In Lieu of Form CMS-2552-10 Health Financial Systems KENTUCKIANA MEDICAL CENTER This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 Worksheet S HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0176 Period: From 01/01/2016 Parts I-III AND SETTLEMENT SUMMARY 12/31/2016 Date/Time Prepared: 5/31/2017 12:15 pm PART I - COST REPORT STATUS Provider 1. [X] Electronically filed cost report Date: 5/31/2017 Time: 12:15 pm use only] Manually submitted cost report 3.[0] If this is an amended report enter the number of times the provider resubmitted this cost report 4.[F] Medicare Utilization. Enter "F" for full or "L" for low.

1]Cost Report Status 5. [1] Cost Report (1) As Submitted 6. Date Received: 10.NPR Date: Contractor 7. Contractor No. 11.Contractor's Vendor Code: use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9. (3) Settled with Audit (4) Reopened (5) Amended

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KENTUCKIANA MEDICAL CENTER (15-0176) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

Encryption Information ECR: Date: 5/31/2017 Time: 12:15 pm PJnTUdNemQxZfwpgN4nooKeNNonj90 n4b7COPkB1nH:m4Md1wjO:fqtnnG8H QtBx0iLChR0.mAth PI: Date: 5/31/2017 Time: 12:15 pm ibxcJjnIQvk6WTBcXsvy5TW1HSnP50 qA1Pn0dCsEac6gFfwVfMrwSh8FZ4c8

L8s40Hu5Z00y15GX

(Signed) Officer or Administrator of Provider(s) Title

Date

			Title	XVIII			
	경우 내가 다른 마음을 받아 보는 아내는 내가 되었다. 그리고 있다면 하는 것이다.	Title V	Part A	Part B	HIT	Title XIX	
	회사 - 발가를 발표하였다. 그 하이 모양 리토 호텔 및 환경 (1988년 - 1988년	1.00	2.00	3.00	4.00	5.00	100
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-81,640	1.	-16,269	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0			12.00
200.00	Total	0	-81,640	1	-16,269	0	200.00

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

In Lieu of Form CMS-2552-10 Health Financial Systems KENTUCKIANA MEDICAL CENTER Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 12:08 pm Provider CCN: 15-0176 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Period: From 01/01/2016 12/31/2016 1.00 3.00 2.00 Hospital and Hospital Health Care Complex Address: 1.00 1.00 Street: 4601 MEDICAL PLAZA WAY PO Box: City: CLARKSVILLE State: IN Zip Code: 47129 County: CLARK 2.00 Payment System (P Component Name CCN CBSA Provider Date T, 0, or N) Number Number Certified Type XVIII XIX 1.00 4.00 6.00 7.00 8.00 2.00 3.00 5.00 Hospital and Hospital-Based Component Identification: 3.00 3.00 KENTUCKIANA MEDICAL 150176 31140 1 09/18/2009 4.00 Subprovider - IPF 4.00 Subprovider - IRF 5.00 5.00 6.00 6.00 Subprovider - (Other) Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 10.00 Hospital-Based NF 11.00 11.00 Hospital-Based OLTC 12.00 Hospital-Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospital-Based Hospice 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15.00 16.00 16.00 Hospital-Based Health Clinic - FQHC 17.00 17.00 Hospital-Based (CMHC) I 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 20 00 21.00 21.00 Type of Control (see instructions) 4 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22,00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be N 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes "N" for no, for the portion of the cost reporting period prior to October 1. Enter column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 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. 23,00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column N 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no In-State In-State Out-of Out-of Medicaid other Medicaid Medicaid State State HMO days Medicaid paid days eligible Medicaid Medicaid days unpaid paid days eligible days unpaid 6.00 3.00 4.00 5.00 1.00 2.00 24,00 112 831 24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3 out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 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.

Health Financial Systems KENTUCKIANA MEDIO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCM	N: 15-0176			Workshe Part I Date/Ti	et S-2 me Pre	pared:
	O SECTION A			V	5/31/20 XI	- 2 1 2 2 4	US PIII
95.00 If line 94 is "Y", enter the reduction percentage in the appl	isabla salumn			1.00 0.00	0.0		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	in the		N	N N		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	icable column		14 3 A 3 B 15 S 5 S	0.00	0.0	0	97.0
105.00 Does this hospital qualify as a critical access hospital (CAH, 106.00 If this facility qualifies as a CAH, has it elected the all-i)? nclusive metho	od of paymer	nt	N N			105.00 106.00
for outpatient services? (see instructions) LO7.00If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on wkst. B, Pt. I, col. 7 reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the pro	ogram is cos	st	N			107.0
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sched	ule? See 42	2	N			108.0
	Physical	Occupationa	1] :	Speech	Respir		
LO9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1,00 N	2.00 N		3.00 N	4.0 N		109.0
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" fo		n project (4	110A Dem	o)for	1.0 N	10	110.0
				1.00	0 2,00	3,00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers	If column 2 i: for long term	s "E", enter m care (inc]	r in col Iudes	n 1 N umn			115.0
Pub.15-1, chapter 22, §2208.1.							
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117.00 Is this facility legally-required to carry malpractice insural no.	nce? Enter "Y	" for yes or	/ is	r Y	Insur		116.0 117.0 118.0
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	C IDENTIFICATION DATA	Provider CCN:	15-0176	Peri From To		of Form CMS- Worksheet S- Part I Date/Time Pr 5/31/2017 12	2 epared:
					1.00	2.00	
133.00 If this is a Medicare certified otl in column 1 and termination date,			ion date				133.00
134.00 If this is an organ procurement or and termination date, if applicable	ganization (OPO), enter th		column 1				134.0
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or "1	N" for no in column 1. If	yes, and home off	ice cost	s	Y		140.0
are claimed, enter in column 2 the	home office chain number		15)		3.00		
If this facility is part of a chai	n organization, enter on	lines 141 through	143 the	name		of the	
home office and enter the home off	ice contractor name and contractor's Name:	ontractor number.	Contrac	ton'c	Number:		141.0
.41.00 Name: .42.00 Street:	PO Box:		Contrac	roi. 2	Mumper:		142.0
143.00 City:	State:		Zip Cod	e:			143.0
						1.00	
144.00 Are provider based physicians' cos	ts included in Worksheet	4?	- 119 B B B B B B B B B B B B B B B B B B	sacos Naño		1.00 Y	144.0
Copin C provider states physicians cos							
					1.00	2.00 N	145.0
145.00 If costs for renal services are clainpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/de	for yes or "N" for no in lude Medicare utilization for no in column 2. y changed from the previou column 1. (See CMS Pub.	column 1. If column for this cost repusly filed cost re	umn 1 is porting eport?	f	N		146.0
147.00 was there a change in the statisti	cal basis? Enter "V" for	ves or "N" for no		1		1.00 N	147.0
		yes or 14 101 110.				14	147.0
148.00 was there a change in the order of	allocation? Enter "Y" for	r ves or "N" for r	10.			N .	148.0
148.00 was there a change in the order of 149.00 was there a change to the simplifi	allocation? Enter "Y" for ed cost finding method? En	r yes or "N" for r nter "Y" for yes o	or "N" fo	r no.		N	
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi	allocation? Enter "Y" for ed cost finding method? En	r yes or "N" for r nter "Y" for yes o Part A	or "N" fo Part B	r no.	Title V	N Title XIX	
149.00 was there a change to the simplification. Does this facility contain a provi	ed cost finding method? Ender that qualifies for an	r yes or "N" for r nter "Y" for yes o Part A 1.00 exemption from t	or "N" fo Part B 2.00 he applic	ation	3.00 of the lowe	N Title XIX 4.00 r of costs	
Does this facility contain a provi or charges? Enter "Y" for yes or "	ed cost finding method? Ender that qualifies for an	r yes or "N" for r nter "Y" for yes o Part A 1.00 exemption from tl ent for Part A and	or "N" fo Part B 2.00 he applic d Part B. N	ation	3.00 of the lowe 42 CFR §413 N	N Title XIX 4.00 r of costs .13)	149.0
Does this facility contain a provi or charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF	ed cost finding method? Ender that qualifies for an	r yes or "N" for reter "Y" for yes of Part A 1.00 exemption from the ent for Part A and N	or "N" fo Part B 2.00 he applic d Part B. N	ation	3.00 of the lowe 42 CFR §413 N	N Title XIX 4.00 r of costs .13) N N	149.0 155.0 156.0
Does this facility contain a provi or charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF	ed cost finding method? Ender that qualifies for an	r yes or "N" for r nter "Y" for yes o Part A 1.00 exemption from tl ent for Part A and	or "N" fo Part B 2.00 he applic d Part B. N	ation	3.00 of the lowe 42 CFR §413 N	N Title XIX 4.00 r of costs .13)	149.0 155.0 156.0 157.0
149.00 was there a change to the simplification. Does this facility contain a provi	ed cost finding method? Ender that qualifies for an	r yes or "N" for reter "Y" for yes of Part A 1.00 exemption from the ent for Part A and N	or "N" fo Part B 2.00 he applic d Part B. N	ation	3.00 of the lowe 42 CFR §413 N	N Title XIX 4.00 r of costs .13) N N	149.0 155.0 156.0 157.0 158.0
Does this facility contain a provior charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY	ed cost finding method? Ender that qualifies for an	r yes or "N" for reter "Y" for yes of Part A 1.00 exemption from the ent for Part A and N	or "N" fo Part B 2.00 he applic d Part B. N N N	ation	3.00 of the lowe 42 CFR §413 N N N N	N Title XIX 4.00 r of costs .13) N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0
Does this facility contain a provior charges? Enter "Y" for yes or "155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY	ed cost finding method? Ender that qualifies for an	r yes or "N" for reter "Y" for yes of Part A 1.00 exemption from the ent for Part A and N N N N N N N N N N N N N N N N N N N	or "N" fo Part B 2.00 he applic d Part B. N N	ation	3.00 of the lowe 42 CFR §413 N N N	N Title XIX 4.00 r of costs .13) N N N N	155.0 156.0 157.0 158.0 159.0 160.0
Does this facility contain a provi or charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	ed cost finding method? Ender that qualifies for an	r yes or "N" for reter "Y" for yes of Part A 1.00 exemption from the ent for Part A and N N N N N N N N N N N N N N N N N N N	or "N" fo Part B 2.00 he applic d Part B. N N N	ation	3.00 of the lowe 42 CFR §413 N N N N	N Title XIX 4.00 r of costs .13) N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0
Does this facility contain a provior charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	ed cost finding method? Ender that qualifies for an N" for no for each compon	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the ent for Part A and N N N N N N N N N N N N N N N N N N N	or "N" fo Part B 2.00 e applic d Part B. N N N N N N N N N N N N N N N N N N	cation (see	3.00 of the lowe 42 CFR §413 N N N N	N Title XIX 4.00 r of costs .13) N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0 161.0
Does this facility contain a provior charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC Multicampus 165.00 Is this hospital part of a Multicam	ed cost finding method? Ender that qualifies for an N" for no for each compon mpus hospital that has one	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the reterior for Part A and N N N N N N N C County	or "N" fo Part B 2.00 to applic d Part B. N N N N N S in diff State Z	erent	3.00 of the lowe 42 CFR §413 N N N N N CBSAs?	N Title XIX 4.00 r of costs .13) N N N N N N N N N Title XIX 1.00 N N N N N N N N N N N N N N N N N N	155.0 156.0 157.0 158.0 159.0 160.0 161.0
Does this facility contain a provior charges? Enter "Y" for yes or " 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC Multicampus 165.00 Is this hospital part of a Multicam	ed cost finding method? Ender that qualifies for an N" for no for each compon	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the reterior for Part A and N N N N N N N C County	or "N" fo Part B 2.00 e applic d Part B. N N N N N N N N N N N N N N N N N N	cation (see	3.00 of the lowe 42 CFR §413 N N N N	N Title XIX 4.00 r of costs .13) N N N N N N N T N N N N N S N N N N S T T T T	148.0 149.0 155.0 156.0 157.0 159.0 160.0 161.0
Does this facility contain a provi or charges? Enter "Y" for yes or "155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC Multicampus 165.00 Is this hospital part of a Multicamenter "Y" for yes or "N" for no. 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	ed cost finding method? Ender that qualifies for an N" for no for each compon mpus hospital that has one	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the reterior for Part A and N N N N N N N C County	or "N" fo Part B 2.00 to applic d Part B. N N N N N S in diff State Z	erent	3.00 of the lowe 42 CFR §413 N N N N N CBSAs?	N Title XIX 4.00 r of costs .13) N N N N N N N T N N N N O T O T O T O T	149.0 155.0 156.0 157.0 158.0 160.0 161.0
Does this facility contain a provior charges? Enter "Y" for yes or "155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC Multicampus 165.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no. 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ed cost finding method? Ender that qualifies for an N" for no for each componed mpus hospital that has one Name	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the reterior for Part A and N N N N N N N 1 N N N N N N N N N N N N	or "N" fo Part B 2.00 e applic d Part B. N N N N S in diff State Z 2.00	erent	3.00 of the lowe 42 CFR §413 N N N N N CBSAs?	N Title XIX 4.00 r of costs .13) N N N N N N N T N N N N N S N N N N S T T T T	149.0 155.0 156.0 157.0 158.0 160.0 161.0
Does this facility contain a provi or charges? Enter "Y" for yes or "155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 158.00 Subprovider - IRF 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC Multicampus 165.00 Is this hospital part of a Multicamenter "Y" for yes or "N" for no. 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	mpus hospital that has one Name O incentive in the Americ under §1886(n)? Enter " is "Y") and is a meaning	r yes or "N" for reter "Y" for yes or Part A 1.00 exemption from the reter to Part A and N N N N N N N N N N N N N N N N N N N	einvestme	erent ip Coc 3.00	3.00 of the lowe 42 CFR §413 N N N N N CBSAS?	N Title XIX 4.00 r of costs .13) N N N N N N N T N N N N O T O T O T O T	149.0 155.0 156.0 157.0 158.0 160.0 161.0

Health Financial Systems KE	NTUCKIANA MEDICAL	In Lieu	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	ION DATA Pro	vider CCN: 15-0176	From 01/01/2016		pared:
			Beginning	Ending	
			1.00	2.00	MASSE
170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy)	and ending date fo	or the reporting	01/01/2016	12/31/2016	170.00
			1 00	2 00	
			1.00	2.00	25/24/06/25/20
171.00 If line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wk "Y" for yes and "N" for no in column 1. If colu 1876 Medicare days in column 2. (see instruction	st. S-3, Pt. I, li mn 1 is yes, enter	ne 2, col. 6? Enter	n Y	1,139	171.00

	Financial Systems KENTUCKIANA MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016		epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ento	1,00 er all dates in i	2,00 the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
L.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N	principal superior s	1.00
antin'i dia ka	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions) Date	V/I	1.4545149
			1.00	2.00	3,00	
3.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the providential officers, medical staff, management personnel, or members of the providential staff, management personnel, or members or members of the providential staff, management personnel, or members of the providential staff, management personnel, or members or members of the providential staff, management personnel, and the providential staff, management personnel, and the providential staff, management personnel, and the providential staff, management personnel staff, management personnel staff, management	n 3, "V" for g management ffices, drug er or its	Y			3.00
	of directors through ownership, control, or family and othe relationships? (see instructions)	r similar				
NV S	remember (see instructions)		Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	4 450 00 00 00
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 ava column 3. (see instructions) If no, see instructions.	or Compiled,	N			4.00
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
	chose of the fried (marcial statements) 11 yes, submit fee			Y/N 1.00	Legal Oper. 2.00	
5.00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider i	s N		6.00
	the legal operator of the program?	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-	
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	during the	N N		8.00
00.0	Are costs claimed for Interns and Residents in an approved		al education	N		9.00
LO.00	program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated o		he current	N		10.00
11.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.00
	Teaching Program of worksheet At 17 yes, see inseruccions.				Y/N	1 53.34
Janaka Pangka	Bad Debts				1.00	
L2.00 L3.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p	, see instruct olicy change o	ions. luring this c	ost reporting	N N	12.00 13.00
14.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see in	structions.	N	14.00
L5.00	Did total beds available change from the prior cost reporti		yes, see ins 't A		N N	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		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	Y	03/17/2017	Y	03/17/2017	17.00
L8.00	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

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016	Date/Time Pro 5/31/2017 12	epared:
		Descr	iption	Y/N	Y/N	1 18 (4) (4.6)
			0	1.00	3.00	4 5.35 (10)
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	Y/N	Date	
		1.00	2.00	3,00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1,00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPITALS)			
	Capital Related Cost	4		Takk man and an madden and addit	Ar	22,00
22.00	Have assets been relifed for Medicare purposes? If yes, see			dura dalar arada	N N	1
3.00	Have changes occurred in the Medicare depreciation expense	due to apprais	ais made dur	ing the cost	N	23.00
	reporting period? If yes, see instructions.					24.00
4.00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?	N	24.00
	If yes, see instructions	Ab		7£	1	35.00
5.00	Have there been new capitalized leases entered into during	tne cost repor	ting period?	it yes, see	N	25.00
	instructions.					20.00
6.00	Were assets subject to Sec.2314 of DEFRA acquired during the	ne cost reporti	ng period? I	т yes, see	N N	26.00
	instructions.					1 27 66
7.00		e cost reportir	ig period? If	yes, submit	N	27.00
	copy.					-
	Interest Expense	a observation and				٠
8.00	Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting	N	28.00
	period? If yes, see instructions.			- 15		20.00
9.00			ebt Service R	eserve Fund)	N	29.00
	treated as a funded depreciation account? If yes, see inst		11.5 -5			30.00
0.00	Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If yes	, see	N	30.00
	instructions.	•	11.5 -6		l	34.00
1.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see	N	31.00
	instructions.	sa i svav alembe 1905.	Printer Land Research and			
	Purchased Services		3		1 11	32.00
2.00			ea through co	ntractuai	N	32.00
2 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uccions. nlied nertainir	na to compoti	tivo hidding? Tf	N	33.00
33.00		pileo pertainii	ig to competi	rive bluding: II	l N	33.00
	no, see instructions.	and the state of the state of	SIN PERMANENTAL S			
	Provider-Based Physicians Are services furnished at the provider facility under an a	nnangomant with	nnovidon ba	sod physicians?	Y	34.00
4.00	If yes, see instructions.	i i angement with	i provider-ba	ised physicians:	'	34.00
E 00	If line 34 is yes, were there new agreements or amended ex	istina samoomor	ate with the	nrovider-hased	N	35.00
,,,,,,	physicians during the cost reporting period? If yes, see in		ics mich che	provider basea	, "	33100
-1015 b/s :	physicians during the cost reporting period: 11 yes, see h	iser acerons.	915 (23.35M) 971 E.K.	Y/N	Date	1 2 1 1 1 2 2 3
				1.00	2.00	
ng to this	Home Office Costs					
6.00	Were home office costs claimed on the cost report?		3 1	N N		36.0
7 00	If line 36 is yes, has a home office cost statement been p	renared by the	home office?			37.0
7.00	If yes, see instructions.	repared by the	nome office.	14		37.10
8.00	1	fice different	from that of	· N	1	38.00
	the provider? If yes, enter in column 2 the fiscal year en			"		
0.00		er chain compo	ents? If vec	, N		39.0
	If line 36 is wes did the provider render services to other		v zi yes	''		-3.0
	If line 36 is yes, did the provider render services to other	er enarm compor				1
9.00	If line 36 is yes, did the provider render services to other see instructions.		Tf ves. see	N		40.00
9.00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the		If yes, see	N		40.00
9.00	If line 36 is yes, did the provider render services to other see instructions.		If yes, see	N		40.00
9.00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	home office?			.00	40.0
9.00	If line 36 is yes, did the provider render services to othesee instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see		.00	40.0
9.00 0.00	If line 36 is yes, did the provider render services to othesee instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	home office?		2.	.00	
9.00 0.00	If line 36 is yes, did the provider render services to othesee instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	home office?			.00	
9.00 0.00	If line 36 is yes, did the provider render services to othesee instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	home office?		2.	.00	41.00
9.00	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	home office?		2.	.00	
9.00	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	home office?		2.	.00	41.0
9.00	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	home office?		2.		41.0

Health	Financial Systems KENTUCKIANA	MEDICAL CENTER	In Lieu of Form CMS-2552-			
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0176	Period: From 01/01/2016 To 12/31/2016			
		3.00				
	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, respectively.	CF0		41.00		
42.00	Enter the employer/company name of the cost report preparer.			42.00		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	:		43.00		

