0 421 200	
72. 00 73. 00	Interim payments Tentative settlement (for contractor use only)				9, 421, 299 0	72. 00 73. 00
74.00	Tentative settlement (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.02) 72 and			83, 471	
74.00	73)	z, 72, anu			03, 471	74.00
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			0	75. 00
, 0, 00	CMS Pub. 15-2, chapter 1, §115.2				Ü	70.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru	ıcti ons)			0. 00	1
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruct	ions)			0	96. 00
				Prior to 10/1		
	HCD D D I A I			1. 00	2. 00	
100.00	HSP Bonus Payment Amount				0	100 00
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	U	100. 00
101 00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	:)		0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	•/		<u> </u>		102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions)	ı		0		104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr		ıstment			
200.00	Is this the first year of the current 5-year demonstration per					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	9 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-year demonst	ration	
204.00	peri od)					004 00
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement					206. 00
207.00	Program reimbursement under the §410A Demonstration (see instr	cuctions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
	209. 00 Adjustment to Medicare IPPS payments (see instructions)			209. 00		
	Reserved for future use					210. 00
	211.00 Total adjustment to Medicare IPPS payments (see instructions)				211. 00	
	Comparision of PPS versus Cost Reimbursement					1
212. 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	*				213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	mbursement)			218. 00
	(line 212 minus line 213) (see instructions)					

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2018 | Part A Exhibit 4 | To 12/31/2018 | Date/Time Prepared: | 5/22/2019 3:09 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0176

						0 12/31/2010	5/22/2019 3:0	9 pm
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		5.00	1. 00
1.00	payments	1.00	Ĭ	J			J	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 814, 988	0	6, 814, 988		6, 814, 988	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, 271, 663	0		2, 271, 663	2, 271, 663	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	C		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for	2. 00	575, 251	0	C	575, 251	575, 251	2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	O	0	C	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	C	0	0	4. 00
	Indirect Medical Education Adju		,					
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
7.00	managed care (see instructions) Indirect Medical Education Adju					0.000000		7.00
7. 00 8. 00	IME payment adjustment factor (see instructions)	27. 00 28. 00	0. 000000	0.000000	0. 000000		0	7. 00 8. 00
8. 01	IME adjustment (see instructions) IME payment adjustment add on	28. 01	0	0			0	8. 01
	for managed care (see instructions)		J	0		,		
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	U	0	(0	0	9. 01
40	Disproportionate Share Adjustme							40 -
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0481	0. 0481	0. 0481	0. 0481		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	109, 267	0	81, 950	27, 317	109, 267	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	204, 225 RD beneficiary	0 di scharges	140, 356	63, 869	204, 225	11. 01
12. 00	Total ESRD additional payment	46. 00	n Denotrerary	0	C	o	0	12. 00
00	(see instructions)	.5. 55		J		Ĭ		
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	9, 975, 394 0	0	7, 037, 294 C	2, 938, 100 0	9, 975, 394 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	9, 975, 394	0	7, 037, 294	2, 938, 100	9, 975, 394	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	887, 533	0	-67, 942	955, 475	887, 533	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	C	O	0	17. 00
17. 01 17. 02	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-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/22/2019 3:0	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	93. 00	0	0		0	0	18. 00

				Title	xVIII	Hospi tal	PPS	, p
		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	93, 00	0	0			0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	6, 969, 352	3, 893, 575	10, 862, 927	19. 00
		W/S L, line	(Amounts from					
		,	L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	731, 767	0	-184, 446	916, 213	731, 767	20.00
20. 01	Model 4 BPCI Capital DRG other		0	0		0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	155, 766	0	116, 504	39, 262	155, 766	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	ol c	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0. 0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0) c	0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	0	0	C	0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	887, 533	0	-67, 942	955, 475	887, 533	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
	I	0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 100179			27. 00
28. 00	Low volume adjustment	70. 96			698, 183	3	698, 183	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)						_	
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)		.,					
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	l			1			l

From 01/01/2018 Part A Exhibit 5 Date/Time Prepared: 12/31/2018 5/22/2019 3:09 pm Hospi tal Title XVIII 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 1.01 1.01 6, 814, 988 6, 814, 988 6, 814, 988 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 271, 663 2, 271, 663 2, 271, 663 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 DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 575, 251 431, 438 143, 813 575, 251 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 2.01 Operating outlier reconciliation 3 00 2 01 O 0 0 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 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 0.000000 0.000000 7.00 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 0.0481 0.0481 0.0481 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 109, 267 81.950 27.317 109, 267 11.00 instructions) 11.01 Uncompensated care payments 36.00 204, 225 140, 356 63, 869 204, 225 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 9, 975, 394 7, 468, 732 2, 506, 662 9, 975, 394 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 9, 975, 394 15.00 15.00 49.00 9, 975, 394 7, 468, 732 2, 506, 662 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 887, 533 665, 333 222, 200 887, 533 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 17.00 0 17.01 Net organ acquisition cost 17.01