KENTUCKIANA MEDICAL CENTER
CAL DATA Provider CCN: 15-0176

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

						5/31/2017 12:	08 pm
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1,00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	46	16,836	0.00	0	1.00
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 beds) (see instructions)		46	16,836	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY					_	13.00
14.00	Total (see instructions)		46	16,836	0.00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER	44.00				_	18.00 19.00
19.00	SKILLED NURSING FACILITY	44.00		0		0	20.00
20.00	NURSING FACILITY	45.00	١	U		0	21.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	101.00				0	22.00
23,00	AMBULATORY SURGICAL CENTER (D.P.)	101.00				U	23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
	RURAL HEALTH CLINIC	88.00				Ŏ	26.00
26,25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				ő	26.25
	Total (sum of lines 14-26)	.52.00	46			-	27.00
28.00	Observation Bed Days					0	28.00
29.00							29.00
	Employee discount days (see instruction)						30.00
.31.00	Employee discount days - IRF						31.00
32.00	1		0	o			32.00
32.01							32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

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

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:

						5/31/2017 12:0	ווע סט
145,531,135,57		I/P Days	/ O/P Visits ,	/ Trips	Full Time (Equivalents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,011	112	9,072			1.00
2.00	HMO and other (see instructions)	1,139	831				2.00
3.00	HMO IPF Subprovider	0	О				3.00
4.00	HMO IRF Subprovider	0	О				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,011	112	9,072			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			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)	5,011	112	9,072	0.00	230.00	
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER	İ					18.00
19.00	SKILLED NURSING FACILITY	0	0	0		0.00	
20.00	NURSING FACILITY	•	0	0	0.00	0.00	
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	-					24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC	0	0	0	0.00		L
26.00	RURAL HEALTH CLINIC	0	0	0	0.00		1
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		1
27.00	Total (sum of lines 14-26)				0.00	230.00	
28.00	Observation Bed Days		0	652			28.00
	Ambulance 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	O	0			32.00
	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0176 Period: From 01,

Period: From 01/01/2016 To 12/31/2016 Part I Date/Time Prepared: 5/31/2017 12:08 pm

						5/31/2017 12:	08 pm
		Full Time Equivalents		Discharges			
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	859	21	1,631	1.00
2.00	HMO and other (see instructions)			152	160		2,00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				o		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 beds) (see instructions)			•			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)	0.00	0	859	21	1,631	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00							21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00							23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0.00					24.10 25.00
25.00	i l	0.00					26.00
26.00 26.25	RURAL HEALTH CLINIC	0.00					26.25
							27.00
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
	Ambulance Trips			İ			29.00
30.00	Employee discount days (see instruction)						30.00
	Employee discount days (see instruction)						31.00
32.00							32.00
32.00	, , , ,						32.01
33.00	LTCH non-covered days						33.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0176

					T	o 12/31/2016	Date/Time Pre 5/31/2017 12:	
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
00	SALARIES Total salaries (see	200,00	10,885,614	0	10,885,614	479,386.00	22.71	1.0
.00	instructions)	200.00	10,665,614	U	10,885,014	475,300.00	22.71	1.0
.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.0
.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3.0
.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.0
.01 .00	Physicians – Part A – Teaching Physician and Non		0 0	0	0	0.00 0.00		ı
.00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	о	0.00	0.00	6.
.00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	7.
.01	approved program) Contracted interns and residents (in an approved		o	0	o	0.00	0.00	7.
.00	programs) Home office and/or related organization personnel		o	0	0	0.00	0.00	8.
.00	SNF	44.00	o	0	o	0.00	0.00	
0.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.
00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		764,636	0	764,636	6,138.00	124.57	11.
.00	Care Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.
.00	services Contract labor: Physician-Part A - Administrative		199,114	0	199,114	1,106.00	180.03	13.
.00	Home office and/or related orgainzation salaries and		o	0	o	0.00	0.00	14.
.01	wage-related costs Home office salaries		0	0	0	0.00	0.00	14.
.02	Related organization salaries		ŏ	0	ō	0.00		
.00	Home office: Physician Part A - Administrative		0	0	0	0.00		
.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
.00	WAGE-RELATED COSTS Wage-related costs (core) (see		2,609,753	0	2,609,753			17
.00	instructions) Wage-related costs (other)		0	0	0			18
	(see instructions) Excluded areas		0	0	0			19
.00	Non-physician anesthetist Part A		0	0				20
.00	В		0	. 0				22
	Administrative Physician Part A - Teaching		0	0	0			22
.00	Physician Part B		ō	Ō	0			23
	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0	0	0			24 25
.50 .51	approved program) Home office wage-related Related orgainzation		0	0	0			25 25
. 52	wage-related Home office: Physician Part A		0	0	0			25
.	- Administrative - wage-related		ء ۔					35
.53	Home office & Contract Physicians Part A - Teaching - wage-related			C	0			25
	OVERHEAD COSTS - DIRECT SALARIE	S						
	Employee Benefits Department	4.00	164,661	Q	,			
00	Administrative & General	5.00	1,293,433	0	1,293,433	49,367.00	26.20	27

Provider CCN: 15-0176

					1 "	0 12/31/2010	5/31/2017 12:0	
		Worksheet A		Reclassificati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col. 5)	
		1,00	2.00	3,00	4.00	5.00	6.00	
28.00	Administrative & General under		1,686,512	0	1,686,512	19,698.00	85.62	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	140,267	0	140,267			29.00
30.00	Operation of Plant	7.00	0	0	0	0.00		30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00		31.00
32.00	Housekeeping	9.00		0	0	0.00		32.00
33.00	Housekeeping under contract		322,400	16,640	339,040	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	299,605	-129,037	170,568			34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00		35.00
36.00	Cafeteria	11.00	0	129,037	129,037	11,342.00		36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	(37.00
38.00	Nursing Administration	13.00	250,642	0	250,642	5,711.00		
39.00	Central Services and Supply	14.00	0	0	0	0.00		39.00
40.00	Pharmacy	15.00	264,666	0	264,666	11,843.00		
41.00	Medical Records & Medical Records Library	16.00	167,011	0	167,011	8,139.00	20.52	41.00
42.00	Social Service	17.00	0	0	0	0.00		42.00
43.00	Other General Service	18.00	ļ	0) o	0.00	0.00	43.00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0176	Period: From 01/01/2016 Part III To 12/31/2016 Date/Time Prepared: 5/31/2017 12:08 pm

						,,	5/31/2017 12:0	08 pm
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				AREST の利用を対す		
1.00	Net salaries (see instructions)		12,894,526	16,640	12,911,166	499,084.00	25.87	1.00
2.00	Excluded area salaries (see instructions)		C	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,894,526	16,640	12,911,166	499,084.00	25.87	3.00
4.00	Subtotal other wages & related costs (see inst.)		963,750	0	963,750	7,244.00	133.04	4.00
5.00	Subtotal wage-related costs (see inst.)		2,609,753	0	2,609,753	0.00	20.21	5.00
6.00	Total (sum of lines 3 thru 5)	İ	16,468,029	16,640	16,484,669	506,328.00	32.56	6.00
7.00	Total overhead cost (see instructions)		4,589,197	16,640	4,605,837	133,633.00	34.47	7.00

		5/31/2017 12: Amount Reported
		1.00
10.193	PART IV - WAGE RELATED COSTS	1,00
	Part A - Core List	
	RETIREMENT COST	
)	401K Employer Contributions	162,075
)	Tax Sheltered Annuity (TSA) Employer Contribution	102,073
,	Nonqualified Defined Benefit Plan Cost (see instructions)	0
0.	Qualified Defined Benefit Plan Cost (see instructions)	o o
U.	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	
0	401K/TSA Plan Administration fees	0
0	Legal/Accounting/Management Fees-Pension Plan	ő
0	Employee Managed Care Program Administration Fees	0
	Employee managed care rising am Administration rees	Disal Crists day (1)
0	Health Insurance (Purchased or Self Funded)	1,257,254
1	Health Insurance (Self Funded without a Third Party Administrator)	0
2	Health Insurance (Self Funded with a Third Party Administrator)	Õ
3	Health Insurance (Purchased)	0
0	Prescription Drug Plan	0
	Dental, Hearing and Vision Plan	-17,259
	Life Insurance (If employee is owner or beneficiary)	-388
	Accident Insurance (If employee is owner or beneficiary)	0
	Disability Insurance (If employee is owner or beneficiary)	0
	Long-Term Care Insurance (If employee is owner or beneficiary)	o o
00	'Workers' Compensation Insurance	152,898
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0
	Non cumulative portion)	•
	TAXES STATEMENT OF THE PROPERTY OF THE PROPERT	
00	FICA-Employers Portion Only	633,111
	Medicare Taxes - Employers Portion Only	150,263
	Unemployment Insurance	0
	State or Federal Unemployment Taxes	271,799
	OTHER STATE OF THE	
	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0
00	Day Care Cost and Allowances	0
	Tuition Reimbursement	0
	Total Wage Related cost (Sum of lines 1 -23)	2,609,753
	Part B - Other than Core Related Cost	
	OTHER WAGE RELATED COSTS (SPECIFY)	0

Health	Financial Systems	KENTUCKIANA MEDICAL CENTER	In Lie	i of Form CMS-2	2552-10
HOSPIT	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0176		Date/Time Prep 5/31/2017 12:	pared:
	Cost Center Description		Contract Labor	Benefit Cost	46.4(86.3
	表演的 1995年 1		1.00	2,00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident				
1.00	Total facility's contract labor and benefit	cost	764,636	2,609,753	1.00
2.00	Hospital		764,636	2,609,753	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF			_	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF		0	0	8.00
9.00	Hospital-Based NF		0	0	9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice				13.00
14.00			0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	· ·		0	. 0	16.00
17.00				•	17.00
18.00	Other		0	0	18.00

HOSPIT	Financial Systems KENTUCKIANA MEDIC	TAL CENTER	In Lie		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0176	Period:	Worksheet S-10	0
			From 01/01/2016 To 12/31/2016	Date/Time Prep 5/31/2017 12:0	
				1.00	
-	Uncompensated and indigent care cost computation				
L.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	ivided by line 202 colum	ın 8)	0.339220	1.0
	Medicaid (see instructions for each line)				
.00	Net revenue from Medicaid			938,385	2.0
.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.0
.00	If line 3 is "yes", does line 2 include all DSH or supplementa	al payments from Medicai	d?	Y	4.0
.00	If line 4 is "no", then enter DSH or supplemental payments from	om Medicaid		0	5.0
5.00	Medicaid charges			12,471,564	6.0
7.00	Medicaid cost (line 1 times line 6)			4,230,604	7.0
3.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	•	•	3,292,219	8.0
	Children's Health Insurance Program (CHIP) (see instructions i	for each line)			
00.0	Net revenue from stand-alone CHIP			0	9.0
10.00				0	10.0
L1.00	Stand-alone CHIP cost (line 1 times line 10)	49.4		0	11.0
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus line 9;	if < zero then '	0	12.0
	enter zero)		¥ ESPECIAL PERSON DISTRICT		
	Other state or local government indigent care program (see ins	structions for each line	()	0	13.0
13.00		cluded on lines 2, 5 or	9) 1 du 7duan C au	0	14.0
L4.00	Charges for patients covered under state or local indigent cal	re program (Not included	i in tines o or	U	14.0
	State or local indigent care program cost (line 1 times line	14)		0	15.0
16.00	State or local indigent care program cost (line 1 times line 1 pifference between net revenue and costs for state or local in	14) ndigent care program (1	ine 15 minus line		
16.00	Difference between net revenue and costs for state or local in	14) ndigent care program (1	ne 15 minus line		
16.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line)	ndigent care program (1	ne 15 minus line		
L6.00 L7.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to	ndigent care program (1 funding charity care	ne 15 minus line		16.0
16.00 17.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of	ndigent care program (1- funding charity care hospital operations		0	16.0 17.0 18.0
16.00 17.00 18.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local	ndigent care program (1- funding charity care hospital operations		0	16.0 17.0 18.0
17.00 18.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of	ndigent care program (1- funding charity care hospital operations al indigent care progran	ns (sum of lines	0 0 0 3,292,219	16.0 17.0 18.0
17.00 18.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local	ndigent care program (1- funding charity care hospital operations al indigent care progran	ns (sum of lines	0 0 0 3,292,219 Total (col 1	16.0 17.0 18.0
.6.00 .7.00 .8.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local	ndigent care program (1- funding charity care hospital operations al indigent care progran Uninsured patients	ns (sum of lines Insured patients	0 0 3,292,219 Total (col. 1 + col. 2)	16.0 17.0 18.0
.6.00 .7.00 .8.00 .9.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local, 12 and 16)	funding charity care hospital operations al indigent care program Uninsured patients 1.00	ns (sum of lines Insured patients 2.00	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00	17.0 18.0 19.0
L6.00 L7.00 L8.00 L9.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions)	funding charity care hospital operations al indigent care program Uninsured patients 1.00	Insured patients 2.00	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036	17.0 18.0 19.0
17.00 18.00 19.00 20.00 21.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line)	funding charity care hospital operations al indigent care program Uninsured patients 1.00	Insured patients 2.00	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036	16.0 17.0 18.0 19.0
17.00 18.00 19.00 20.00 21.00 22.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fovernment grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care	funding charity care hospital operations al indigent care program Uninsured patients 1.00	Insured patients 2.00 0326 0 0	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0	16.0 17.0 18.0 19.0 20.0 21.0 22.0
.6.00 .7.00 .8.00 .9.00 .9.00 .1.00 .2.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local lo	funding charity care hospital operations al indigent care program Uninsured patients 1.00	Insured patients 2.00 0326 0 0	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036	16.0 17.0 18.0 19.0 20.0 21.0 22.0
.6.00 .7.00 .8.00 .9.00 .9.00 .1.00 .2.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fovernment grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care	funding charity care hospital operations al indigent care program Uninsured patients 1.00	Insured patients 2.00 0326 0 0	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	16.0 17.0 18.0 19.0 20.0 21.0 22.0
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17.00 18.00 19.00 20.00 21.00 22.00 23.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local lo	funding charity care hospital operations al indigent care program Uninsured patients 1.00 s) 110, 20) 37, at days beyond a length	Insured patients 2.00 0326 0 0 0 0326 0 0	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0
17.00 18.00 19.00 20.00 21.00 22.00 23.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care	funding charity care hospital operations al indigent care program Uninsured patients 1.00 s) 110, 20) 37, nt days beyond a length e program?	Insured patients 2.00 036 0 026 0 0 0 0326 0 0 of stay limit	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	17.0 18.0 19.0 20.0 21.0 23.0
27.00 8.00 19.00 21.00 22.00 23.00 24.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent caralled in the second of the seco	funding charity care hospital operations al indigent care program Uninsured patients 1.00 37,	Insured patients 2.00 036 0 026 0 0 0 0326 0 0 of stay limit	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0
17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 26.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care if line 24 is "yes," charges for patient days beyond an inditated bad debt expense for the entire hospital complex (see in	funding charity care hospital operations al indigent care program Uninsured patients 1.00 37, 20 37, 37, 37, Int days beyond a length e program? gent care program's length instructions)	Insured patients 2.00 036 0 026 0 0 0 0326 0 0 of stay limit	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0 26.0
20.00 21.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care (cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care If line 24 is "yes," charges for patient days beyond an indit Total bad debt expense for the entire hospital complex (see instructions)	funding charity care hospital operations al indigent care program (1-100 s) 110, 20) 37, 37, 11 days beyond a length e program? gent care program's lengentstructions)	Insured patients 2.00 036 0 026 0 0 0 0326 0 0 of stay limit	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	20.0 21.0 22.0 23.0 24.0 25.0 26.0 27.0
16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to a Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care if line 24 is "yes," charges for patient days beyond an inditated bad debt expense for the entire hospital complex (see in	funding charity care hospital operations al indigent care program (1-100 s) 110, 20) 37, 37, 110 days beyond a length e program? gent care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program is lengular car	Insured patients 2.00 036 0 326 0 0 0 0326 0 of stay limit	0 0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326	16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0 26.0 27.0 28.0
17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fore government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Charity care charges for the entire facility (see instructions cost of patients approved for charity care (line 1 times line Partial payment by patients approved for charity care (cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care If line 24 is "yes," charges for patient days beyond an indigent care bad debt expense for the entire hospital complex (see instructions) in the complex is the medicare bad debts for the entire hospital complex (see instructions) in the complex is the medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare bad debt expense (cost of non-Medicare and non-reimbursable Medicare and non-reimbursable Medicare and non-reimbursable Medicare and non-reimbursable Med	funding charity care hospital operations al indigent care program (1-100 s) 110, 20) 37, 37, 110 days beyond a length e program? gent care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program's lengular care program is lengular car	Insured patients 2.00 036 0 326 0 0 0 0326 0 of stay limit	0 0 3,292,219 Total (col. 1 + col. 2) 3.00 110,036 37,326 0 37,326 1.00 N	20.0 21.0 22.0 23.0 24.0 25.0 26.0 27.0 28.0 29.0

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09000 CLINIC

09900 CMHC

191.00 19100 RESEARCH

09100 EMERGENCY

101.00 10100 HOME HEALTH AGENCY

113.00 11300 INTEREST EXPENSE

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

SUBTOTALS (SUM OF LINES 1-117)

TOTAL (SUM OF LINES 118-199)

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS

NONREIMBURSABLE COST CENTERS

192.00 19200 PHYSICIANS' PRIVATE OFFICES

194.00 07951 MARKETING/ ADVERTISING

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BA	KENTUCKIANA MED LANCE OF EXPENSES	Provider CO	N: 15-0176	Period:	u of Form C Worksheet	
					From 01/01/2016 To 12/31/2016	Date/Time	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation 7.00			5/31/2017	12;08 pm
10 000	GENERAL SERVICE COST CENTERS		7.00				
.00	00100 CAP REL COSTS-BLDG & FIXT	-2,792,023	1,276,932				1.0
.00	00200 CAP REL COSTS-MVBLE EQUIP	0	2,970,934				2.0
.00	00300 OTHER CAP REL COSTS	0	0				3.0
.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-455	2,867,647				4.0
.00	00500 ADMINISTRATIVE & GENERAL	-3,258,842	4,801,093				6.0
.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	-10,945	1,420,621				7.
.00	00800 LAUNDRY & LINEN SERVICE		646,772				8.
.00	00900 HOUSEKEEPING	ام	381,754				9.
0.00		ol	56,263				10.
1.00	1 1	-154,044	155,652				11.
3.00	1 1	0	286,308				13.
4.00	01400 CENTRAL SERVICES & SUPPLY	0	4,390,857				14.
5.00	01500 PHARMACY	0	752,748				15.
6.00		-4,328	207,181				16.
	01700 SOCIAL SERVICE	0	0				17.
9.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	18.575-74 (1865-1964)		To a security for the standard	19.
A AA	INPATIENT ROUTINE SERVICE COST CENTER		4 C7E 24C	Activities and the second	Alternative designation of the second control of the second contro	* 4	30.
0.00 1.00		0	4,575,246				31.
4.00) N	0				44.
5.00		o	0				45.
3,00	ANCILLARY SERVICE COST CENTERS	reviews who specimens in					3900
0.00		-897,090	1,841,130				50.
1.00	1	o	0				51.
3,00	05300 ANESTHESIOLOGY	0	0				53.
4.00	P	-207,297	214,518				54.
5.00		0	0				55.
6.00		0	278,356				56.
7.00		O O	461,231 0				57.
8.00 9.00	1 I		956,313				59.
0.00	I 1	Ĭ	2,130,616				60.
1.00		ONLY 0	0,150,010				61.
2,00			0				62.
4.00		o	0				64.
5.00	06500 RESPIRATORY THERAPY	o	618,587				65.
6.00		0	0				66.
7.00		0	0				67.
00.8		0	0				68.
9.00		0	309,281				69.0
	07000 ELECTROENCEPHALOGRAPHY	TENT 0	0				70.
1.00 2.00	1 1	TEM!	0				72.
3.00		ام	852,736				73.
3.00	OUTPATIENT SERVICE COST CENTERS		7/5/2/3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				35/35
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9.00		ER 0	0				89.
0.00	· · · · · · · · · · · · · · · · · · ·	o	0				90.
	09100 EMERGENCY	-1,177,906	926,891				91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT	PART					92.
	OTHER REIMBURSABLE COST CENTERS					differ projects All	200
	09900 CMHC	0	0	i			99.
01.0	0 10100 HOME HEALTH AGENCY	0	0			88 4 400 - 17.554	101.
12 0	SPECIAL PURPOSE COST CENTERS	0	0	GOVERNMENT OF STREET		aggi magan na wasan gand	113.
13.0	0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1-117)	-8,502,930					118.
το. υ	NONREIMBURSABLE COST CENTERS	-0,302,930	790,875,66	L		300000000000000000000000000000000000000	The second second
വ വ	0 19000 GIFT, FLOWER, COFFEE SHOP & CAN	TEEN 0	0		And the second second second second	*** * * * * * * * * * * * * * * * * *	190.
	0 19100 RESEARCH	0	n				191.
	0 19200 PHYSICIANS' PRIVATE OFFICES	Ĭ	· o				192.
	0 07951 MARKETING/ ADVERTISING	l o	21,754				194.
	O TOTAL (SUM OF LINES 118-199)	-8,502,930		l	•		200.0

						ime Prepare 2017 12:08 p
		Increases				
	Cost Center	Line #	Salary	Other		
0.88	2.00	3.00	4.00	5,00		
	A - CAFETERIA COSTS					
0	CAFETERIA	11.00	129,037	180,659		1
	TOTALS		129,037	180,659		ŀ
	B - RECLASS CHARGEABLE SUPPLI	ES	A SA SA SA SA SA SA SA SA SA SA SA SA SA			SZESTORALI
0	CENTRAL SERVICES & SUPPLY	14.00	0	4,390,857	A Company of the Comp	1
0	ADULTS & PEDIATRICS	30.00	ol	2,015		1 2
0		0.00	ol	0		
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			0	9		1
0		0.00				
	TOTALS		0	4,392,872		
	C - PHARMACY RECLASS		Symple Conference of States			
0	DRUGS CHARGED TO PATIENTS	73.00	•	<u>852,7</u> 36		1
	TOTALS		0	852,736		
	D - CAPITAL COSTS					
0	CAP REL COSTS-BLDG & FIXT	1.00	0	211,356		:
0	ADMINISTRATIVE & GENERAL	5.00	0	2,410,740		2
0	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,949		3
0		0.00	0	o		4
	TOTALS			2,637,045		
	G - RECLASS BENEFITS			rana biyaying desteri		1288945
0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,466,072		
-	TOTALS			2,466,072		
	H - RECLASS EQUIPMENT RENTAL		usery company			TWEET
0	CAP REL COSTS-MVBLE EQUIP	2.00	0	519,854		1
0	CAP REE COSTS WINDEL EQUIT	0.00	ŏ	015,054		
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	TOTALS		0	519,854		
	K - RECLASS CRNA COSTS					Preference .
0	OPERATING ROOM	50.00	0	89 <u>7,0</u> 97		
	TOTALS		0	897,097		
	N - RECLASS NUC MED & CT COST	S				
0	RADIOISOTOPE	56.00	74,244	204,112		
0	CT SCAN	57.00	261,996	185,708		
	TOTALS	 +	336,240	389,820		
	O - MARKETING RECLASS		s consider vivials in			100000000000000000000000000000000000000
0	MARKETING ADVERTISING	194.00	U)	21,754	<u> </u>	1
~	TOTALS			$-\frac{21,754}{21,754}$		-
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O - MARKETING RECLASS

ADMINISTRATIVE & GENERAL

TOTALS

TOTALS
500.00 Grand Total: Decreases

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0176 Period

Period: Worksheet A-7
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/31/2017 12:08 pm

Acquisitions Total Beginning Purchases Disposals and Donation Balances Retirements 2.00 3.00 4.00 1.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 0 1.00 2.00 Land Improvements 0 0 0 2.00 0 0 0 0 Buildings and Fixtures 0 3.00 3.00 0 Building Improvements 1,389,500 230,517 4.00 4.00 230,517 5.00 Fixed Equipment 639,027 0 5.00 304,470 6.00 Movable Equipment 13,388,946 304.470 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 15,417,473 0 534,987 0 8.00 Reconciling Items 0 0 9.00 9.00 10.00 Total (line 8 minus line 9) 15,417,473 534,987 534,987 0 10.00 Ending Balance Fully Depreciated Assets 6,00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 0 0 0 0 0 2.00 Land Improvements 2.00 3.00 Buildings and Fixtures 3.00 Building Improvements 1,620,017 4.00 4.00 5.00 639,027 5.00 Fixed Equipment Movable Equipment 6.00 6.00 13,693,416 7.00 7.00 HIT designated Assets Subtotal (sum of lines 1-7) Reconciling Items 8.00 15,952,460 8.00 9.00 9.00 10.00 Total (line 8 minus line 9) 15,952,460 10.00

Healt	n Financial Systems	KENTUCKIANA MEDI	ICAL CENTER		In Lie	u of Form CMS-	<u> 2552-10</u>
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	N: 15-0176	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part II Date/Time Pre 5/31/2017 12:	pared:
			SUN	MARY OF CAP	ITAL		
U.S.	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9.00	10,00	11.00	12.00	13.00	4 5 6 6 5
	PART II - RECONCILIATION OF AMOUNTS FR	OM WORKSHEET A, COLUMN	2, LINES 1 an	d 2			
1.00	CAP REL COSTS-BLDG & FIXT	3,857,599	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,436,131	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	6,293,730	0		0 0	0	3.00
		SUMMARY OF	CAPITAL				
	Cost Center Description	Capital-Relate	otal (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FR	OM WORKSHEET A, COLUMN	2, LINES 1 an	d 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,857,599				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,436,131				2.00
3.00	Total (sum of lines 1-2)	0	6,293,730				3.00

Health	n Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	1	Period: From 01/01/2016 Fo 12/31/2016		
		СОМІ	PUTATION OF RAT	rios	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
		1.00	2,00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COS						
1.00	CAP REL COSTS-BLDG & FIXT	24,071,039		24,071,03		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,693,416		13,693,41		0	2.00
3.00	Total (sum of lines 1-2)	37,764,455	0	37,764,45			3.00
		ALLOCA"	TION OF OTHER	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1,065,576	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2,955,985	0	2.00
3.00	Total (sum of lines 1-2)	0	0		4,021,561	0	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	1000
	PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS	न्यक्षिक्ष रेड्ड कर्ने होते.		Carl and the Charles		
1.00	CAP REL COSTS-BLDG & FIXT	0	0	211,35	6 0	1,276,932	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,949		0	2,970,934	2.00
3.00	Total (sum of lines 1-2)	0	14.949	211.35	6 0	4,247,866	3.0

Provider CCN: 15-0176

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared:

					To 12/31/2016	Date/Time Prep 5/31/2017 12:0	
				Expense Classification o			JO DIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	220030
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1,00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)			-	2.22		
3.00	Investment income – other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	o	4.00
5.00	discounts (chapter 8) Refunds and rebates of	8	FE 201	ADMINISTRATIVE & GENERAL	5.00	0	5.00
3.00	expenses (chapter 8)	b	30,281	ADMINISTRATIVE & GENERAL	3.00		3.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay	Α	-12 396	ADMINISTRATIVE & GENERAL	5.00	0	7.00
7.00	stations excluded) (chapter		-12,550	ADMINISTRATIVE & GENERAL	3.00	Ŭ	7.00
0.00	21)		10.045	MATUTENANCE & REPAIRS	6.00	10	9 00
8.00	Television and radio service (chapter 21)	Α	-10,945	MAINTENANCE & REPAIRS	6.00	10	8.00
9.00	Parking lot (chapter 21)		0		0.00	1	
10.00	Provider-based physician adjustment	A-8-2	-2,282,293	,		0	10.00
11.00	Sale of scrap, waste, etc.		o		0.00	o	11.00
	(chapter 23)						42.00
12.00	Related organization transactions (chapter 10)	A-8-1	-5,123,411			0	12.00
13.00	Laundry and linen service		0		0.00	o	13.00
14.00	Cafeteria-employees and guests		-154,044	CAFETERIA	11.00		
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than						
17.00	Sale of drugs to other than		0		0.00	o	17.00
10.00	patients	_	4 220	MEDICAL RECORDS & LIBRARY	15.00		10.00
18.00	Sale of medical records and abstracts	В	-4,328	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees,	,	0		0.00	0	19.00
20.00	books, etc.) Vending machines				0.00	0	20.00
	Income from imposition of	В	-53,861	ADMINISTRATIVE & GENERAL	5.00		
	interest, finance or penalty		-				
22.00	charges (chapter 21) Interest expense on Medicare		o		0.00	0	22.00
22100	overpayments and borrowings to	o				_	
22 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	,	RESPIRATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of	A-6-3	٥	RESPIRATORY THERAPY	03.00		23,00
	limitation (chapter 14)		_				
24.00	Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSICAL THERAPY	66.00		24.00
	limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
	(chapter 21)			4			
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		_	CAP REL COSTS-MVBLE EQUIP	2.00	م	27.00
27.00	COSTS-MVBLE EQUIP		Ĭ	CAI KEE COSTS MADEE EQUIT	2.00	Ĭ	27.00
28.00			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0.00 67.00	,	29.00 30.00
20.00	therapy costs in excess of						
30.99	limitation (chapter 14) Hospice (non-distinct) (see		_	ADULTS & PEDIATRICS	30.00		30.99
20.23	instructions)			UDOCIO & LEDIMIKICO	30.00		30.93
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)	1					
32.00	CAH HIT Adjustment for		0		0.00	О	32.00
33 VV	Depreciation and Interest	D.	637	ADMINISTRATIVE & GENERAL	5.00	o	33.00
33.00 34.00	· ·	В	-637	1	0.00		34.00

In Lieu of Form CMS-2552-10 KENTUCKIANA MEDICAL CENTER Health Financial Systems Period: From 01/01/2016 Provider CCN: 15-0176 Worksheet A-8 ADJUSTMENTS TO EXPENSES Date/Time Prepared: 5/31/2017 12:08 pm То 12/31/2016 Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 3.00 4.00 5.00 1.00 2.00 -94,248 ADMINISTRATIVE & GENERAL 5.00 35.00 35.00 NON-ALLOWABLE EXPENSES Α 0.00 35.01 35.01 4.00 0 35.02 -455 EMPLOYEE BENEFITS DEPARTMENT 35.02 BENEFITS APPLICABLE TO PATIENT Α PHONE 0.00 0 37.00 37.00 40.00 -673,306 ADMINISTRATIVE & GENERAL 40.00 ADMIN TAXES -HAF PAYMENTS Α 5.00 0 40.01 INTEREST PAID MEDICARE -36,725 ADMINISTRATIVE & GENERAL 5.00 40.01

-8,502,930

50.00

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

50.00

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

⁽Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

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.

STATEME OFFICE	Financial Systems ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0176	Period: From 01/01/2016 To 12/31/2016		pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTI HOME OFFICE COSTS:			ORGANIZATIONS OR		1 00
1.00		CAP REL COSTS-BLDG & FIXT	FACILITY LEASE	907 515	3,689,538	1.00 2.00
2.00		CAP REL COSTS-BLDG & FIXT	DEPRECIATION	897,515	2 221 200	3.00
3.00 4.00		ADMINISTRATIVE & GENERAL	INTEREST	0	2,331,388	4.00
4.00	0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to			897,515	6,020,926	5.00

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (
	(1)	Name	Percentage of Ownership	Name	Percentage of Ownership
1.00		2.00	3.00	4.00	5,00

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	CARDIOVASCULAR	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		1			100.00
	non-financial) specify:					

- (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

<u>Health</u>	Financial Systems		KENTUCKIANA MEDI	CAL CENTER	In Lie	u of Form C	
STATEM! OFFICE		VICES FROM RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-0176	Period: From 01/01/2016 To 12/31/2016	Worksheet Date/Time 5/31/2017	Prepared:
	Adjustments (col. 4 minus col. 5)*	7.00					
	A. COSTS INCURRED HOME OFFICE COSTS:		QUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAIMED	
1.00	-3,689,538	9					1.00
2.00	897,515	9					2.00
3.00	-2,331,388	o					3.00
4.00	0	0					4.00
5.00	-5,123,411						5.00
appropi	riate.Positive amou	nts increase cost	as appropriate) are trar and negative amounts decr 1 and/or 2, the amount a	rease cost.For related o	rganization or hom	ne office co	ost which
	Related Organiza and/or Home O						
	Type of Busi	ness					

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

I C I BIDUI	Selliette attact cicle varrri	
6.00	REAL ESTATE	6.00
7.00	REAL ESTATE	7.00
8.00	REAL ESTATE	8.00
9.00	HOSPITAL	9.00
10.00		10.00
100.00		100.00

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

6.00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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.

In Lieu of Form CMS-2552-10 Health Financial Systems KENTUCKIANA MEDICAL CENTER Period: From 01/01/2016 PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0176 Worksheet A-8-2 Date/Time Prepared: 5/31/2017 12:08 pm Physician/Prov 12/31/2016 Provider RCE Amount Cost Center/Physician Professional Wkst. A Line # Total Remuneration ider Component Identifier Component Component Hours 7.00 5.00 6.00 4.00 1.00 2,00 3.00 1.00 1.00 0.00 0000000 0 2.00 0.00 0 2.00 0 3.00 3.00 0.00 4.00 50.00 OPERATING ROOM 897,090 897,090 4.00 0 5.00 5.00 91.00 EMERGENCY 1,177,906 1,177,906 0 6.00 6.00 0.00 0 7.00 207,297 207,297 7.00 54,00 RADIOLOGY-DIAGNOSTIC 0 8.00 0.00 8.00 9.00 0.00 0 9.00 10.00 10.00 0.00 200.00 2,282,293 2,282,293 200.00 Provider Physician Cost Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Wkst. A Line # Unadjusted RCE Memberships & Component of Malpractice Identifier Limit Continuing Share of col. Insurance Limit Education 12 14.00 9.00 13.00 1.00 2.00 8.00 12.00 1.00 1.00 0.00 0 0 n 0 0 2.00 0.00 00000000 2.00 0 0 0 0 0 0 0 0 3.00 3.00 0.00 0 4.00 4.00 50.00 OPERATING ROOM 0 0 5.00 91.00 EMERGENCY 0 5.00 0 000 6.00 6.00 0.00 0 7.00 54.00 RADIOLOGY-DIAGNOSTIC 7.00 8,00 8.00 0.00 9.00 0.00 9.00 0 10.00 0.00 10.00 200.00 200.00 Adjusted RCE Cost Center/Physician Provider RCE Adiustment Wkst. A Line # Disallowance Component Limit Identifier Share of col. 14 17.00 18.00 2.00 15.00 16.00 1.00 1.00 1.00 0.00 0000000 0 0 2.00 2.00 0.00 3.00 0.00 0 3.00 50.00 OPERATING ROOM 0 897,090 4.00 4.00 000000 5.00 5.00 91.00 EMERGENCY 0 0 0 0 1,177,906 6.00 0.00 6.00 207.297 7.00 54.00 RADIOLOGY-DIAGNOSTIC 7.00 8.00 8.00 0.00

0

0

9.00

10.00

200.00

2,282,293

9.00

10.00

200.00

0.00

0.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0176

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | Part I |
| To | 12/31/2016 | Date/Time | Prepared: | 5/31/2017 | 12:08 pm

				To	12/31/2016	Date/Time Pre 5/31/2017 12:	
			CAPITAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		col. 7) 0	1,00	2.00	4.00	4A	26 (2006)
[activation	GENERAL SERVICE COST CENTERS	1 0	1.00	2,00	4,00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1,276,932	1,276,932				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2,970,934	• •	2,970,934			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2,867,647	17,983	41,839	2,927,469		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4,801,093	115,676		353,186	5,539,088	5.00
6.00	00600 MAINTENANCE & REPAIRS	1,420,621	362,725	843,922	38,301	2,665,569	6.00 7.00
7.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	646 772	19,535	45,451	0	0 711,758	8.00
8.00 9.00	00900 HOUSEKEEPING	646,772 381,754	28,274		ŏ	475,810	9.00
10.00	01000 DIETARY	56,263	47,948		46,575	262,343	í
11.00	01100 CAFETERIA	155,652	26,215	60,993	35,235	278,095	11.00
13.00	01300 NURSING ADMINISTRATION	286,308	9,070	21,102	68,441	384,921	1
14.00	01400 CENTRAL SERVICES & SUPPLY	4,390,857	34,745	80,837	0	4,506,439	
15.00	01500 PHARMACY	752,748	9,000	20,940	72,270	854,958	
16.00	01600 MEDICAL RECORDS & LIBRARY	207,181	23,704	55,150	45,604	331,639 0	1
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	i .
19.00	INPATIENT ROUTINE SERVICE COST CENTERS						13.00
30.00	03000 ADULTS & PEDIATRICS	4,575,246	369,824	860,437	1,100,245	6,905,752	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	L .
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS	4 044 420	120 000	200.204	270 900	2 520 622	FO 00
50.00 51.00	05000 OPERATING ROOM	1,841,130	128,600	299,204	270,899	2,539,833 0	50.00
53.00	05100 RECOVERY ROOM 05300 ANESTHESIOLOGY	0	0	٥	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	214,518	11,093	25,810	69,565	320,986	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	
56.00	05600 RADIOISOTOPE	278,356	12,750	29,665	20,273	341,044	56.00
57.00	05700 CT SCAN	461,231	11,390	26,499	71,541	570,661	
58.00	05800 MRI	0	0	0	0.	1 100 735	1
59.00	05900 CARDIAC CATHETERIZATION	956,313	25,430		155,815	1,196,725	
60.00 61.00	06000 LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	2,130,616	9,628	22,401	107,138	2,269,783 0	I .
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	ŏ	0	o	0	ő	
64.00	06400 INTRAVENOUS THERAPY	0	0	o	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	618,587	3,174	7,386	155,461	784,608	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	200 201	4 330	0 961	81,999	0 405,379	68.00
69.00 70.00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	309,281	4,238	9,861	01,999	403,379	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ŏ	ő	o	ő	Ö	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	o	0	0	72.00
73.00	1 I	852,736	0	o	0	852,736	73.00
	OUTPATIENT SERVICE COST CENTERS			MERICAL SOLUTIONS			
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	0	
90.00	09000 CLINIC	926,891	5,930	13,798	234,921	1,181,540	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	920,691	3,930	13,796	234,321	0	1
32.00	OTHER REIMBURSABLE COST CENTERS			\$50\$9\$\$\$\$\$\$\$\$\$\$			1
99.00	09900 CMHC	0	0	0	0	0	99.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00 118.00		33,379,667	1,276,932	2,970,934	2,927,469	33,379,667	113.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l 0	0	ol	n	n	190.00
	19100 RESEARCH	0		Ö	ő		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	Ö	Ö	ا م	ō	0	192.00
	07951 MARKETING/ ADVERTISING	21,754	0	0	0	21,754	194.00
200.00						0	200.00
201.00	1 1 7		0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	33,401,421	1,276,932	2,970,934	2,927,469	33,401,421	202,00