68.00

93.00

0

2, 728, 862

8, 134, 065

0 17.02

10, 862, 927 19. 00

18.00

17.02

18.00

19.00 SUBTOTAL

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

amount (see instructions)

Capital outlier reconciliation adjustment

Health Financial Systems	KENTUCKI ANA ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	F	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/22/2019 3:0	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	731, 767	548, 829	182, 938	731, 767	20.00
20 01 Madel 4 DDCI Carital DDC athem them autilian	4 04					0000

						5/22/2019 3:0	9 pm
			Title	Title XVIII Hospital		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	731, 767	548, 82	9 182, 938	731, 767	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	155, 766	116, 50	4 39, 262	155, 766	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	887, 533	665, 33	3 222, 200	887, 533	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		O	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	-86, 339	-64, 75	4 -21, 585	-86, 339	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	'	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-272, 600	-204, 45	-68, 150	-272, 600	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	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		78, 64	9 26, 391	105, 040	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Υ				100. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/22/2019 3:09 pm		

			10 12/01/2010	5/22/2019 3:0	9 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1		
1.00	Medical and other services (see instructions)			0	
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		4, 279, 064	
3.00	OPPS payments			2, 647, 148	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			46, 010 0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruc	stions)		0. 000	
6. 00	Line 2 times line 5	etions)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0.00	•
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. Line 200		0	
10.00	Organ acqui si ti ons	.,,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	vifling 10 avegade lin	0 11) (600	0	
19.00	instructions)	y II IIIle 18 exceeds IIII	e II) (See	U	19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds lin	e 18) (see	0	20. 00
20.00	instructions)	· ·	20.00		
21. 00	Lesser of cost or charges (see instructions)	0	21. 00		
22.00	Interns and residents (see instructions)	0	22. 00		
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2, 693, 158	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		0	
26. 00	Deductibles and Coinsurance amounts relating to amount on line			499, 653	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	2, 193, 505	27. 00
20.00	instructions)	no FO)		0	28. 00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 193, 505	
31. 00	Primary payer payments			1, 988	•
32. 00	Subtotal (line 30 minus line 31)			2, 191, 517	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CFS)		2, 1, 1, 01,	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
34.00	Allowable bad debts (see instructions)			98, 809	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			64, 226	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		45, 627	
37. 00	Subtotal (see instructions)			2, 255, 743	1
38. 00	MSP-LCC reconciliation amount from PS&R			38	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration		: >	0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	ions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 2, 255, 705	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)			45, 114	1
40. 02	Demonstration payment adjustment amount after sequestration			45, 114	
41. 00	Interim payments			2, 147, 646	
42. 00	Tentative settlement (for contractors use only)		0		
43.00					43.00
44.00					44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	,			0	
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91. 00		
92. 00				0.00	
93.00	Time Value of Money (see instructions)			0	
74. UU	Total (sum of lines 91 and 93)		ı	Ü	94. 00

Health Financial Systems KENT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/22/2019 3:09 pm Provider CCN: 15-0176