				To	o 12/31/2016	Date/Time Pre 5/31/2017 12:	
	Cost Center Description	ADMINISTRATIVE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	JO PIII
		& GENERAL	REPAIRS	PLANT	LINEN SERVICE	0.00	
<u> Herrican</u>	GENERAL SERVICE COST CENTERS	5.00	6.00	7,00	8.00	9,00	9357253344
1.00	00100 CAP REL COSTS-BLDG & FIXT	1	- <u> </u>		TO CONTRACT AND AND AND AND AND AND AND AND AND AND		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	5,539,088					5.00
6.00	00600 MAINTENANCE & REPAIRS	529,920	3,195,489				6.00
7.00	00700 OPERATION OF PLANT	0	0	0			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	141,499	79,975		933,232	606 151	8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DIETARY	94,592	115,749		0	686,151 44,900	
11.00	01100 CAFETERIA	52,154 55,286	196,295 107,323		0	24,549	
13.00	01300 NURSING ADMINISTRATION	76,523	37,131		0	8,493	1
14.00	01400 CENTRAL SERVICES & SUPPLY	895,889	142,241		0	32,535	1
15.00	01500 PHARMACY	169,967	36,845		0	8,428	1
16.00	01600 MEDICAL RECORDS & LIBRARY	65,930	97,041		ō	22,197	1
17.00	01700 SOCIAL SERVICE	0	0	o	0	. 0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	o	0	o	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1,372,878	1,514,021		933,232	346,308	
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	1
	04400 SKILLED NURSING FACILITY	. 0	0	0	0	0	1
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	504,924	526,476		0	120,424	1
	05100 RECOVERY ROOM	0	0	0	U	0	
53.00 54.00	05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	63,813	45,414	0	0	10,388	
55.00	05500 RADIOLOGY-THERAPEUTIC	03,613	43,414	0	0	10,388	l
56.00	05600 RADIOISOTOPE	67,800	52,198	Ŏ	0	11,939	1
57.00	05700 CT SCAN	113,449	46,628		0	10,665	1
58.00	05800 MRI	0	0	_ :	0	0	l
59.00	05900 CARDIAC CATHETERIZATION	237,911	104,110	o	0	23,814	
60.00	06000 LABORATORY	451,237	39,416		0	9,016	,
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	155,982	12,996	0	0	2,973	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	1
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY	80 500	17 757	0	U	3 060	68.00
69.00 70.00	06900 ELECTROCARDIOLOGY	80,590	17,352	0	0	3,969	1
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	١			1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	n o	0	١	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	169,526	n	ŏ	ő	ا	1
, . , . , .	OUTPATIENT SERVICE COST CENTERS	1000					1
88,00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	o	0	0	90.00
91.00	09100 EMERGENCY	234,893	24,278	0	0	5,553	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS				A LEXING MARKING TO		
	09900 CMHC	0	0		0		
101.00	10100 HOME HEALTH AGENCY	[0	0	0	0	U	101.00
443.00	SPECIAL PURPOSE COST CENTERS			(957) (984) 974) (916)			112 00
	11300 INTEREST EXPENSE	E 524 762	2 105 400	o	022 222	696 151	113.00
118.00		5,534,763	3,195,489	<u>, 0</u>	933,232	686,151	110.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	0		190.00
	19100 RESEARCH		0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	1 0	0	0	0		192.00
	07951 MARKETING/ ADVERTISING	4,325	0	0	0		194.00
200.00		7,525	•				200.00
201.00		0	0	0	0	0	201.00
202.00		5,539,088	3,195,489	o	933,232	· ·	
			, , ,			,	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0176

| Period: | Worksheet B | Part I | | To | 12/31/2016 | Date/Time Prepared: | 5/31/2017 | 12:08 pm |

Cost Center Description						12/31/2010	5/31/2017 12:	
CEMERAL SERVICE COST CENTERS		Cost Center Description	DIETARY	CAFETERIA		SERVICES &		
GENERAL SERVICE COST CENTERS			10.00	11.00	13.00		15.00	
0.0200 CAP REL COSTS-MUSLE EQUIP		GENERAL SERVICE COST CENTERS						
0.0400 DMPLOYEE BENEFITS DEPARTMENT								1.00
0.000 0.00								2.00
0.000 0.0600 MAINTENANCE & REPAIRS								4.00
7.00 0.0700 OPERATION OF PLANT		The state of the s						5.00
8.00 00800 LANDRY & LTNEN SERVICE								6.00
9.00 00900 HOUSEKEPING 11.00 01000 OTEPARY 555,692 11.00 01100 CAFETRIA 0 465,253 11.00 01100 CAFETRIA 0 6,804 513,872 11.00 01300 MURSING ADMINISTRATION 0 6,804 513,872 11.00 01300 MURSING ADMINISTRATION 0 0 0 0 0 0 0 0 1,084,2 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0,674 0 0 0 0 0 0 0 0 0								7.00
10.00 01000 DETRARY 555,692								9.00
11.00 01000 CAFETERIA 0 465,255 14.00 01400 MUSRIMG ADMINISTRATION 0 60,00 513,872 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 5,577,104 16.00 01600 MEDICAL RECORDS & LIBRARY 0 9,674 0 0 0 0 19.00 01600 MEDICAL RECORDS & LIBRARY 0 9,674 0 0 0 0 19.00 01600 MEDICAL RECORDS & LIBRARY 0 9,674 0 0 0 0 19.00 01900 MONPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 19.00 01900 MONPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 19.00 03000 ADULTS & PEDIATRICS 555,692 195,675 308,615 0 0 0 0 0 44.00 04000 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0			555 692					10.00
13.00 0.300 NURSING ADMINISTRATION 0 6,804 513,872 1.400 0.140 0.140 0.140 0.140 0.140 0.140 0.140 0.150 0.150 0.150 0.140 0.150 0.150 0.140 0.150			333,032	465.253				11.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 5,577,104			l ől					13.00
15.00 01500 PHARMACY 0 14.078 0 0 1,084,2			ol	0,511	l	5.577.104		14.00
16.00 01600 MEDICAL RECORDS & LIBRARRY 0 9,674 0 0 0 0 0 0 0 0 0			o	14.078	Ö	0	1,084,276	1
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0			0			o	0	
INPATIENT ROUTINE SERVICE COST CENTERS			o	_	_1	o	0	17.00
30.00 03000 ADULTS & PEDIATRICS 555,692 195,675 308,615 0 0 0 0 0 0 0 0 0	19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	o	o	0	19.00
31.00 03100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS				10 man 2000 Miles (2)		
44.00 04400 SKILLED NURSING FACILITY		i e e e e e e e e e e e e e e e e e e e	555,692	195,675	308,615	0	0	30.00
AS-DO			0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS			0	0	0	0	0	1
50.00 05000 0PERATING ROOM	45.00		0	0	0	0	0	45.00
11.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
53.00 05300 ANESTHESIOLOGY 0 0 0 0 0 0 0 0 0			0	59,131	93,243	1	0	1
54.00 05400 RADIOLOGY-DIACNOSTIC 0 10,391 0 0 0 0 0 0 0 0 0			0	0	0	0	0	1
55.00 05500 RADIOLOGY-THERAPEUTIC			0	40.704	0	0	0	1
56.00 05600 RADIOISOTOPE 0 3,018 0 0 0 0 0 0 0 0 0			0	10,391	0	0	0	1
57.00 05700 CT SCAN 0 10,688 0 0 0 0 0 0 0 0 0			0	2.010	0	0	0	
\$8.00 05800 MRI 0						U	0	1 20100
59.00 05900 CARDIAC CATHETERIZATION 0 43,890 34,612 0 0 0 0 0 0 0 0 0			0	10,088		o o	0	57.00
60.00 06000 Laboratory 0 20,238 0 0 0 0 0 0 0 0 0				43 900	24 612	o o	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0			0			0	0	33.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0			9	20,236	١	٩	U	61.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0				0	ام	0	0	1
65.00 06500 RESPIRATORY THERAPY 0 28,007 44,180 0 06.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1		ŏ	28.007	44 180	ام	0	65.00
67.00 06700 OCCUPATIONAL THERAPY O O O O O O O O O			ŏ	20,007	0	o o	Ŏ	66.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0			o	Ö	o	o	Ö	67.00
69.00 06900 ELECTROCARDIOLOGY 0 21,055 33,222 0 70.00 07000 ELECTROCEPHALOGRAPHY 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 668,843 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 4,908,261 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 074.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 075.00 O75.00 DRUGS CHARGED TO PATIENTS 0 0 0 075.00 O75.00 DRUGS CHARGED TO PATIENTS 0 0 0 08800 RURAL HEALTH CLINIC 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 090.00 09000 EMERGENCY 0 42,604 0 0 090.00 091.00 EMERGENCY 0 42,604 0 0 092.00 OBSERVATION BEDS (NON-DISTINCT PART 07HER REIMBURSABLE COST CENTERS 99.00 O9900 CMHC 0 0 0 09000 OMBO OMBO OMBO OMBO 09000			0	0	o	o	Ö	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0			o	21,055	33,222	o	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 4,908,261 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 000 074,000 074,000 0 0 000 074,000 0 0 0 000 074,000 0 0 000 074,000 0 0 000 074,000 0 000 0 0 0 000 0 0	70.00	07000 ELECTROENCEPHALOGRAPHY	0	, O	0	o	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 1,084,2	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	o	668,843	0	71.00
SERVICE COST CENTERS SUBJUSTIALS (SUM OF LINES 1-117) S55,692 SUBTOTALS (SUM OF LINES 1-117) S10,000 S10,000 SESARCH SUBTOTALS (SUM OF LINES 1-117) S10,000	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	o	4,908,261	0	72.00
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	O	0	1,084,276	73.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0						13, 44,7124,081,197,787		
90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0		0	1
91.00 09100 EMERGENCY 0 42,604 0 0 0 0 0 0 0 0 0			0	0	0		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS O9900 CMHC O O O O O O O O O			0	0	0	- 1	0	
OTHER REIMBURSABLE COST CENTERS 99.00 OHEC O O O O O O O O O			0	42,604	0	0	.0	
99.00 09900 CMHC 0 0 0 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0			1,000,000,000,000,000	reference to the first and the			arianda a secola esta esta esta esta esta esta esta est	92.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 0	the same and same				
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) 555,692 465,253 513,872 5,577,104 1,084,2			1 .				0	
113.00 11300 INTEREST EXPENSE	101.00	CRECTAL PURPOSE COST SENTERS	<u> </u>	U Control selektron e strete	<u> </u>		U	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 555,692 465,253 513,872 5,577,104 1,084,2				e a con estáblica de ser decen	and a second bloods and advanta	Stranger False and and other	57 BN 1304 (1368 74 14	113.00
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 19100 RESEARCH 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 0 0			EEE 602	465 353	E12 072	E 577 104	1 004 376	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191.00 19100 RESEARCH 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0				403,233] 313,6/Z	3,3/1,104	1,004,270	1110.00
191.00 19100 RESEARCH 0 0 0 0 0 0 192.00 19	190.00	19000 GTET. FLOWER, COFFEE SHOP & CANTEEN	l ol	Λ	ام	n	Λ	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0					1	l.		191.00
			0	0	1	0		192.00
			0	0	ام	0		194.00
200.00 Cross Foot Adjustments			1	U	١	٩	U	200.00
201.00 Negative Cost Centers 0 0 0 0			o	0	o	o	0	201.00
			555.692	465.253	513.872	5,577.104	1,084,276	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				Т	o 12/31/2016	Date/Time Pre 5/31/2017 12:	
	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16,00	17.00	19.00	24.00	25.00	100
G	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00500 ADMINISTRATIVE & GENERAL						5.
	00600 MAINTENANCE & REPAIRS						6.
	00700 OPERATION OF PLANT						8.
I	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						9,
	01000 DIETARY						10.
	01100 CAFETERIA						111
	01300 NURSING ADMINISTRATION						13.
	01400 CENTRAL SERVICES & SUPPLY						14.
	01500 PHARMACY						15.
6.00	01600 MEDICAL RECORDS & LIBRARY	526,481					16.
7.00	01700 SOCIAL SERVICE	0	0				17.
9.00 🛭	01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.
	INPATIENT ROUTINE SERVICE COST CENTERS					· 1 / 2015 · 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1	
	03000 ADULTS & PEDIATRICS	68,446	0		, ,	0	1
	03100 INTENSIVE CARE UNIT	0	0	0		0	
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	1
	04500 NURSING FACILITY	<u>0</u>	0		l U		45
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	44,357	0	0	3,888,388	0	50
	D5100 RECOVERY ROOM	0	0	0	3,000,300	ő	1
	05300 ANESTHESIOLOGY	0	0	0	0	ŏ	1
	05400 RADIOLOGY-DIAGNOSTIC	19,635	0	0	470,627	Ö	1
	D5500 RADIOLOGY-THERAPEUTIC	0	Ō	ō	0	o	1
	D5600 RADIOISOTOPE	22,574	0	0	498,573	o	1
	05700 CT SCAN	20,161	0	o	772,252	0	57
3.00	05800 MRI	0	0	0	0	0	58
9.00 0	05900 CARDIAC CATHETERIZATION	81,932	0	0	1,722,994	0	59
0.00	06000 LABORATORY	107,962	0	0	2,897,652	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			*	0		61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
	06400 INTRAVENOUS THERAPY	0	0	0	0	0	1
	06500 RESPIRATORY THERAPY	18,476	0	0	1,047,222	0	1
	06600 PHYSICAL THERAPY	U	U	0	0	0	1
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		0	1
	06900 ELECTROCARDIOLOGY	14,379	0	0	575,946	-	1
	07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	14,375	0	0	373,540	Ö	1
- 1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,767	0	, o	673,610	1	
	07200 IMPL. DEV. CHARGED TO PATIENTS	34,985	0	0	4,943,246	1	1
	07300 DRUGS CHARGED TO PATIENTS	66,735	0	0	2,173,273		73.
C	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88
00.6	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	. 0	0	0	1
	09000 CLINIC	0	0	0		0	
	09100 EMERGENCY	22,072	0	0	1,510,940		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	To A TIN Horse Nectors are on the Area.	Devolutes to thought on the first			0	92
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	. 0	99
	09900 CMHC 10100 HOME HEALTH AGENCY	0	0	ł	£	l .	101
	SPECIAL PURPOSE COST CENTERS						101
	11300 INTEREST EXPENSE	- 6	and the first of the same of the same	19. 10. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19	1	Street, 100 March 2010 100 March 100	113
8.00	SUBTOTALS (SUM OF LINES 1-117)	526,481	0	0	33,375,342	n	118
	NONREIMBURSABLE COST CENTERS	ing the second				Breson Baselin	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19100 RESEARCH	o	0	0	O		191
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192
	07951 MARKETING/ ADVERTISING	0	0	0	26,079		194
00.00	Cross Foot Adjustments			0	0		200
01.00	Negative Cost Centers	0	0	0	1		201
02.00	TOTAL (sum lines 118-201)	526,481	0	l 0	33,401,421	1 0	202

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0176

Period: From 01/01/2016

Worksheet B
Part I
Date/Time Prepared: 12/31/2016 5/31/2017 12:08 pm Cost Center Description Total 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DIETARY 10.00 11.00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 |01600|MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12,200,619 30.00 31.00 03100 INTENSIVE CARE UNIT 31,00 04400 SKILLED NURSING FACILITY 44.00 44.00 45.00 04500 NURSING FACILITY 0 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3,888,388 50.00 51.00 05100 RECOVERY ROOM 51.00 05300 ANESTHESIOLOGY 53.00 53,00 54,00 05400 RADIOLOGY-DIAGNOSTIC 470,627 54.00 05500 RADIOLOGY-THERAPEUTIC 55.00 55.00 56.00 05600 RADIOISOTOPE 498,573 56.00 05700 CT SCAN 57.00 772,252 57.00 58.00 05800 MRI 58.00 59.00 05900 CARDIAC CATHETERIZATION 1,722,994 59.00 06000 LABORATORY 60.00 2,897,652 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 64.00 06400 INTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 1,047,222 65.00 66.00 06600 PHYSICAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 68,00 69.00 06900 ELECTROCARDIOLOGY 575,946 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71,00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 673,610 71.00 72,00 07200 IMPL. DEV. CHARGED TO PATIENTS 4,943,246 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,173,273 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLINIC 90.00 90.00 91.00 09100 EMERGENCY 1,510,940 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92,00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 33,375,342 118,00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191.00 19100 RESEARCH 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 194.00 07951 MARKETING/ ADVERTISING 26.079 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118-201) 33,401,421 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0176

| Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 5/31/2017 12:08 pm

2.00 0.0200 CAP REL COSTS-MURLE EQUIP		en en adres de la companya del companya de la companya de la companya del companya de la company	· Frank, was the control of the			Starten and the second	5/31/2017 12:	08 pm
SEMBRAL SERVICE COST CENTERS				CAPITAL REI	LATED COSTS			
CREMENT SERVICE COST CENTERS		Cost Center Description	Assigned New Capital	BLDG & FIXT		Subtotal	BENEFITS DEPARTMENT	
1.00 00.000 CAP REL COSTS-BLOG & FENT	[max/self]		0	1.00	2.00	2A	4.00	2,862.48
2.00 00200 CAP REL COSTS-MMBLE EQUIP	4 00				and State State States a		alternative freeze and a	4 00
4.00 00000 DePLOYEE SERVETTS DEPARTMENT 0 17,983 14,839 59,822 3 384,809 7,217 5 6 6 6 6 6 6 6 6 6								1.00
0.000 0.000 AMENISTRATURE & CEMERAL 0 115,676 269,133 334,800 7,217 783 6.00 0.000 AMENISTRANCE & REPAIRS 0 362,725 843,922 1,206,647 783 6.00 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000				17 002	41 920	EG 922	ະດ ຄວວ	2.00
0.000 0.0000 MAINTERNANCE & REPAIRS 0 362,725 843,922 1,206,647 783 6 8.00 8 9.00 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000						- 1		
0,000 0,00			o o					t .
8.00 00500 LANDRY & LINEN SERVICE 0 19,535 45,451 64,986 0 8 10.00			ő	302,723 N	043,322	1,200,047		
9.00 0.9900 MUSEKEEPINS			ő	19.535	45.451	64,986		F.
10.00 0.1000 DETARY 0 47,948 111,577 159,505 595 10			ol	•			0	F .
11.00 01100 CAFETERIA 0 26,215 60,993 87,208 720 11 11.00 01300 MURSING ADMINISTRATION 0 9,0707 21,102 30,172 1,399 13 14.00 01400 CENTRAL SERVICES & SUPPLY 0 34,745 80,837 115,582 0 14 15.00 01500 MURSING ADMINISTRATION 0 20,940 20,940 29,940 1,477 15.00 01500 MEDICAL RECORDS & LIBRARY 0 23,704 55,150 78,854 932 16 10.00 10.00 01500 MURSING ADMINISTRATION 0 0 0 0 0 0 0 0 0			o			, ,	952	1
14.00 0.1400 CENTRAL SERVICES & SUPLY 0 34.745 80.837 115.582 0.14 15.00 0.1500 PIRAPMACY 0 9.000 20.940 29.940 1.477 15.10 15.00 0.1500 DIRAPMACY 0 23.7704 55.150 78.854 932 16.10 17.00 17.00 0.1700 SOCIAL SERVICE 0 0 0 0 0 0 17.00 17.00 0.1700 SOCIAL SERVICE 0 0 0 0 0 0 19.00 0.900 NORPHYSICIAN ANISTHETISTS 0 0 0 0 0 0 0 19.00 NORPHYSICIAN ANISTHETISTS 0 0 0 0 0 0 0 19.00 NORPHYSICIAN ANISTHETISTS 0 0 0 0 0 0 0 0 19.00 NORPHYSICIAN ANISTHETISTS 0 0 0 0 0 0 0 0 19.00 SOULD ABULTS & PEDIATRICS 22.481 0 0 0 0 0 0 0 0 19.00 SUILLED WIRSTING FACILITY 0 0 0 0 0 0 0 0 0	11.00	01100 CAFETERIA	o				720	11.00
15.00 01500 PHARNACY 0 9,000 20,940 29,940 1,477 15.10 01600 01600 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0	13.00	01300 NURSING ADMINISTRATION	0	9,070	21,102	30,172	1,399	13.00
16.00 0.1600 MEDICAL RECORDS & LIBRARY 0 23,704 55,150 78,854 932 19.00 19	14.00	01400 CENTRAL SERVICES & SUPPLY	0	34,745	80,837	115,582	0	14.00
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0	15.00		0	9,000	20,940	29,940	1,477	15.00
19.00 0.900 NONPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 0 0			0	23,704	55,150	78,854	932	
INFATIENT ROUTINE SERVICE COST CENTERS 0 369,824 860,437 1,230,261 22,481 31.00 3000 ADUITS & PEDITATRICS 0 369,824 860,437 1,230,261 22,481 31.00 3100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0	0	0		1
30.00 3000 ADULTS & PEDIATRICS 0 369,824 860,437 1,230,261 22,481 30.00 31.00 310.00 MINENSIVE CARE WINT 0 0 0 0 0 0 0 0 0	19.00		0	0	0	0	0	19.00
31.00 03100 INTENSIVE CARE UNIT	20.00			200 024	000 405	4 220 264	07.404	30.00
44.00		1	١	· _	860,437	1,230,261	·	
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MACILLARY SERVICE COST CENTERS				0	0	0		1
50.00	43.00						F \$ Jain Hardes Sec. 18	43.00
51.00 OS100 RECOVERY ROOM	50.00		1 0	128 600	299.204	427.804	5 536	50.00
53.00 OS300 ANSTHESTOLOGY			o		0	0		1
54.00 05400 RADIOLOGY-DIACNOSTICE 0 11.093 25,810 36,903 1.422 55 50.00 05500 RADIOLOGY-THERAPEUTCC 0 0 0 0 0 0 5 5 5 5			ol	Ō	ō	0		53.00
55.00 OSDOO RADIOLOGY-THERAPEUTIC	54.00		o	11.093	25,810	36,903	1,422	
56.00 05600 RADIOTISOTOPE 0 12,750 29,665 42,415 414 55 57.00 570.00	55.00		o	. 0	0	0		
58.00 05800 MRI	56.00	05600 RADIOISOTOPE	o	12,750	29,665	42,415	414	56.00
59.00 05900 CARDIAC CATHETERIZATION 0 25,430 59,167 84,597 3,184 59 60.00 66000 LABORATORY 0 9,628 22,401 32,029 2,189 60 61.00 0 0 0 0 0 0 0 62.00 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	11,390	26,499	37,889	1,462	57.00
60.00 06000 LABORATORY 0 9,628 22,401 32,029 2,189 50 61.00 60.0	58.00		0	0	0	0	0	58.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 62 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 3,174 7,386 10,560 3,177 65.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 67.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 67.10 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 67.10 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 67.10 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 67.10 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 68.00 08900 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 68.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 68.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 68.00 09900 CLINIC 0 0 0 0 0 0 69.00 09900 CLINIC 0 0 0 0 0 0 69.00 09900 CMIC 0 0 0 0 0 0 69.00 09900 CMIC 0 0 0 0 0 69.00 09900 CMIC 0 0 0 0 0 69.00 09900 CMIC 0 0 0 0 0 0 69.00 09900 CMIC 0 0 0 0 0 69.00 09900 0FECTAL PURPOSE COST CENTERS 0 0 0 0 0 0 69.00 09900 0FFINENBURSABLE COST CENTERS 0 0 0 0 0 69.00 09900 0FFINENBURSABLE COST CENTERS 0 0 0 0 0 0 69.00 09900 0FFINENBURSABLE COST CENTERS 0 0 0 0 0 0 69.00 09900 09900 09900 09900 09900 09900 09900 09900 09900 09900 09900 09900 09900 09			0		· · ·			
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64.00 06400 INTERAVENOUS THERAPY 0 0 0 0 0 64 65.00 06500 RESPIRATORY THERAPY 0 3,174 7,386 10,560 3,177 65.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 67.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 67.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 67.00 06600 PHYSICAL THERAPY 0 0 0 0 0 68.00 06600 PHYSICAL THERAPY 0 0 0 0 0 68.00 06600 PHYSICAL THERAPY 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 4,238 9,861 14,099 1,676 69 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 69.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 68.00 08900 DEVERTION SERVICE COST CENTERS 68.00 08900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 69.00 07000 DIPATIENT SERVICE COST CENTERS 69.00 09000 CLINIC 0 0 0 0 0 69.00 09000 CLINIC 0 0 0 0 0 69.00 09000 CLINIC 0 0 0 0 69.00 09000 08FREGENCY 0 0 0 0 0 60.00 09000 08FREGENCY 0 0 0 0 0 60.00 09000 09000 09000 09000 09000 60.00 09000 09000 09000 09000 09000 60.00 09000 09000 09000 09000 60.00 09000 09000 09000 09000 60.00 09000 09000 09000 09000 60.00 09000 09000 09000 09000 60.00 09000 09000 09000 60.00 09000 09000 09000 60.00 09000 09000 09000 60.00 09000 09000 09000 60.00 09000 09000 09000 60.00 09000 09000 60.00 09000 09000						0		61.00
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68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68 69.00 06900 ELECTROCARDIOLOGY 0 4,238 9,861 14,099 1,676 69 70.00 70000 ELECTROCARDIOLOGY 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 70300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 70300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 75.00 07300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 76.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 0 78.00 09000 CLINIC 0 0 0 0 0 79.00 09000 DEBROGRICY 0 5,930 13,798 19,728 4,801 79.00 09000 DRERGENCY 0 5,930 13,798 19,728 4,801 70 07HER REIMBURSABLE COST CENTERS 0 0 0 0 0 70 010100 HOME HEALTH AGENCY 0 0 0 0 0 70 010100 HOME HEALTH AGENCY 0 0 0 0 0 70 010100 THEREST EXPENSE 113 70 11300 THEREST EXPENSE 113 718.00 SUBTOTALS (SUM OF LINES 1-117) 0 1,276,932 2,970,934 4,247,866 59,822 719.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 71 191.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 72 194.00 07951 MARKETING/ ADVERTISING 0 0 0 0 73 0 0 0 0 0 0 74 0 0 0 0 0 0 75 0 0 0 0 0 76 0 0 0 0 77 0 0 0 0 0 78 0 0 0 0 79 0 0 0 0 70 0 0 0 0 70 0 0 0 71 0 0 0 0 72 0 0 0 0 73 0 0 0 0 74 0 0 0 75 0 0 0 76 0 0 0 77 0 0 0 78 0 0 0 79 0 0 0 79 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0			0	0	0	0		67.00
69.00 06900 ELECTROCARDIOLOGY 0 4,238 9,861 14,099 1,676 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90.00 09100 EMERGENCY 0 5,930 13,798 19,728 4,801 91 92.00 09200 DRISERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 90.00 09000 CHINIC 0 0 0 0 0 910.00 09000 ONDO CLINIC 0 0 0 0 0 910.00 09000 ONDO CLINIC 0 0 0 0 0 910.00 09000 ONDO CLINIC 0 0 0 0 0 910.00 09100 MERCENCY 0 0 0 0 0 910.00 09100 MERCENCY 0 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 0 910.00 09100 ONDO CLINIC 0 0 0 0 910.00 ONDO CLINIC 0 0 0 0 0 910.00 ONDO CLINIC 0 0 0 0 0 910.00 ONDO CLINIC 0 0 0 0 0			٥	0	0	0		68.00
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73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73			o	0	o	o	0	72.00
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89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 90 90.00 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 90 90.00 91.00 EMERGENCY 0 5,930 13,798 19,728 4,801 91 92.00 99200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS						
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OTHER REIMBURSABLE COST CENTERS 99.00 09900 09			0	5,930	13,798	19,728	4,801	
99.00 09900 CMHC 0 0 0 0 0 0 0 0 0 0 0 0 101. SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113. 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 1,276,932 2,970,934 4,247,866 59,822 118. 100 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 191.00 19100 RESEARCH 0 0 0 0 0 0 0 191. 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 192. 194.00 07951 MARKETING/ ADVERTISING 0 0 0 0 0 0 194. 200.00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	92.00		10.00 March 1975 17 March 1970 1970 1970 1970 1970 1970 1970 1970			<u> </u>		92.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101	00 00			م المحمد	م	<u>^</u>	20.00.000.000	00.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) 0 1,276,932 2,970,934 4,247,866 59,822 118 113			1			-	-	
113.00	101.00		1 9	.	(VI	<u>이</u> 17382년 - 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계	Variable de la Company	101.00
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190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190 191.00 19100 RESEARCH 0 0 0 0 0 0 191 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 192 194.00 07951 MARKETING/ ADVERTISING 0 0 0 0 0 0 0 0 190 200.00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 201.00 Negative Cost Centers 0 0 0 0 0 0 0							No. 32 and Table Colleges Control of the con-	1
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						0		200.00
000 001 C 31 440 004)				0	0	0		201.00
202.00 TOTAL (sum lines 118-201) 0 1,276,932 2,970,934 4,247,866 59,822 202	202.00	TOTAL (sum lines 118-201)	0	1,276,932	2,970,934	4,247,866	59,822	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

		,				5/31/2017 12:	08 p
	Cost Center Description	ADMINISTRATIVE		OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		& GENERAL 5.00	REPAIRS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9,00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0,00	V. 10 (10 (10 (10 (10 (10 (10 (10 (10 (10	
.00	00100 CAP REL COSTS-BLDG & FIXT				I		1.
.00	00200 CAP REL COSTS-MVBLE EQUIP						2.
.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
.00	00500 ADMINISTRATIVE & GENERAL	392,026					5.
.00	00600 MAINTENANCE & REPAIRS	37,505	1,244,935				6.
.00	00700 OPERATION OF PLANT	0	0	0			7.
.00	00800 LAUNDRY & LINEN SERVICE	10,014	31,157	0	106,157		8
.00	00900 HOUSEKEEPING	6,695	45,095	0	0	145,846	9.
00.0	01000 DIETARY	3,691	76,475	0	0	9,544	10
1.00	01100 CAFETERIA	3,913	41,812	0	0	5,218	11.
3.00	01300 NURSING ADMINISTRATION	5,416	14,466	0	0	1,805	13
1.00	01400 CENTRAL SERVICES & SUPPLY	63,406	55,416	0	0	6,916	14
5.00	01500 PHARMACY	12,029	14,355	0	0	1,791	. 15
5.00	01600 MEDICAL RECORDS & LIBRARY	4,666	37,806	0	0	4,718	16
7.00	01700 SOCIAL SERVICE	0	0	0	0	0	17
9.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19
	INPATIENT ROUTINE SERVICE COST CENTERS	第四日的新兴美国的					1
0.00	03000 ADULTS & PEDIATRICS	97,168	589,849	0	106,157	73,610	30
1.00	03100 INTENSIVE CARE UNIT	0	0	0	· -	0	
1.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	1
5.00	04500 NURSING FACILITY	0	0	0	0	0	45
	ANCILLARY SERVICE COST CENTERS						
00.0	05000 OPERATING ROOM	35,735	205,111	. 0	6	25,597	
L.00	05100 RECOVERY ROOM	0	0	0	0	0	1
.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53
.00	05400 RADIOLOGY-DIAGNOSTIC	4,516	17,693	0	0	2,208	54
.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55
.00	05600 RADIOISOTOPE	4,798	20,336	0	0	2,538	56
.00	05700 CT SCAN	8,029	18,166	i o	0	2,267	57
3.00	05800 MRI	0	0	0	0	0	58
00.0	05900 CARDIAC CATHETERIZATION	16,838	40,560	0	0	5,062	59
0.00	06000 LABORATORY	31,936	15,356	0	0	1,916	60
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62
1.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64
5.00	06500 RESPIRATORY THERAPY	11,039	5,063	0	0	632	65
5.00	06600 PHYSICAL THERAPY	0	Ö	0	0	0	66
.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67
3.00	06800 SPEECH PATHOLOGY	0	0	ı o	0	0	68
00.0	06900 ELECTROCARDIOLOGY	5,704	6,760	.0	0	844	69
00.0	07000 ELECTROENCEPHALOGRAPHY	0	Ċ	0	0	0	70
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	d o	0	0	71
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	d o	0	0	72
.00	07300 DRUGS CHARGED TO PATIENTS	11,998	0) o	0	0	73
	OUTPATIENT SERVICE COST CENTERS				TO VELLET SERVED		1
3.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88
.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	O	l o	o o	0	1
.00	09000 CLINIC	o	Ö	o o	0	. 0	1
.00	09100 EMERGENCY	16,624	9,459	l o	o o	1,180	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	'	*				92
	OTHER REIMBURSABLE COST CENTERS						
.00	09900 CMHC	0	0	l 0	0	0	99
	10100 HOME HEALTH AGENCY	o					101
	SPECIAL PURPOSE COST CENTERS	A PROPERTY OF THE PROPERTY OF					1 -
3.00	11300 INTEREST EXPENSE	T					113
8.00		391,720	1,244,935	l o	106,157	145,846	
	NONREIMBURSABLE COST CENTERS	() - () - () - () - () - () - () - () -				and State of Contractors	1
o.on	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	О	0) 0	n	190
	19100 RESEARCH	Ö	Ö	Ĭ			191
11 00	quouvoj nederinei)		-				192
	19200 PHYSTCTANS' PRTVATE OFFICES	į ni	0				1
2.00	19200 PHYSICIANS' PRIVATE OFFICES	306					194
92.00 94.00	07951 MARKETING/ ADVERTISING	306	0	ă			
2.00	07951 MARKETING/ ADVERTISING Cross Foot Adjustments	-1	0		0	0	194 200 201

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | Part II |
| To | 12/31/2016 | Date/Time Prepared: | F/31/2017 | 13/08 pm KENTUCKIANA MEDICAL CENTER
Provider CCN: 15-0176

				To	12/31/2016	Date/Time Pre 5/31/2017 12:
	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
		10.00	11.00	13.00	14.00	15.00
C	SENERAL SERVICE COST CENTERS					
00 0	00100 CAP REL COSTS-BLDG & FIXT					
	00200 CAP REL COSTS-MVBLE EQUIP					
	00400 EMPLOYEE BENEFITS DEPARTMENT					
	00500 ADMINISTRATIVE & GENERAL					
	00600 MAINTENANCE & REPAIRS					
	00700 OPERATION OF PLANT					
	00800 LAUNDRY & LINEN SERVICE					
	00900 HOUSEKEEPING					
	01000 DIETARY	250,167				
	01100 CAFETERIA	0	138,871			
	01300 NURSING ADMINISTRATION	0	2,031	55,289	244 222	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	241,320	co 7 04
	01500 PHARMACY	0	4,202	0	0	63,794
	01600 MEDICAL RECORDS & LIBRARY	0	2,887	0	0	0
	01700 SOCIAL SERVICE	0	0	0	Ü	0
	01900 NONPHYSICIAN ANESTHETISTS] 0	0	0	0	0
	INPATIENT ROUTINE SERVICE COST CENTERS	1 250 46-1			V-946/9-1968, 19/8-19/	
	03000 ADULTS & PEDIATRICS	250,167	58,405	33,206	0	0
	03100 INTENSIVE CARE UNIT	0	0	0	Ü	0
	04400 SKILLED NURSING FACILITY		. 0	٥	Ü	0
-	04500 NURSING FACILITY	0	<u>U</u>	1 U	0	0
	ANCILLARY SERVICE COST CENTERS	l ol	17 650	10.00	0	0
	05000 OPERATING ROOM	0	17,650	10,032	0	0
- 1	05100 RECOVERY ROOM		0		0	0
	05300 ANESTHESIOLOGY	0	2 107		0	0
	05400 RADIOLOGY-DIAGNOSTIC	0	3,102		0	0
	05500 RADIOLOGY-THERAPEUTIC		901		0	Ö
	05600 RADIOISOTOPE			1	0	ő
	05700 CT SCAN	0	3,190		0	Ö
	05800 MRI	0	13,101	2 724	0	
	05900 CARDIAC CATHETERIZATION	0	6,041	1	0	ő
	06000 LABORATORY	١	0,041	١	U	U
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	ا	0	o
	06400 INTRAVENOUS THERAPY		0) o	0	ő
	06500 RESPIRATORY THERAPY	0	8,360	4,753	0	Ö
	06600 PHYSICAL THERAPY	0	0,300	7,70	0	Ö
	06700 OCCUPATIONAL THERAPY	٥	0		0	Ö
	06800 SPEECH PATHOLOGY	0	0	0	0	Ö
	06900 ELECTROCARDIOLOGY	0	6,284	3,574	0	ŏ
	07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY		0,204	3,374	0	Ĭ
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		28,941	Ö
	07200 IMPL. DEV. CHARGED TO PATIENTS	١	0	0	212,379	•
	07300 DRUGS CHARGED TO PATIENTS	١	0	l o	212,373	
	OUTPATIENT SERVICE COST CENTERS		A. 195 - Charles			100
F-	08800 RURAL HEALTH CLINIC	0	0	o	0	0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	ő
	09000 CLINIC	0	n	١	n	Ŏ
	09100 EMERGENCY	0	12,717	o	0	l -
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	12,717	1	•	'
	OTHER REIMBURSABLE COST CENTERS			NAMES OF THE PARTY OF THE	\$55.53 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S. 18 S	
	09900 CMHC	0	0	ol ol	0	0
	10100 HOME HEALTH AGENCY	o	Ö	1	0	
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE	T		T I		
8.00	SUBTOTALS (SUM OF LINES 1-117)	250,167	138,871	55,289	241,320	63,794
F-	NONREIMBURSABLE COST CENTERS	250,207			<u>- 1-1,920</u>	TO CHARSEN
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	O	ol	n	0
	19100 RESEARCH	0	ň	ا م	n	ő
	19200 PHYSICIANS' PRIVATE OFFICES	0	ñ	ا م	ñ	ŏ
	07951 MARKETING/ ADVERTISING	0	ă	ا م	n	Ö
00.00	Cross Foot Adjustments		·		v	
	Negative Cost Centers	0	n	n	n	o
		250, 167	138.871	55.289	241, 320	
201.00	Negative Cost Centers TOTAL (sum lines 118-201)	250,167	138,871	55,289	241,320	(

Worksheet B Provider CCN: 15-0176 Period: From 01/01/2016 Tο 12/31/2016

Part II Date/Time Prepared: 5/31/2017 12:08 pm Subtotal Intern & Cost Center Description MEDICAL SOCIAL SERVICE NONPHYSICIAN RECORDS & **ANESTHETISTS** Residents Cost & Post LTBRARY Stepdown Adjustments 25.00 19.00 24.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 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 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 9.00 10.00 01000 DIETARY 10.00 01100 CAFETERIA 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 15.00 01500 PHARMACY 16.00 16.00 01600 MEDICAL RECORDS & LIBRARY 129,863 17.00 01700 SOCIAL SERVICE 17.00 19.00 19.00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS 0 2,478,189 30.00 16,885 30.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 0 0 31.00 31.00 0 0 0 44.00 44.00 |04400 SKILLED NURSING FACILITY 0 45.00 0 0 04500 NURSING FACILITY 0 45.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 10,942 0 738,407 0 05100 RECOVERY ROOM 0 51.00 51.00 0 0 53.00 05300 ANESTHESIOLOGY 53.00 0 0 05400 RADIOLOGY-DIAGNOSTIC 70,688 54.00 4.844 54.00 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 76.971 56.00 0 56.00 05600 RADIOISOTOPE 5.569 0 4,973 0 57.00 05700 CT SCAN 75,976 57.00 0 0 58,00 58.00 05800 MRI 20,211 187,277 0 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 60.00 06000 LABORATORY 26,621 116,088 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 64.00 0 64.00 06400 INTRAVENOUS THERAPY O 65.00 06500 RESPIRATORY THERAPY 48,142 O 65.00 66.00 06600 PHYSICAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 42.488 06900 ELECTROCARDIOLOGY 69.00 3,547 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,176 0 30.117 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8,630 0 221,009 O 72.00 07300 DRUGS CHARGED TO PATIENTS 16,462 92,254 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 0 0 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 0 0 0 90.00 90.00 09000 CLINIC 69,954 91.00 0 09100 EMERGENCY 5.445 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC n 99.00 0 0 101.00 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 0 4,247,560 0 118.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 129,863 0 NONREIMBURSABLE COST CENTERS 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191.00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 194.00 07951 MARKETING/ ADVERTISING 0 0 194.00 0 306 0 200.00 0 200.00 Cross Foot Adjustments 0 201.00 201.00 Negative Cost Centers 0 0 n 4,247,866 0 202.00

129.863

0

202.00

TOTAL (sum lines 118-201)

200.00

201.00

202.00

Worksheet B Part II Date/Time Prepared: 5/31/2017 12:08 pm ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0176 Period: From 01/01/2016 12/31/2016 Cost Center Description Total 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPING 9.00 10.00 01000 DIETARY 10.00 01100 CAFETERIA 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 17.00 17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,478,189 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 44.00 04400 SKILLED NURSING FACILITY 0 45.00 04500 NURSING FACILITY 0 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 738,407 50.00 05100 RECOVERY ROOM 51.00 51.00 53.00 05300 ANESTHESIOLOGY 53,00 54,00 05400 RADIOLOGY-DIAGNOSTIC 70.688 54.00 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOISOTOPE 56.00 56.00 76,971 57.00 05700 CT SCAN 75,976 57.00 58.00 05800 MRI 58.00 59.00 05900 CARDIAC CATHETERIZATION 187,277 59.00 60.00 06000 LABORATORY 116,088 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 64.00 06400 INTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 48,142 65.00 66.00 06600 PHYSICAL THERAPY 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDIOLOGY 42.488 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 30,117 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 221,009 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 92,254 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 09000 CLINIC 90,00 90.00 91.00 09100 EMERGENCY 69,954 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113,00 SUBTOTALS (SUM OF LINES 1-117) 4,247,560 118.00 118,00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191.00 19100 RESEARCH 0 191.00 192,00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 194.00 07951 MARKETING/ ADVERTISING 194.00 306