Inpati ent Part A						5/22/2019 3:09	9 pm
mm/dd/yyyy					Hospi tal	PPS	
Total interim payments paid to provider 1.00 2.00 3.00 4.00			Inpatien	t Part A	Par	⁻t B	
Total interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero in the cost reporting period. If none, write "NONE" or enter a zero in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			mm/dd/yyyy				
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00		3. 00	4. 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				9, 421, 299		2, 147, 646	1.00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero test as zero test separately each retracactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00			0		0	2. 00
write NoME" or enter a zero							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 0	3 ∩1			0			3 ∩1
3. 03 3. 04 3. 05		ADJUSTIMENTS TO TROVIDER					
3.04 0 0 0 3.04 3.05 3.							
3.05 Provider to Program				_			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.50 3.51 0 0 0 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.59 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
3. 50 ADJUSTMENTS TO PROGRAM	0.00	Provider to Program					0.00
3.52 Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 3.01-3.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines 5.01-5.49 minus sum of lines Subtotal (sum of lines sum of lines sum of lines Subtotal (sum of lines sum of lines sum of	3.50			0		0	3. 50
3.53 3.54 0 0 0 3.53 3.54 0 0 0 0 3.53 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 9,421,299 2,147,646 4.00 4	3. 51			0		0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.50-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.59-3.98) 0 3.69-3.98) 0 3.59-3.98) 0 3.69-3.08) 0 3.6	3.53			0		0	3. 53
3. 50-3. 98 Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)	3.54			0		0	3. 54
1.00	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			9, 421, 299		2, 147, 646	4. 00
TO BE COMPLETED BY CONTRACTOR		· ·					
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	F 00						F 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
5.02 0	5 01			0		0	5 01
5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 5.51 0 0 0 5.51 5.52 0 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.52 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 83,471 62,945 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 9,504,770 2,210,591 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		TERMINE TO THOMBEN					
Provider to Program							
5.51 5.52 5.52 5.53 5.52 5.54 5.55		Provider to Program		•			
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 83,471 62,945 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 9,504,770 2,210,591 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5.50			0		0	5. 50
5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 83,471 62,945 6.01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 9,504,770 2,210,591 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 51			0		0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 83,471 62,945 6.01 9,504,770 2,210,591 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 83,471 62,945 6.01 9,504,770 2,210,591 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 83,471 62,945 6.01 6.02 7.00 Total Medicare program liability (see instructions) 9,504,770 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6 00						6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 6.02 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01			83. 471		62, 945	6. 01
7.00 Total Medicare program liability (see instructions) 9,504,770 2,210,591 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0		0	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				9, 504, 770		2, 210, 591	7. 00
Number (Mo/Day/Yr) 0 1.00 2.00					Contractor		
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems	KENTUCKIANA MEDIO	CAL CENTER	In Lieu of Form CMS-2552		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0176	Peri od: From 01/01/2018	Worksheet E-1 Part II	
				To 12/31/2018	Date/Time Pre	
					5/22/2019 3:0)9 pm
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARI					4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION			1.		1.00
1.00						
2. 00						
3.00						
4.00	Total inpatient days from S-3, Pt. I col. 8	·	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, c					5. 00
6. 00	Total hospital charity care charges from Wks	·				6. 00
7. 00	CAH only - The reasonable cost incurred for	the purchase of c	ertified HII technology	WKSt. S-2, Pt. I		7. 00
0.00	line 168	a instructions)				8.00
8.00	Calculation of the HIT incentive payment (se	,				
9.00	Sequestration adjustment amount (see instruc		/ ! ! 			9.00
10. 00	Calculation of the HIT incentive payment aft		(see instructions)			10. 00
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &					30.00
	Initial/interim HIT payment adjustment (see	rnstructions)				
						31.00
32.00	barance due provider (Tine 8 (or Tine 10) mi	nus irne 30 and i	ine 31) (See Instruction	5)		32. 00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0176	From 01/01/2018	Worksheet E-3 Part VII Date/Time Prepared:		

			10 12/31/2018	Date/lime Pre 5/22/2019 3:0	
		Title XIX	Hospi tal	Cost	, biii
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		179, 739		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		179, 739	0	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		179, 739	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		223, 754		8. 00
	Ancillary service charges		237, 084	0	9. 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)		460, 838	0	12. 00
	CUSTOMARY CHARGES		, , , , , , , , , , , , , , , , , , , ,		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 4	2 CFR §413. 13(e)	0. 000000	0. 000000	15. 00
				0.000000	16.00
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	v if line 14 eveneds	460, 838 281, 099	0	17. 00
17.00	line 4) (see instructions)	y IT TITLE TO exceeds	201, 099	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIle 4 exceeds IIIle	ı o	O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
	Cost of covered services (enter the lesser of line 4 or line 1		179, 739	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		o		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		179, 739	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		179, 739	0	31. 00
	Deducti bl es		0	0	32. 00
	Coinsurance		0	0	33. 00
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0	_	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	179, 739	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	Subtotal (line 36 ± line 37)		179, 739	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		179, 739	0	40.00
	Interim payments		166, 382	0	41.00
	Balance due provider/program (line 40 minus line 41)	on with CMC Dut 15 0	13, 357	0	42.00
	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	ice with two Pub 15-2,	0	0	43. 00
	Gridptor 1, \$110.2		ı		ı

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: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/22/2019 3:09 pm