0

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4,247,866

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

KENTUCKIANA MEDICAL CENTER
Provider CCN: 15-0176

						o 12/31/2016	Date/Time Pre 5/31/2017 12:	
			CAPITAL RE	LATED COSTS				
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5,00	4/2/
		AL SERVICE COST CENTERS						
00		CAP REL COSTS-BLDG & FIXT	73,210					1
00	1 1	CAP REL COSTS-MVBLE EQUIP	1 021	73,210	10 730 053			4
00		EMPLOYEE BENEFITS DEPARTMENT	1,031	1	10,720,953	1)	27,862,333	5
)0)0		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	6,632		1,293,433 140,267		2,665,569	1
0	1 1	OPERATION OF PLANT	20,790	20,790	140,207		2,003,309	l _
0		LAUNDRY & LINEN SERVICE	1,120	1,120	n	1 1	711,758	i
0		HOUSEKEEPING	1,621	1,621	Ö	o	475,810	
00		DIETARY	2,749		170,568	o	262,343	
00		CAFETERIA	1,503		129,037		278,095	
00		NURSING ADMINISTRATION	520		250,642		384,921	
00		CENTRAL SERVICES & SUPPLY	1,992	1,992	0	0	4,506,439	1
00	01500	PHARMACY	516	516	264,666	0	854,958	1
00	01600	MEDICAL RECORDS & LIBRARY	1,359	1,359	167,011	. 0	331,639	1
		SOCIAL SERVICE	0	0	0	1	0	1
00		NONPHYSICIAN ANESTHETISTS	0	0	. 0	0	0	1.9
		CENT ROUTINE SERVICE COST CENTERS			4 020 221		C 00F 750	١.
		ADULTS & PEDIATRICS	21,203	1 -1	4,029,314		6,905,752	
00		INTENSIVE CARE UNIT	0		0	0	0	ł
		SKILLED NURSING FACILITY NURSING FACILITY				0	0	1
UU		ARY SERVICE COST CENTERS						7
00		OPERATING ROOM	7,373	7,373	992,084	0	2,539,833	5
00		RECOVERY ROOM	1,7510	1	0	Ō	0	
00		ANESTHESIOLOGY		0	O	0	0	5
00		RADIOLOGY-DIAGNOSTIC	636	636	254,761	. 0	320,986	5
00		RADIOLOGY-THERAPEUTIC	0	o	Ċ	0	0	5
00	05600	RADIOISOTOPE	731	731	74,244	0	341,044	5
00	05700	CT SCAN	653	653	261,996	0	570,661	
00	05800		0	1	C	0	0	1
00		CARDIAC CATHETERIZATION	1,458		570,623		1,196,725	
00		LABORATORY	552	552	392,360	0	2,269,783	
00		PBP CLINICAL LAB SERVICES-PRGM ONLY				9	_	6
00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	1
00		INTRAVENOUS THERAPY	100	1 1 1 1	רבת אים מיני בי			1
00		RESPIRATORY THERAPY PHYSICAL THERAPY	182	182	569,328		784,608 0	
00		OCCUPATIONAL THERAPY			Ċ		. 0	1
00		SPEECH PATHOLOGY		j ő	Č	ŏ	ő	1
00		ELECTROCARDIOLOGY	243	243	300,296	ŏ	405,379	
00		ELECTROENCEPHALOGRAPHY	C	0	Ć	0	, o	
00		MEDICAL SUPPLIES CHARGED TO PATIENT		0	C	0	0	7
00		IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	0	
00		DRUGS CHARGED TO PATIENTS	C	0	C	0	852,736	7
		FIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC	0	0	C	0	0	8
		FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	o	0	
		CLINIC	1	0	200 200	0	1 191 540	1
		EMERGENCY	340	340	860,323		1,181,540	9
00	-	OBSERVATION BEDS (NON-DISTINCT PART	I SANGERANGE SESSO SANGER SE			#1595.50 P.J. N. 1897 P.J. N	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	۱۶
nn	09900	REIMBURSABLE COST CENTERS	C	ol ol	(0	0	9
		HOME HEALTH AGENCY			C		-	1 -
		AL PURPOSE COST CENTERS			gstrist, primarek			1
.00		INTEREST EXPENSE						11
.00		SUBTOTALS (SUM OF LINES 1-117)	73,210	73,210	10,720,953	-5,539,088	27,840,579	11
	NONRE	IMBURSABLE COST CENTERS						4
		GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	C	1		19
		RESEARCH		o	C	0		19
		PHYSICIANS' PRIVATE OFFICES	0	이	C	0		19
		MARKETING/ ADVERTISING		o	C	0	21,754	
.00		Cross Foot Adjustments						20
1.00		Negative Cost Centers	4 3== ===	2 070 071	2 027 122		# #30 000	20
2.00	4	Cost to be allocated (per Wkst. B,	1,276,932	2,970,934	2,927,469	"	5,539,088	20
, ^^	J	Part I)	17.442043	40.580986	0.273061		0.198802	20
3.00 4.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	17.442043	40.380986	59,822		392,026	20
	71 İ	Part II)	1	1 !	22,022	-1	332,020	1-0

Health Fin	ancial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider Co		Period: From 01/01/2016 Fo 12/31/2016		pared:
		CAPITAL REL	ATED COSTS				18 S. 18 S.
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.00558)	0.014070	205.00

In Lieu of Form CMS-2552-10
Worksheet B-1 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0176

					o 12/31/2016	Date/Time Pre 5/31/2017 12:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	Ĭ ,
		REPAIRS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(TIME SPENT)	(PATIENT DA			
		6.00	7.00	YS)	9.00	10.00	50 14 5 C
145 Amer 201	GENERAL SERVICE COST CENTERS	6.00	7.00	8,00	9.00	10.00	2200
.00	00100 CAP REL COSTS-BLDG & FIXT	1	French and control of the control of	Sign a consiste in consiste in order		I	1.
.00	00200 CAP REL COSTS-MVBLE EQUIP						2.
.00	00400 EMPLOYEE BENEFITS DEPARTMENT				,		4.
.00	00500 ADMINISTRATIVE & GENERAL						5.
.00	00600 MAINTENANCE & REPAIRS	44,751			,		6.
.00	00700 OPERATION OF PLANT	0	0				7.
.00	00800 LAUNDRY & LINEN SERVICE	1,120	0	9,072			8.
.00	00900 HOUSEKEEPING	1,621	0	· 0	42,010		9.
0.00	01000 DIETARY	2,749	0	0	2,749		10.
1.00	01100 CAFETERIA	1,503	0	0	1,503		1
3.00	01300 NURSING ADMINISTRATION	520	0	0	520	0	13.
4.00	01400 CENTRAL SERVICES & SUPPLY	1,992	0	0	1,992	0	14.
5.00	01500 PHARMACY	516	0	0	516	0	15.
6.00	01600 MEDICAL RECORDS & LIBRARY	1,359	0	o	1,359	0	16.
7.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.
9.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	21,203	0	9,072	21,203	29,172	
1.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	1
4.00	04400 SKILLED NURSING FACILITY	0	.0	0	0	0	1
5.00	04500 NURSING FACILITY	0	0	0	0	0	45.
	ANCILLARY SERVICE COST CENTERS						1
0.00	05000 OPERATING ROOM	7,373	0	1	7,373		1
1.00	05100 RECOVERY ROOM	0	0	0	0	0	1
3.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.
1.00	05400 RADIOLOGY-DIAGNOSTIC	636	0	0	636		54.
.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.
.00	05600 RADIOISOTOPE	731	0	0	731	i	56.
.00	05700 CT SCAN	653	0	0	653	i e	
3.00	05800 MRI	0	0	0	0		
00.0	05900 CARDIAC CATHETERIZATION	1,458	0	0	1,458		1
0.00	06000 LABORATORY	552	0	0	552	0	
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	.0		1
4.00	06400 INTRAVENOUS THERAPY	0	0	0	0		
5.00	06500 RESPIRATORY THERAPY	182	0	0	182		
5.00	06600 PHYSICAL THERAPY	0	0	0	0	0	
7.00	06700 OCCUPATIONAL THERAPY	0	U	0	0	1	- ' '
8.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
9.00	06900 ELECTROCARDIOLOGY	243	0	0	243	0	
0.00	07000 ELECTROENCEPHALOGRAPHY	0	U	0	0	0	70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	U	0	0	0	71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	U	0	0	0	1
3.00	07300 DRUGS CHARGED TO PATIENTS	0	U	U	0	0	73.
	OUTPATIENT SERVICE COST CENTERS	1		1		J A	00
3.00	08800 RURAL HEALTH CLINIC	0	0	0		_	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		
	09000 CLINIC	0		0	0	1 '	
00	09100 EMERGENCY	340	C	1	340	0	
.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS	(60 × 64 × 54 × 170 × 1	(ga sagaa tabaasaa) •		en ekkejanjulja nekjadi. •	Protestigar general region	00
	09900 CMHC	0					
)T,0(10100 HOME HEALTH AGENCY	0	C	0	0	ղ <u>Մ</u>	101
ם מי	SPECIAL PURPOSE COST CENTERS	menangga mengentikkilas	<u> </u>	kuma stepyetej ta Pitetta na Patit. I	- 1945 (1947) (1947) (1947) 	in and refer a total consistent a page.	113
.3.00 .8.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	AA 751	C	9,072	42,010	29,172	
ال . ه.	NONREIMBURSABLE COST CENTERS	44,751		9,072	1 42,010	ų <u>29,1/2</u>	1110
0.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	^		^	190
	119000 GIFI, FLOWER, COFFEE SHOP & CANTEEN	0			0		191
	19200 PHYSICIANS' PRIVATE OFFICES	0	า		0		192
	07951 MARKETING/ ADVERTISING				0		194
14.00				Ï	1		200
							201
1.00		2 105 490	o	רכר ככם	686,151	555,692	
02.00	Part I)	3,195,489		933,232	000,151	333,092	202
03.00		71.405980	0.000000	102.869489	16.333040	19.048814	203
04.00		1,244,935		102.869469			
,-, . Ul	Part II)	1,244,333		100,137	145,646	230,107	
		1		11 701600	3.471697	8.575586	205
05.00	Unit cost multiplier (Wkst. B, Part	27.819155	0.000000	11.701609	3.4/189/		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

KENTUCKIANA MEDICAL CENTER
Provider CCN: 15-0176

					To	12/31/2016	Date/Time Pre 5/31/2017 12:	
		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY	
				(DIRECT NRSING HRS)	(COSTED REQUIS.)		(GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
	GENER	AL SERVICE COST CENTERS		SECTION SECTION				
.00	00100	CAP REL COSTS-BLDG & FIXT						1
.00	00200	CAP REL COSTS-MVBLE EQUIP						2
.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4
.00	00500	ADMINISTRATIVE & GENERAL						5
.00	00600	MAINTENANCE & REPAIRS			Ĭ			6
.00	00700	OPERATION OF PLANT						7
.00		LAUNDRY & LINEN SERVICE						8
.00		HOUSEKEEPING						9
		DIETARY						10
	1	CAFETERIA	18,805					11
		NURSING ADMINISTRATION	275					13
		CENTRAL SERVICES & SUPPLY	_	1 .	7 420 002			1
		PHARMACY	0	1	7,428,903	053 736		14
			569		o _l	852,736		15
		MEDICAL RECORDS & LIBRARY	391	1	0	0	98,388,590	
		SOCIAL SERVICE	0	1	O	0	0	
.00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19
		IENT ROUTINE SERVICE COST CENTERS	agus den kirilik ke				grap, of grading the	1
		ADULTS & PEDIATRICS	7,909	164,506	0	0	12,791,333	30
.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	3:
		SKILLED NURSING FACILITY	0	o	o	0	Ō	1 .
		NURSING FACILITY	Ô	o	o	ō	ō	1
·		LARY SERVICE COST CENTERS	EQUIPMENT ARVING STATES		SSESSESSI LANGES			1 "
.00	05000	OPERATING ROOM	2,390	49,703	ol	0	8,289,485	51
		RECOVERY ROOM	2,550	·	ŏ	0	0,203,403	,
		ANESTHESIOLOGY	0	0	0	0	1	1
			420		0	0	2 550 450	1
		RADIOLOGY-DIAGNOSTIC	420	U	0	Ü	3,669,459	
		RADIOLOGY-THERAPEUTIC		O)	0	U	U	5
		RADIOISOTOPE	122		0	0	4,218,561	
		CT SCAN	432	0	0	0	3,767,712	
	05800		0	0	0	0	0	5
.00	05900	CARDIAC CATHETERIZATION	1,774	18,450	0	0	15,311,537	59
.00	06000	LABORATORY	818	0	0	0	20,175,381	60
.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61
.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	o	0	0	62
		INTRAVENOUS THERAPY	0	0	0	.0	0	64
	l .	RESPIRATORY THERAPY	1,132	23,550	ol	0	3,452,868	1
		PHYSICAL THERAPY	-,0	0	0	ñ	0,752,000	
		OCCUPATIONAL THERAPY	ŏ	ام	ñ	Ŏ	0	1
		SPEECH PATHOLOGY	ñ		0	0	Ö	1
		ELECTROCARDIOLOGY	851	17 700	0	0		
			927	1 1	0	0	2,687,089	4
		ELECTROENCEPHALOGRAPHY	0	0	222 224	Ü	0	<u>Z</u>
		MEDICAL SUPPLIES CHARGED TO PATIENT	U	0	890,924	0	890,924	
		IMPL. DEV. CHARGED TO PATIENTS	0	0	6,537,979	0	6,537,979	
		DRUGS CHARGED TO PATIENTS	0	0	0	852,736	12,471,453] 7
1		TIENT SERVICE COST CENTERS	**************************************					
		RURAL HEALTH CLINIC	0	O	0	0	0	8
00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	. 0	0	0	0	8
		CLINIC	0	l ol	o	0	0	9
		EMERGENCY	1,722	0	o	o	4,124,809	
		OBSERVATION BEDS (NON-DISTINCT PART	_,	1	7	Ĭ	.,,000	9
		REIMBURSABLE COST CENTERS	494. N. S. V. G. J. J. C. V.					1 "
	09900		0	0	O	0	0	9:
		HOME HEALTH AGENCY	. 0	1 -1	o	0		10
			Seutra - STAAGOS - Letter Propins (C		υ ₁	U _I		10.
		AL PURPOSE COST CENTERS INTEREST EXPENSE		The second section is a second of the second	<u> </u>	वितेषात्त्र हा देव सम्बद्धान्य प्रतासन्तर्भाः र		
3.00			10 000	373 040	7 420 003	050 700	00 300 500	113
ł		SUBTOTALS (SUM OF LINES 1-117)	18,805	273,918	7,428,903	852,736	98,388,590	TT
		IMBURSABLE COST CENTERS		gen eg sekske skiptingsk	TO COMPANY THE CONSTRUCTION OF			1.
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	0		190
		RESEARCH	0	0	0	0		19:
		PHYSICIANS' PRIVATE OFFICES	0	0	o	0		192
.00	07951	MARKETING/ ADVERTISING	0	0	o	0	0	19
00.0		Cross Foot Adjustments						20
.00		Negative Cost Centers				Ì		20
.00		Cost to be allocated (per Wkst. B,	465,253	513,872	5,577,104	1,084,276	526,481	1
		Part I)	.00,233) 223,072	5,5,7,104	2,007,270	320, 701	-"
3.00		Unit cost multiplier (Wkst. B, Part I)	24.740920	1.876007	0.750730	1.271526	0.005351	20:
4.00		Cost to be allocated (per Wkst. B,		l t		i i		1
,,,,,,		Part II)	138,871	55,289	241,320	63,794	129,863	204
		Unit cost multiplier (Wkst. B, Part	7.384791	0.201845	0.032484	0.074811	0.001320	201
5,00								

	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS		
			ANESTHETISTS		
				! . 이 가진 전에 1차 되었다고 있는 아이는 사람 하다 보다 가는 아니라 가장 하는 사람들이 가는 것을 받는 것을 하는 것이다. 하는 사람들이 되었다. 하는 사람들이 다른 사람들이 되었다. 하는	
		(PATIENT DA	(ASSIGNED		
		YS)	TIME)		
08/80%		17.00	19.00		10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	GENERAL SERVICE COST CENTERS			n yn de Stadt yn daethad daethad ac an ar de ar daethau yn de an ar de ar daethad a'r daethad ar daethad a'r d Cannaill a chair a chair a gan a chair a chair a chair a chair a chair a chair a chair a chair a chair a chair	┦ .
	00100 CAP REL COSTS-BLDG & FIXT				1
	00200 CAP REL COSTS-MVBLE EQUIP				2
	00400 EMPLOYEE BENEFITS DEPARTMENT				4
00	00500 ADMINISTRATIVE & GENERAL				5
	00600 MAINTENANCE & REPAIRS				6
00	00700 OPERATION OF PLANT	1			7
00	00800 LAUNDRY & LINEN SERVICE				8
00	00900 HOUSEKEEPING				9
.00	01000 DIETARY				10
	01100 CAFETERIA				11
	01300 NURSING ADMINISTRATION				13
	01400 CENTRAL SERVICES & SUPPLY				14
	01500 PHARMACY	1			15
	l i				16
	01600 MEDICAL RECORDS & LIBRARY				17
	01700 SOCIAL SERVICE	U			
	01900 NONPHYSICIAN ANESTHETISTS	0	0		19
	INPATIENT ROUTINE SERVICE COST CENTERS				의
	03000 ADULTS & PEDIATRICS	0	0		30
.00	03100 INTENSIVE CARE UNIT	0	0		31
.00	04400 SKILLED NURSING FACILITY	0	0	1	44
	04500 NURSING FACILITY	0	0		45
1	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0	0		50
	05100 RECOVERY ROOM	o	Ö		51
	05300 ANESTHESIOLOGY	o	١		53
		0	0		54
	05400 RADIOLOGY-DIAGNOSTIC		0		55
	05500 RADIOLOGY-THERAPEUTIC	U U	0		- 1
	05600 RADIOISOTOPE	U	U		56
	05700 CT SCAN	0	0		57
.00	05800 MRI	0	0)	58
00.0	05900 CARDIAC CATHETERIZATION	0	0		59
0.00	06000 LABORATORY	0	0		60
L.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62
1.00	06400 INTRAVENOUS THERAPY	0	0)	64
	06500 RESPIRATORY THERAPY	0	o		65
	06600 PHYSICAL THERAPY	0	0		66
	06700 OCCUPATIONAL THERAPY	o o	i o		67
	06800 SPEECH PATHOLOGY	Ď	ň		68
1	{	0	٥		69
	06900 ELECTROCARDIOLOGY	0	"		70
	07000 ELECTROENCEPHALOGRAPHY	0	U		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	U	U		71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72
.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	73
	OUTPATIENT SERVICE COST CENTERS	HARRY BERKERS			143
	08800 RURAL HEALTH CLINIC	0		l e	88
.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	89
.00	09000 CLINIC	0	0		90
	09100 EMERGENCY	0	0)	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92
	OTHER REIMBURSABLE COST CENTERS				
nn	09900 CMHC	0	0)	99
	10100 HOME HEALTH AGENCY	0	-		101
4.00	SPECIAL PURPOSE COST CENTERS	Yalas isan bada sa is			177
2 00		giga nasagat mgajahaki		and the control of th	113
	11300 INTEREST EXPENSE		_		
8.00		0	0		118
	NONREIMBURSABLE COST CENTERS		2015 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		<u> </u>
0.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190
	19100 RESEARCH	0	0)	191
	19200 PHYSICIANS' PRIVATE OFFICES	0	0)	192
	07951 MARKETING/ ADVERTISING	0	0)	194
0.00			1		200
1.00					201
2.00		0	l o)	202
۷,00	Part I)		1	<u>'</u>	[-02
2 60		0.000000	0.000000		203
3.00		0.000000	0.000000		203
04.00		1		'	204
	Part II)	0.000000	0.000000		205
05.00	Unit cost multiplier (Wkst. B, Part				1705

In Lieu of Form CMS-2552-10
Period: Worksheet C
From 01/01/2016 Part I

					To 12/31/2016	Date/Time Pre 5/31/2017 12:	
			Title	XVIII	Hospital	PPS	
The State					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5,00	(354 (348)
	INPATIENT ROUTINE SERVICE COST CENTERS						
30,00	03000 ADULTS & PEDIATRICS	12,200,619		12,200,61	9 0	12,200,619	
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0			0	0	
45.00	04500 NURSING FACILITY	0			0 0	0	45.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	3,888,388		3,888,38	8 0	3,888,388	
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
53.00	05300 ANESTHESIOLOGY	0			0 0	. 0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	470,627		470,62	7 0	470,627	
55.00	05500 RADIOLOGY-THERAPEUTIC	0			0	0	55.00
56.00	05600 RADIOISOTOPE	498,573		498,57		498,573	I .
57.00	05700 CT SCAN	772,252		772,25	2 0	772,252	
58.00	05800 MRI	0		4 700 00	0	0	
59.00	05900 CARDIAC CATHETERIZATION	1,722,994		1,722,99		1,722,994	
60.00	06000 LABORATORY	2,897,652		2,897,65	2	2,897,652	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
64.00 65.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	1 047 333		1,047,22	0	1,047,222	65.00
66.00	06600 PHYSICAL THERAPY	1,047,222	0	1,047,22	2	1,047,222	1
67.00	06700 OCCUPATIONAL THERAPY		0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY		. 0		0	0	
69.00	06900 ELECTROCARDIOLOGY	575,946		575,94	6 0	575,946	1
70.00	07000 ELECTROENCEPHALOGRAPHY	373,340		373,34	0	0,75,540	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	673,610		673,61	0	673,610	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,943,246		4,943,24		4,943,246	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,173,273		2,173,27		2,173,273	
,5,40	OUTPATIENT SERVICE COST CENTERS		Viji i i saman geriji je	100 MA 130 HA 1458			1
88,00	08800 RURAL HEALTH CLINIC	1 0	1		ol o	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			o o	0	89.00
90.00	09000 CLINIC	0			o o	0	90.00
91.00	09100 EMERGENCY	1,510,940		1,510,94	o o	1,510,940	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	818,058		818,05	8	818,058	92.00
	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0			0	0	99.00
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS			HENCHWARES.		引 医甲基基酚酸甲醛	1
	11300 INTEREST EXPENSE						113.00
200.00		34,193,400		34,193,40		34,193,400	
201.00		818,058		818,05	l I	818,058	
202.00	Total (see instructions)	33,375,342	0	33,375,34	2 0	33,375,342	202.00

				T	o 12/31/2016	Date/Time Pre 5/31/2017 12:	
-			Title	XVIII	Hospital	PPS	, , , , , , , , , , , , , , , , , , , ,
New State			Charges		Facilities and services	CESSES STREET	
	Cost Center Description	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	32,000
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	12,108,906		12,108,906	i,		30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	i l		31.00
44.00	04400 SKILLED NURSING FACILITY	0		0)		44.00
45.00	04500 NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6,127,681	2,161,804	8,289,485	0.469075	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,726,081	1,943,378	3,669,459	0.128255	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600 RADIOISOTOPE	1,036,495	3,182,066	4,218,561	0.118186	0.000000	56.00
57.00	05700 CT SCAN	1,653,603	2,114,109	3,767,712	0.204966	0.000000	57.00
58.00	05800 MRI	0	0	0	0.000000	0.000000	58.00
59,00	05900 CARDIAC CATHETERIZATION	8,900,123	6,411,414	15,311,537	0.112529	0.000000	59.00
60.00	06000 LABORATORY	14,727,285	5,448,096		0.143623	0.000000	60.00
61,00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	l c	0.000000	0.000000	62.00
64,00	06400 INTRAVENOUS THERAPY	o	0	l o	0.000000	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	3,343,198	109,670	3,452,868	0.303290	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	ol	. 0	· · · c	0.000000	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	o	0	l	0.000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	o	0	· c	0.000000	0.000000	1
69.00	06900 ELECTROCARDIOLOGY	1,680,433	1,006,656	2,687,089		0.000000	
70,00	07000 ELECTROENCEPHALOGRAPHY	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,000000	0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	635,096	255,828	890,924		0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,832,106	2,705,873			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	10,638,623	1,832,830			0.000000	,
75.00	OUTPATIENT SERVICE COST CENTERS	A. 146			- 10 A CONTRACTOR - 10 A SEC.		1
88.00	08800 RURAL HEALTH CLINIC	0	0	0			88,00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	Ö	آ			89.00
90.00	09000 CLINIC	Ö	Õ	0	0.000000	0.000000	1
91.00	09100 EMERGENCY	621,093	3,503,716	4,124,809	1	0.000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	140,000	542,427			0.000000	1
22.00	OTHER REIMBURSABLE COST CENTERS	2,0,000					1
99.00	09900 CMHC	ol	0	l c			99.00
	10100 HOME HEALTH AGENCY	Ö	Ö		1		101.00
202.00	SPECIAL PURPOSE COST CENTERS		Villa de la composição		Light Service Selection		
113 00	11300 INTEREST EXPENSE	T	and the second second			a in the children to the tag	113.00
200.00	1 P	67,170,723	31,217,867	98,388,590			200.00
201.00		07,170,723	31,211,007	30,300,390	1		201.00
202.00		67,170,723	31,217,867	98,388,590			202.00
202.00	liocal (see inscinections)	, 0,,1,0,,723	31,211,001	1 20,200,250	1	ı	1202.00

Health Financial Systems
COMPUTATION OF RATIO OF COSTS TO CHARGES

KENTUCKIANA MEDICAL CENTER
Provider CCN: 15-0176

				5/31/2017 12:08
		Title XVIII	Hospital	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30
31.00 03100 INTENSIVE CARE UNIT				31
4.00 04400 SKILLED NURSING FACILITY				44
5.00 04500 NURSING FACILITY				45
ANCILLARY SERVICE COST CENTERS		(25) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1		1876000000000000000000000000000000000000
0.00 05000 OPERATING ROOM	0.469075			50
1.00 05100 RECOVERY ROOM	0.000000			51
3.00 05300 ANESTHESIOLOGY	0.000000	1		53
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128255			54
5.00 05500 RADIOLOGY-THERAPEUTIC	0.000000			55
6.00 05600 RADIOISOTOPE	0.118186			56
7.00 05700 CT SCAN	0.204966			57
8.00 05800 MRI	0.000000			58
9.00 05900 CARDIAC CATHETERIZATION	0.112529			59
0.00 06000 LABORATORY	0.143623			60
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62
4.00 06400 INTRAVENOUS THERAPY	0.000000			64
5.00 06500 RESPIRATORY THERAPY	0.303290			65
6.00 06600 PHYSICAL THERAPY	0.000000			66
7.00 06700 OCCUPATIONAL THERAPY	0.000000			67
	0.000000			68
8.00 06800 SPEECH PATHOLOGY	0.00000			69
9.00 06900 ELECTROCARDIOLOGY				
0.00 07000 ELECTROENCEPHALOGRAPHY	0.000000			70
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.756080			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.756082			72
3.00 O7300 DRUGS CHARGED TO PATIENTS	0.174260			73
OUTPATIENT SERVICE COST CENTERS	ana iku ali ususa salisati 1992 sa usi			Aarte Litter by the Pipella (B) 1
8.00 08800 RURAL HEALTH CLINIC				88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89
0.00 09000 CLINIC	0.000000			90
1.00 09100 EMERGENCY	0.366305			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.198748			92
OTHER REIMBURSABLE COST CENTERS				
9.00 09900 CMHC	<u> </u>			99
01.00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
13.00 11300 INTEREST EXPENSE				113
00.00 Subtotal (see instructions)				200
201.00 Less Observation Beds				201
202.00 Total (see instructions)				202

Period: From 01/01/2016 Worksheet C

818,058 201.00

33,375,342 202.00

o

Part I
Date/Time Prepared: 12/31/2016 5/31/2017 12:08 pm Title XIX Hospital PP5 Costs Total Cost Total Costs Total Costs Therapy Limit RCF Cost Center Description Disallowance from Wkst. B Adj. Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 12,200,619 12,200,619 0 12,200,619 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04400 SKILLED NURSING FACILITY 0 0 0 0 44.00 44.00 04500 NURSING FACILITY 0 0 45.00 0 45,00 ANCILLARY SERVICE COST CENTERS 3.888.388 50.00 50.00 05000 OPERATING ROOM 3,888,388 3,888,388 Ω 51.00 05100 RECOVERY ROOM 0 51.00 53.00 05300 ANESTHESIOLOGY 0 0 53.00 05400 RADIOLOGY-DIAGNOSTIC 470,627 470,627 470,627 54.00 54.00 0 05500 RADIOLOGY-THERAPEUTIC 0 55.00 55.00 498,573 498,573 498,573 56.00 05600 RADIOISOTOPE 56.00 0 57,00 57.00 05700 CT SCAN 772,252 772,252 772,252 0 58.00 05800 MRI n 58.00 59.00 05900 CARDIAC CATHETERIZATION 1,722,994 1,722,994 1,722,994 59.00 0 06000 LABORATORY 2,897,652 2,897,652 2,897,652 60.00 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY 0 0 62.00 62.00 0 0 0 0 64.00 64.00 1,047,222 1,047,222 65.00 1,047,222 65,00 06500 RESPIRATORY THERAPY 66.00 66.00 06600 PHYSICAL THERAPY C 0 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDIOLOGY 575,946 575,946 0 0 0 575,946 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 673,610 673,610 71.00 673,610 71.00 4,943,246 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4,943,246 4,943,246 73.00 07300 DRUGS CHARGED TO PATIENTS 2,173,273 2,173,273 2,173,273 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 09000 CLINIC 0 90.00 90.00 09100 EMERGENCY 1,510,940 1,510,940 0 1,510,940 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 818,058 818,058 92.00 92.00 818,058 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 34,193,400 0 34,193,400 200.00

34,193,400

33,375,342

818,058

0

0

818,058

33,375,342

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

			1	l l		5/31/2017 12:	08
			Titl	e XIX	Hospital	PPS	-
			Charges				1000
	Cost Center Description	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7,00	8.00	9.00	10.00	33
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	12,108,906		12,108,906	i l		30
.00	03100 INTENSIVE CARE UNIT	. 0		C			31
.00	04400 SKILLED NURSING FACILITY	0		C			44
.00	04500 NURSING FACILITY	0		C			45
1	ANCILLARY SERVICE COST CENTERS						
.00	05000 OPERATING ROOM	6,127,681	2,161,804	8,289,485	0.469075	0.000000	50
.00	05100 RECOVERY ROOM	0	0	C	0.000000	0.000000	51
.00	05300 ANESTHESIOLOGY	0	0	C	0.000000	0.000000	53
.00	05400 RADIOLOGY-DIAGNOSTIC	1,726,081	1,943,378	3,669,459	0.128255	0.000000	54
.00	05500 RADIOLOGY-THERAPEUTIC	0	0	l c	0.000000	0.000000	55
.00	05600 RADIOISOTOPE	1,036,495	3,182,066	4,218,561	0.118186	0.000000	5€
.00	05700 CT SCAN	1,653,603	2,114,109	3,767,712	0.204966	0.000000	57
.00	05800 MRI	0	0	C	0.000000	0.000000	58
.00	05900 CARDIAC CATHETERIZATION	8,900,123	6,411,414	15,311,537	0.112529	0.000000	59
.00	06000 LABORATORY	14,727,285	5,448,096	20,175,381	0.143623	0.000000	60
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	6:
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	(0.000000	0.000000	6
	06400 INTRAVENOUS THERAPY	o	0	(0.000000	0.000000	6
	06500 RESPIRATORY THERAPY	3,343,198	109,670	3,452,868	0.303290	0.000000	6
	06600 PHYSICAL THERAPY	0	. 0		0.000000	0.000000	6
	06700 OCCUPATIONAL THERAPY	o	0	(0.000000	0.000000	6
	06800 SPEECH PATHOLOGY	o	0	(0.000000	0.000000	68
	06900 ELECTROCARDIOLOGY	1,680,433	1,006,656	2,687,089	0.214338	0.000000	69
	07000 ELECTROENCEPHALOGRAPHY	0	. 0		0.000000	0.000000	70
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	635,096	255,828	890,924	0.756080	0.000000	7
	07200 IMPL. DEV. CHARGED TO PATIENTS	3,832,106	2,705,873			0.000000	7
	07300 DRUGS CHARGED TO PATIENTS	10,638,623	1,832,830			0.000000	7.
	OUTPATIENT SERVICE COST CENTERS	PV/Y/Valadata/8/8/00					1
	08800 RURAL HEALTH CLINIC	0	0	(0.000000	0.000000	8
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	(0.000000	0.000000	8
	09000 CLINIC	0	0	1	0.000000	0.000000	9
	09100 EMERGENCY	621,093	3,503,716	4,124,809	0.366305	0.000000	9
	09200 OBSERVATION BEDS (NON-DISTINCT PART	140,000	542,427		1.198748	0.000000	9
	OTHER REIMBURSABLE COST CENTERS	NATURAL AND AND AND AND AND AND AND AND AND AND	grades de la Comparia	Spanish to the state of the sta			1
	09900 CMHC	0	0				99
	10100 HOME HEALTH AGENCY	o	0	i i)		10:
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						111
0.00		67,170,723	31,217,867	98,388,590)		200
1.00		3.,2.3,.25	,,,90.				201
2.00	l i	67,170,723	31,217,867	98,388,590			202

			10 12/31/2010	5/31/2017 12:0	
		Title XIX	Hospital	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY				-	44.00
45.00 04500 NURSING FACILITY					45.00
ANCILLARY SERVICE COST CENTERS				Carlo de Perry Visita de Carlo de Carlo	
50.00 O5000 OPERATING ROOM	0.469075				50.00
51.00 05100 RECOVERY ROOM	0.000000				51.00
53.00 O5300 ANESTHESIOLOGY	0.000000				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128255				54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000				55.00
56.00 05600 RADIOISOTOPE	0.118186				56.00
57.00 05700 CT SCAN	0.204966				57.00 58.00
58.00 05800 MRI	0.000000				59.00
59.00 O5900 CARDIAC CATHETERIZATION	0.112529				60.00
60.00 06000 LABORATORY	0.143623 NLY 0.000000				61.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD C					62.00
64.00 06400 INTRAVENOUS THERAPY	0.000000				64.00
65.00 06500 RESPIRATORY THERAPY	0.303290				65.00
66,00 06600 PHYSICAL THERAPY	0.000000				66.00
67.00 06700 OCCUPATIONAL THERAPY	0.00000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69.00 06900 ELECTROCARDIOLOGY	0.214338				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENT 0.756080				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.756082				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.174260				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTE					89.00
90.00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0.366305				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P		Country on a training the second of the second on the second			92.00
OTHER REIMBURSABLE COST CENTERS			Section of section and design and an experience		00.00
99.00 09900 CMHC					99.00
101.00 10100 HOME HEALTH AGENCY			ANNA Specific District Control of Control		101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE	ngarat was ng Ninjing Nanggi gapa (jada ninga)		Telephone S1003 - No. 38850 24155	A REAL PROPERTY OF THE PROPERTY OF	113.00
200.00 Subtotal (see instructions)				ſ	200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
LUZION (Jee HISCHUCCIONS)	1			ı	1-32.00

EDUCTIONS FOR MEDICALD ONLY			To	12/31/2016	Date/Time Pre 5/31/2017 12:		
	***	•	Tit	le XIX	Hospital	PPS	
Cost Center Des	cription	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Par	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COS	T CENTERS						
50.00 O5000 OPERATING ROOM		3,888,388	738,407	3,149,981	0	0	
51.00 05100 RECOVERY ROOM		0	(0	0	0	
53.00 05300 ANESTHESIOLOGY		0	(0	0	0	
54.00 05400 RADIOLOGY-DIAGNO	OSTIC	470,627	70,688	399,939	0	0	54.00
55.00 05500 RADIOLOGY-THERA	PEUTIC	0	(0	0	0	55.00
56.00 05600 RADIOISOTOPE		498,573	76,97	421,602	0	. 0	56.00
57.00 05700 CT SCAN		772,252	75,976	696,276	0	0	57.00
58.00 05800 MRI		0	. (0	0	0	58.00
59.00 05900 CARDIAC CATHETE	RIZATION	1,722,994	187,27	1,535,717	0	. 0	59.00
60.00 06000 LABORATORY		2,897,652	116,088	2,781,564	0	0	60.00
61.00 06100 PBP CLINICAL LA	3 SERVICES-PRGM ONLY	0	. (o o	0	0	61.00
62.00 06200 WHOLE BLOOD & PA	ACKED RED BLOOD CELL	0		o o	0	.0	62.00
64.00 06400 INTRAVENOUS THE	RAPY	0	(ol o	0	0	64.00
65.00 06500 RESPIRATORY THE		1,047,222	48,14	999,080	0	0	65.00
66.00 06600 PHYSICAL THERAP		, , ,	, (0	0	0	66.00
67.00 06700 OCCUPATIONAL TH		0		ol ol	0	0	67.00
68.00 06800 SPEECH PATHOLOG		o	(ol ol	0	0	68.00
69.00 06900 ELECTROCARDIOLO		575,946	42,48	533,458	0	0	69.00
70.00 07000 ELECTROENCEPHAL		0	,	ol ol	0	0	70.00
71.00 07100 MEDICAL SUPPLIE		673,610	30,11	643,493	0	0	71.0
72.00 07200 IMPL. DEV. CHAR		4,943,246			0	0	72.00
73.00 07300 DRUGS CHARGED TO		2,173,273	92,25		0	0	1
OUTPATIENT SERVICE CO							1
88.00 08800 RURAL HEALTH CL		0		0	0	0	88.00
89.00 08900 FEDERALLY QUALI		0		ol ol	0	0	89.00
90.00 09000 CLINIC		0			0	0	1
91.00 09100 EMERGENCY		1,510,940	69,95	1,440,986	0	0	91.00
92.00 09200 OBSERVATION BED	S (NON-DISTINCT PART	818,058			0	. 0	
OTHER REIMBURSABLE CO		STATE OF THE STATE		K says a Wassanis in.			
99.00 09900 CMHC		0		0	0	0	99.00
101.00 10100 HOME HEALTH AGE	NCY:	ő			0		101.00
SPECIAL PURPOSE COST		de personal de la company			as areas garti		
113.00 11300 INTEREST EXPENS						<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	113.00
	F lines 50 thru 199)	21,992,781	1,935,53	20,057,246	0	o	200.00
201.00 Less Observation		818,058	166,16		ő		201.00
202.00 Total (line 200		21,174,723			ő		202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet C | Part II |
| To | 12/31/2016 | Date/Time Prepared: | 5/31/2017 | 12:08 pm

					10 12/31/20	5/31/2017 12	2:08 pm
			Tit	e XIX	Hospital	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and	(Worksheet C,	Cost to Charg	je		
			Part I, column		6		
		Reduction	8) 7,00	/ col. 7) 8.00			
854004904040	TILLIAN DEPLETE COCT CENTERS	6.00	7,00	8.00			
	ILLARY SERVICE COST CENTERS	3,888,388	8,289,485	0,46907	75	State and adversary of the hypercolor	50.0
	LOO RECOVERY ROOM	3,000,300	0,209,403	0.00000	3		51.0
	00 ANESTHESIOLOGY			0.00000			53.0
	100 RADIOLOGY-DIAGNOSTIC	470,627	3,669,459				54.0
		470,027	3,009,438	0.00000			55.0
	000 RADIOLOGY-THERAPEUTIC	498,573	4,218,561	1 .			56.0
	500 RADIOISOTOPE	1					57.0
	700 CT SCAN	772,252	3,767,712	0.20490			58.0
	300 MRI	1 722 004	15 211 52		1		59.0
	000 CARDIAC CATHETERIZATION	1,722,994			1		60.0
	000 LABORATORY	2,897,652	20,175,381	0.14362			61.0
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY	l u		0.00000			62.0
	000 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.00000			64.0
	00 INTRAVENOUS THERAPY	1 047 222	2 452 000	3			65.0
	000 RESPIRATORY THERAPY	1,047,222	3,452,868	0.00000			66.0
	000 PHYSICAL THERAPY	0					67.0
	700 OCCUPATIONAL THERAPY	0	1	0.00000			68.0
	300 SPEECH PATHOLOGY	O	2 507 006	0.00000			69.0
	000 ELECTROCARDIOLOGY	575,946	2,687,089				70.0
	000 ELECTROENCEPHALOGRAPHY	677 646	200 024	0.00000			70.0
	LOO MEDICAL SUPPLIES CHARGED TO PATIENT	673,610			ŧ		72.0
	200 IMPL. DEV. CHARGED TO PATIENTS	4,943,246					
	300 DRUGS CHARGED TO PATIENTS	2,173,273	12,471,453	0.17426	50	4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4	73.0
	PATIENT SERVICE COST CENTERS	T				final strain and the state of	88.0
	300 RURAL HEALTH CLINIC	0	(0.00000			89.0
	000 FEDERALLY QUALIFIED HEALTH CENTER		(0.00000	· · ·		90.0
	000 CLINIC	0	(0.00000			1
	LOO EMERGENCY	1,510,940					91.0
	200 OBSERVATION BEDS (NON-DISTINCT PART	818,058	682,427	1.1987	48	Section Committee Committe	92.0
	IER REIMBURSABLE COST CENTERS	garing ang agramag ana san				and a series of the contribution	
99.00 099	The state of the s	0					99.0
	LOO HOME HEALTH AGENCY	<u> </u>	(0.00000			101.0
	CIAL PURPOSE COST CENTERS	- RECORD (1985) 1 11/2 11/2 11/2 11/2 11/2 11/2 11/2 1			9845 2023 BBC 1210 13		112 ^
	300 INTEREST EXPENSE	24 000	04 070 44				113.0
200.00	Subtotal (sum of lines 50 thru 199)	21,992,781		1			200.0
201.00	Less Observation Beds	818,058					
202.00	Total (line 200 minus line 201)	21,174,723	86,279,684	1			202.0