Offi y)					5/22/2019 3:0	9 pm
	<u> </u>	General Fund		Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CHIDDENT ACCETS	1.00	2. 00	3. 00	4. 00	
1.00	CURRENT ASSETS Cash on hand in banks	307, 704	. 0	0	0	1.00
2. 00	Temporary investments	307, 704				2.00
3. 00	Notes recei vabl e			0	0	3.00
4. 00	Accounts receivable	12, 311, 216	٦ ~	0	Ö	4. 00
5. 00	Other receivable	0		0	Ö	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-7, 738, 934	Ö	0	Ō	6. 00
7.00	Inventory	761, 340		0	0	7. 00
8.00	Prepai d expenses	499, 040	0	0	0	8. 00
9.00	Other current assets	8, 291, 476	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	14, 431, 842	2 0	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	0	0			12.00
13.00	Land improvements	0	0	_	0	13.00
14.00	Accumulated depreciation	0	0	_	0	14.00
15. 00	Bui I di ngs	1, 645, 888		_	0	15.00
16.00	Accumulated depreciation	-296, 076	•	_	0	16.00
17. 00	Leasehold improvements	502, 596	1		0	17.00
18.00	Accumulated depreciation Fixed equipment	-21, 360		_	0	18.00
19. 00 20. 00	Accumulated depreciation	639, 027	1	0	0 0	19. 00 20. 00
21. 00	Automobiles and trucks	-547, 286		0	0	20.00
21.00	Accumulated depreciation			0	0	22.00
23. 00	Major movable equipment	15, 697, 071	1	0	0	23.00
24. 00	Accumulated depreciation	-10, 453, 908		0	0	24.00
25. 00	Mi nor equi pment depreciable	10, 433, 900		_	0	25. 00
26. 00	Accumulated depreciation			_	Ö	26.00
27. 00	HIT designated Assets			0	Ö	27. 00
28. 00	Accumul ated depreciation			0	Ö	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	Ö	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	7, 165, 952		_		30.00
	OTHER ASSETS	, , , , , , ,				
31.00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	4, 357, 539	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4, 357, 539		_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	25, 955, 333	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	7 400 007		_		
37. 00	Accounts payable	7, 488, 807	1	_	_	37. 00
38. 00	Salaries, wages, and fees payable	764, 577	1	_	0	38.00
39. 00	Payroll taxes payable	0 25 404 254	0	_	0	39.00
40.00	Notes and Loans payable (short term) Deferred income	35, 191, 251	0	0	0	40. 00 41. 00
41. 00 42. 00			,	0	U	41.00
43. 00	Accel erated payments Due to other funds			0	0	42.00
44. 00	Other current liabilities			0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	43, 444, 635		0		45. 00
43.00	LONG TERM LIABILITIES	43, 444, 033	,	0	0	43.00
46. 00	Mortgage payable	1 0	0	0	0	46.00
47. 00	Notes payable	0	1		_	47. 00
48. 00	Unsecured Loans	0	o o			48. 00
49. 00	Other long term liabilities	71, 755, 568	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	71, 755, 568		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	115, 200, 203		0	0	51.00
	CAPITAL ACCOUNTS		•			
52.00	General fund balance	-89, 244, 870				52.00
53.00	Specific purpose fund		0			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	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
-a	repl acement, and expansi on]			
59. 00	Total fund balances (sum of lines 52 thru 58)	-89, 244, 870	1	_	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	25, 955, 333	0	0	0	60. 00
	[59]	I	I	l	I	l

Provider CCN: 15-0176

Peri od: Worksheet G-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					То	12/31/2018	Date/Time Pre 5/22/2019 3:0	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		-63, 765, 371			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-25, 479, 060					2. 00
3.00	Total (sum of line 1 and line 2)		-89, 244, 431			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00 7. 00
8. 00		0			0		0	7. 00 8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0		٥	0	O	10.00
11. 00	Subtotal (line 3 plus line 10)		-89, 244, 431			0		11. 00
12. 00	MI SC	439	07, 211, 101		0	Ŭ	0	12. 00
13. 00		0			Ö		0	13. 00
14. 00		o			O		0	14. 00
15.00		o			0		0	15. 00
16.00		o			0		0	16. 00
17.00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		439			0		18. 00
19. 00	Fund balance at end of period per balance		-89, 244, 870			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	DI ont	Fund				
		Endownient Fund	Plant Fund					
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)		J		0			10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	MI SC		0					12. 00
13.00			0					13.00
14.00			0					14.00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	I I		I	- 1			

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

			T	0 12/31/2018	Date/Time Prep 5/22/2019 3:00	
	Cost Center Description		Inpati ent	Outpati ent	Total	, p
	•		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		11, 188, 918		11, 188, 918	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		0	5. 00
6.00	Swing bed - NF		0		0	
7. 00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE		44 400 040		44 400 040	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		11, 188, 918		11, 188, 918	10. 00
11 00	Intensive Care Type Inpatient Hospital Services					11. 00
11. 00 12. 00	INTENSIVE CARE UNIT					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		0	
10.00	11-15)	111103			O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		11, 188, 918		11, 188, 918	17. 00
18. 00	Ancillary services		52, 572, 574	36, 062, 332	88, 634, 906	
19. 00	Outpatient services		723, 504	4, 787, 471	5, 510, 975	
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	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 SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26. 00
27. 00	HI LLVI EW		114, 074	3, 356, 051	3, 470, 125	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	64, 599, 070	44, 205, 854	108, 804, 924	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			54, 554, 142		29. 00
30. 00	ADD (SPECIFY)		0			30. 00
31. 00			0			31. 00
32.00			0			32. 00
33.00			0			33. 00
34.00			0			34. 00
35. 00	Total additions (sum of lines 20 25)		0	0		35. 00 36. 00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		_	U		
37. 00 38. 00	DEDUCT (SPECIFY)		0			37. 00 38. 00
39.00			0			39. 00
40.00			0			40.00
41. 00						40.00
42.00	Total deductions (sum of lines 37-41)			n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		54, 554, 142		43. 00
.5. 50	to Wkst. G-3, line 4)	, (a)		0.,00.,112		
			•	'		

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10						
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0176 Period:			Worksheet G-3			
			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/22/2019 3:09		
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			108, 804, 924	1. 00	
2. 00	Less contractual allowances and discounts on patients' accour	nts		79, 964, 191	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			28, 840, 733	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		54, 554, 142	4. 00	
5. 00	Net income from service to patients (line 3 minus line 4)			-25, 713, 409	5. 00	
	OTHER I NCOME			0	/ 00	
6.00	Contributions, donations, bequests, etc			0	6. 00	
7.00	Income from investments			0	7. 00	
8.00	Revenues from telephone and other miscellaneous communication services			0	8. 00	
9. 00 10. 00	Revenue from tellevision and radio service			0	9. 00 10. 00	
11. 00	Purchase discounts Rebates and refunds of expenses			0	10.00	
12. 00	Parking lot receipts			0	12.00	
	Revenue from Laundry and Linen service			0	13. 00	
	Revenue from meals sold to employees and guests					
	Revenue from rental of living quarters			0		
	Revenue from sale of medical and surgical supplies to other 1	than nationts		0	16. 00	
	Revenue from sale of drugs to other than patients	than patrents		0	17. 00	
	Revenue from sale of medical records and abstracts			0	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			ő	22. 00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	OTHER REVENUE			234, 349		
25. 00	Total other income (sum of lines 6-24)			234, 349	25. 00	
26. 00	Total (line 5 plus line 25)			-25, 479, 060		
27. 00	OTHER EXPENSES (SPECIFY)			23, 477, 000	27. 00	
	Total other expenses (sum of line 27 and subscripts)			ő	28. 00	
	Net income (or loss) for the period (line 26 minus line 28)			-25, 479, 060		
			'	.,		

Hool +h	Financial Cystems	NICAL CENTED	la lio	u of Form CMC (DEE2 10
Health Financial Systems KENTUCKIANA MEDIC CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0176	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title XVIII	Hospi tal	5/22/2019 3:00	9 pm
	PPS				
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD		1.00		
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier				1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			155, 766	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0 20. 40	
3.00					
4.00	Number of interns & residents (see instructions)			0. 00 0. 00	
5. 00 6. 00					6.00
0.00	1.01) (see instructions)	le suil of fiftes falla f.or	, corumns i and	0	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8. 00
9.00	Sum of lines 7 and 8	,		0.00	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11. 00
12.00	0 Total prospective capital payments (see instructions)				12.00
	DART II. DAVMENT UNDER REACONARIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST		0	1. 00	
2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)				2.00
3. 00					
4. 00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
	DADT LLL COMPUTATION OF EVAFORION DAVISATO			1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstar	ocos (soo instructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs for extraordinary circumstar	ices (see Fristructions)		0	3.00
4. 00	Applicable exception percentage (see instructions)		0.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	
7.00				0	7. 00
8.00				0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appl			0	9. 00
10. 00	Current year comparison of capital minimum payment level to		′ ′	0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	
12. 00				0	
13.00				0	13.00
14. 00				0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line)) Current year allowable operating and capital payment (see instructions)			o	15. 00
16. 00		isti doti olisj		0	
	OU Current year exception offset amount (see instructions)				17. 00
			'		•