Health Financial Systems	KENTUCKIANA ME	KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-1			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016				
		Title	≥ XVIII	Hospital	PPS			
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - co 2)	Days	Per Diem (col. 3 / col. 4)			
	1.00	2.00	3,00	4.00	5.00	2.7833		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 ADULTS & PEDIATRICS	2,478,189		2,478,18	39 9,724		1		
31.00 INTENSIVE CARE UNIT	0			0	0.00	1		
44.00 SKILLED NURSING FACILITY	0			0	0.00			
45.00 NURSING FACILITY	0			0 0	0.00	1		
200.00 Total (lines 30-199)	2,478,189		2,478,18	39 9,724		200.00		
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)						
	6.00	7.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 ADULTS & PEDIATRICS	5,011	1,277,053	3			30.00		
31.00 INTENSIVE CARE UNIT	0	C				31.00		
44.00 SKILLED NURSING FACILITY	0	į c)			44.00		
45.00 NURSING FACILITY	0	C)			45.00		
200.00 Total (lines 30-199)	5,011	1,277,053	3			200.00		

Health	Financial Systems	KENTUCKIANA ME	~~ ~~			u of Form CMS-2	<u> 2552-10</u>
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016		pared: 08 pm
				Title XVIII		PPS	
	Cost Center Description		Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	738,407	8,289,485		, ,		
51.00	05100 RECOVERY ROOM	0	0	0.00000		0	
53.00	05300 ANESTHESIOLOGY	0	C	0.00000	- 1	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	70,688	3,669,459			17,390	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	C	0.00000		0	
56.00	05600 RADIOISOTOPE	76,971				•	
57.00	05700 CT SCAN	75,976	3,767,712				
58.00	05800 MRI	0	0	0.00000		0	
59.00	05900 CARDIAC CATHETERIZATION	187,277					
60.00	06000 LABORATORY	116,088	20,175,381	0.00575	8,330,117	47,931	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	į c	0.00000		0	02.00
64.00	06400 INTRAVENOUS THERAPY	0		0.00000		26.073	64.00
65.00	06500 RESPIRATORY THERAPY	48,142	3,452,868			26,972	
66.00	06600 PHYSICAL THERAPY	0	9	0.00000		0	
67.00	06700 OCCUPATIONAL THERAPY	0	į c	0.00000		0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0 227	0.00000		1	68.00
69.00	06900 ELECTROCARDIOLOGY	42,488	2,687,089			15,129	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	1	0	1.0.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30,117					
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	221,009					
73.00	07300 DRUGS CHARGED TO PATIENTS	92,254	12,471,453	0.00739	5,789,449	42,825	73.00

69,954

166,164 1,935,535

0

0

4,124,809

86,279,684

682,427

0

0.000000

0.000000 0.000000 0.016959

0.243490

0 88.00

0 89.00

0 90.00

6,134 91.00 33,454 92.00

657,124 200.00

0

361,724

137,395

30,270,359

200.00

90.00 09000 CLINIC

91.00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

88.00 08800 RURAL HEALTH CLINIC

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50-199)

Health Financial Systems	KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COSTS	Provider Co		Period: From 01/01/2016 To 12/31/2016			
			XVIII	Hospital	PPS		
Cost Center Description	Nursing School A	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)		
	1.00	2.00	3.00	4.00	5.00	108109999	
INPATIENT ROUTINE SERVICE COST CENTERS		建筑设计的平均的					
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY Total (lines 30-199) Cost Center Description	0 0 0 0 0 Total Patient Pa	0 0 0 0 er Diem (col. 5 ÷ col. 6)	Inpatient Program Days	0 0 1 0 Inpatient Program	0 0 0 0	30.00 31.00 44.00 45.00 200.00	
	6,00	7.00	8.00	Pass-Through Cost (col. 7 x col. 8) 9.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 44.00 04400 SKILLED NURSING FACILITY	9,724 0 0	0.00 0.00 0.00	ŕ	1 0 0 0 0 0		30.00 31.00 44.00	
45.00 04500 NURSING FACILITY 200.00 Total (lines 30-199)	9,724	0.00		0 1 0		45.00 200.00	

In Lieu of Form CMS-2552-10

Period:	Worksheet D	Part IV	
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Date/Time Prepared:	Part IV
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
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To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
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To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV	
To	12/31/2016	Part IV Health Financial Systems KENTUCKIANA MEDICAL CENTER	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0176

THROUGH COSTS

				'	0 12/31/2016	5/31/2017 12:08 pm	
			Title	XVIII	Hospital	PPS	
	Cost Center Description	Non Physician N Anesthetist Cost	Nursing School		Medical Education Cost	4)	
		1.00	2.00	3.00	4.00	5.00	Second Williams
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	į c	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	C	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	C	0	0:	55.00
56.00	05600 RADIOISOTOPE	0	0	c) 0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	į c	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	C	0	0	59.00
60.00	06000 LABORATORY	0	Ō	C) 0	0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C) 0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	C) 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	C	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	C) 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(o o	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	l c	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	C	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	C) 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	() 0	0	89.00
90.00	09000 CLINIC	0	0	() 0	0	90.00
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0	0	92.00
200.00	Total (lines 50-199)	0	0	() 0	0	200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	KENTUCKIANA ME		CN: 15-0176	Period:	u of Form CMS-1 Worksheet D	-332 10
THROUGH COSTS	ERVICE OTHER TAD	5 Movider C		From 01/01/2016	Part IV	
				To 12/31/2016	Date/Time Pre 5/31/2017 12:	pared:
		T+1-1	XVIII	Hospital	5/31/2017 12: PPS	U8 pm
Cost Center Description	Total	Total Charges			Inpatient	STATES.
Cost Center Description	Outpatient	(from Wkst. C.		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7,00	8,00	9,00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	8,289,485			3,312,510	
51.00 05100 RECOVERY ROOM	0	ıl c	0.00000		0	I .
53.00 O5300 ANESTHESIOLOGY	0) C	0.00000		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	3,669,459			902,717	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	rj c	0.00000		0	
56.00 05600 RADIOISOTOPE	0	4,218,561			703,655	
57.00 05700 CT SCAN	0	3,767,712			897,669	
58.00 05800 MRI	0	ų c	0.00000		0	
59.00 05900 CARDIAC CATHETERIZATION	0	15,311,537		1 1	4,331,952	
60.00 06000 LABORATORY	0	20,175,381	0.00000	0.000000	8,330,117	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	ų c	0.00000		0	
64.00 06400 INTRAVENOUS THERAPY	0	(C	0.00000		0	
65.00 06500 RESPIRATORY THERAPY	0	3,452,868			1,934,420	
66.00 06600 PHYSICAL THERAPY	0	9	0.00000		0	
67.00 06700 OCCUPATIONAL THERAPY	0	9	0.00000		0	
68.00 06800 SPEECH PATHOLOGY	0		0.00000		0	
69.00 06900 ELECTROCARDIOLOGY	0	2,687,089	1		956,824	
70.00 07000 ELECTROENCEPHALOGRAPHY	. 0		0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	890,924			381,740	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,537,979			2,230,187	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	12,471,453	0.00000	0.000000	5,789,449	73.00
OUTPATIENT SERVICE COST CENTERS	N 40 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2	1	0.0000	0.00000	7 30 - 1 (8 1) (3) (8) (8) (9) (4) (4) (4) (4) (4) (4) (4	00.00
88.00 08800 RURAL HEALTH CLINIC	0]	0.00000		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	"]	0.00000		0	
91.00 09100 EMERGENCY	"	4,124,809			361,724	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		4,124,809			137,395	
200.00 Total (lines 50-199)	"	86,279,684		0.000000	30,270,359	
Socion linear (Lines 20-Taa)	1	00,219,004	1	1	30,210,339	1200.00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2016 Part IV
To 12/31/2016 Date/Time Prepared:

			['	ro 12/31/2016	Date/Time Pr 5/31/2017 12	
		Title	⊇ XVIII	Hospital	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS				20170 22 200 21 20 <u>0</u>	s, also est a de la companione de	
50.00 O5000 OPERATING ROOM	0	745,352	9	2		50.00
51.00 05100 RECOVERY ROOM	O O	C))		51.00
53.00 05300 ANESTHESIOLOGY	o o	C) ()		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	474,109) (P		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	C) ()		55.00
56.00 05600 RADIOISOTOPE	0	1,253,322	2 ()		56.00
57.00 05700 CT SCAN	0	571,340) ()		57.00
58.00 05800 MRI	0	C) ()		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	2,434,217	' ()		59.00
60.00 06000 LABORATORY	0	1,027,545	5 ()		60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C				62.00
64.00 06400 INTRAVENOUS THERAPY	0	C) (64.00
65.00 06500 RESPIRATORY THERAPY	0	19,271	L) ()		65.00
66.00 06600 PHYSICAL THERAPY	o	C) (66.00
67.00 06700 OCCUPATIONAL THERAPY	o	C) (67.00
68.00 06800 SPEECH PATHOLOGY	0	C				68.00
69.00 06900 ELECTROCARDIOLOGY	o	354,925	5 (o		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	, c				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	227,383	3) .		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	1,266,319				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	515,619		ol		73.00
OUTPATIENT SERVICE COST CENTERS						ÿ.
88.00 08800 RURAL HEALTH CLINIC	0	C) (88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ċ				89.00
90.00 09000 CLINIC	l	Č				90.00
91.00 09100 EMERGENCY	o	722,523	3			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	257,786				92.00
200.00 Total (lines 50-199)	0	9,869,711				200.00

					To 12/31/2016	Date/Time Pro 5/31/2017 12	
***************************************			Title	XVIII	Hospital	PPS	
		Co	sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7,00				
<u> </u>	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATING ROOM	0	0				50.00
51.00	The state of the s	0	0	Ú.			51.00
53.00		0	0	(53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	Ų.			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	ı.			55.00
56.00	05600 RADIOISOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MRI	0	0	ł			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	1			59.00
60.00	06000 LABORATORY	0	0				60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		1			61.00
62.00	t I	0	0	1			62.00
	06400 INTRAVENOUS THERAPY	0	0	1			64.00
	06500 RESPIRATORY THERAPY	0	1 0				65.00
66.00		0	9	1			66.00
67.00		0	9	1			67.00
68.00	1	0	0	}			68.00
69.00	(0	0				69.00 70.00
70.00	1 ' 1						71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			()			72.00
72.00				1			73.00
73.00				A Sana a 196 de l'hydrighest			1 /3.00
88.00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	- C	ıl c	1			88.00
89.00			1	1			89.00
90.00			i c				90.00
91.00			i c				91.00
92.00			j č				92.00
200.00		ì	ا				200.00
201.0			·				201.00
20210	Only Charges		}				
202.00	1 1 2	(c	C				202.00

Health Financial Systems	KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016			
		Tit	le XIX	Hospital	PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3,00	4.00	5.00	1254842	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2,478,189	(2,478,18	9,724			
31.00 INTENSIVE CARE UNIT	0			0	0.00		
44.00 SKILLED NURSING FACILITY	0			0	0.00	1	
45.00 NURSING FACILITY	0			0	0.00	45.00	
200.00 Total (lines 30-199)	2,478,189		2,478,18	9,724		200.00	
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
	6,00	7.00				33,311,715,71	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	112	28,54	3			30.00	
31.00 INTENSIVE CARE UNIT	0	(D		•	31.00	
44.00 SKILLED NURSING FACILITY	0	(0			44.00	
45.00 NURSING FACILITY	0	(o			45.00	
200.00 Total (lines 30-199)	112	28,543	3			200.00	

0

0

0

69,954

166,164

1,935,535

0.000000

0.000000

0.000000

0.016959

0.243490

8,871

610,256

0

0

4,124,809

86,279,684

682,427

0 88.00

0 89.00

0 90.00

150 91.00

8,556 200.00

0 92.00

88.00

89.00

91.00

200.00

90.00 09000 CLINIC

09100 EMERGENCY

08800 RURAL HEALTH CLINIC

08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50-199)

Health Financial Systems	KENTUCKIANA ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C	Provider CCN: 15-0176		Worksheet D Part III Date/Time Pre 5/31/2017 12:	pared: 08 pm
		Tit	e XIX	Hospital	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0	1	O	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	0	}		0	44.00
45.00 04500 NURSING FACILITY	0	0			0	45.00
200.00 Total (lines 30-199)	0	0)	0	0	200.00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS					人名英格兰英格兰英	
30.00 03000 ADULTS & PEDIATRICS	9,724		i .	2] 0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0.00		0 0		31.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0 0		45.00
200.00 Total (lines 30-199)	9,724		11	2 0		200.00

	PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PAS HROUGH COSTS		Provider CCN: 15-0176		Period: From 01/01/201 To 12/31/201		pared:
				e XIX	Hospital	PPS	T
	Cost Center Description	Non Physician Nu Anesthetist Cost	irsing School	Allied Heal	th All Other Medical Education Cos	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	1000000
	ANCILLARY SERVICE COST CENTERS					A .	
	05000 OPERATING ROOM	0	(]	0	0	1
	05100 RECOVERY ROOM	0	(1	0	0 0	51.00
	05300 ANESTHESIOLOGY	0		(0	0	54.00
	05400 RADIOLOGY-DIAGNOSTIC	0	((0	55.00
	05500 RADIOLOGY-THERAPEUTIC	0	(0	0 0	
	05600 RADIOISOTOPE 05700 CT SCAN	0			0	0 0	57.00
	05800 MRI	0		ίl	0	0 0	58.00
	05900 CARDIAC CATHETERIZATION	0	í	á	o o	o o	59.00
	06000 LABORATORY	ő	Č	á	o	o o	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		•		1		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(o	0 0	62.00
	06400 INTRAVENOUS THERAPY	o	()	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	()	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	(0	0 0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	(0	0	
68.00	06800 SPEECH PATHOLOGY	0	()	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	(O	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	(P	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(9	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1 0	(וט	OI .	0 0	72.00

0 73.00

0

0 0

88.00 89.00 90.00 91.00

0 92.00 0 200.00

07100 MEDICAL SUPPLIES CHARGED TO PATIENT
07200 IMPL. DEV. CHARGED TO PATIENTS
07300 DRUGS CHARGED TO PATIENTS
0UTPATIENT SERVICE COST CENTERS

88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50-199)

73.00

90.00 09000 CLINIC 91.00 09100 EMERGENCY

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETHROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/31/2017 12:	pared: 08 pm
			e XIX	Hospital	PPS	
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8,00	9,00	10.00	(Maniya)
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0	8,289,485			25,593	
51.00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
33.00 05300 ANESTHESIOLOGY	0	0	0.00000		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	3,669,459			15,889	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.00000		0	55.00
66.00 05600 RADIOISOTOPE	0	4,218,561		1	16,340	
57.00 05700 CT SCAN	0	3,767,712			12,575	
58.00 05800 MRI	0	0	0.00000		0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	15,311,537	1		116,419	
50.00 06000 LABORATORY	0	20,175,381	0.00000	0.000000	167,945	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000		0	
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000		0	64.00
55.00 06500 RESPIRATORY THERAPY	0	3,452,868			64,327	
66.00 06600 PHYSICAL THERAPY	0	0	0.00000	· ·	0	66.00
57.00 06700 OCCUPATIONAL THERAPY	0	0	0.00000		0	67.00
58.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
59.00 06900 ELECTROCARDIOLOGY	0	2,687,089			21,474	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	890,924			2,427	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-,,			14,668	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12,471,453	0.00000	0.000000	143,728	73.00
OUTPATIENT SERVICE COST CENTERS				Appropriate property of the	<u> </u>	
38.00 08800 RURAL HEALTH CLINIC	0	·	0.00000			88.00
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	9	,			89.00
00.00 09000 CLINIC	0		0.00000			90.00
91.00 09100 EMERGENCY	0	.,,				91.00
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	682,427		0.000000		1
200.00 Total (lines 50-199)	0	86,279,684	ł	1	610,256	200.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS		RVICE OTHER PASS	CE OTHER PASS Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepar 5/31/2017 12:08	
	La company		Tit	le XIX	Hospital	PPS	
	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12) 13.00	h 9		
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	()	0		50.0
51.00	05100 RECOVERY ROOM	0	(oj .	0		51.0
53.00	05300 ANESTHESIOLOGY	0	(0	0		53.0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	(o	0		54.0
55.00	05500 RADIOLOGY-THERAPEUTIC	0	(0	0		55.0
56.00	05600 RADIOISOTOPE	0	(o	0		56.0
57.00	05700 CT SCAN	0	(o	0		57.0
8.00	05800 MRI	0	(0	0		58.0
59.00	05900 CARDIAC CATHETERIZATION	0	(0	0		59.0
60.00	06000 LABORATORY	0	(O	0		60.0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(o	0		62.0
64.00	06400 INTRAVENOUS THERAPY	O	(0	0		64.0
65.00	06500 RESPIRATORY THERAPY	0	(o	0		65.0
56.00	06600 PHYSICAL THERAPY	0	(0	0		66.0
57.00	06700 OCCUPATIONAL THERAPY	0	()	0		67.0
00.88	06800 SPEECH PATHOLOGY	0	(O	0		68.0
59.00	06900 ELECTROCARDIOLOGY	0	(O	0		69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(D	0		70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(D	0		71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(o	0		72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0		D	0		73.0
	OUTPATIENT SERVICE COST CENTERS						M.
88.00	08800 RURAL HEALTH CLINIC	0		0	0		88.0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(D	0		89.0
90.00	09000 CLINIC	0	(0	0		90.0
91.00	09100 EMERGENCY	0	(0	0		91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	•	0	0		92.0
200.00		0		0	0		200.

0.000000

0.756080

0.756082

0.174260

0.000000

0.000000

0.000000

0.366305

1.198748

0

0

0

0

568

5,966

21,669

98,264

372.102

372,102

4,431

O 70.00

0 71.00

0 72.00

0 73.00

0 88.00

0

0

O 91.00

0 92.00

89.00

90.00

200.00

201.00

0 202.00

0

0

0

0

0

07000 ELECTROENCEPHALOGRAPHY

08800 RURAL HEALTH CLINIC

09000 CLINIC

09100 EMERGENCY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Subtotal (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

70.00

71.00

72.00

73.00

88.00

89.00

90.00

91.00

92.00

200.00

201.00

202.00

In Lieu of Form CMS-2552-10
Period: Worksheet D
From 01/01/2016 Part V

					To 12/31/2016	Date/Time Pre 5/31/2017 12	epared: :08 pm
	A STATE OF THE STA		Tit	e XIX	Hospital	PPS	
1344843		Cos	sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6,00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS			- 400 10 A 1740 154			
	05000 OPERATING ROOM	1,957	C)			50.00
	05100 RECOVERY ROOM	0	l c)			51.00
53.00	05300 ANESTHESIOLOGY	0	C)			53.00
	05400 RADIOLOGY-DIAGNOSTIC	2,053	C				54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	C				55.00
56.00	05600 RADIOISOTOPE	1,945	C	o			56.00
57.00	05700 CT SCAN	8,947	i c)			57.00
58.00	05800 MRI	0	c)			58.00
59.00	05900 CARDIAC CATHETERIZATION	3,224	l c)			59.00
60.00	06000 LABORATORY	16,657	1 0)			60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	ļ)			62.00
	06400 INTRAVENOUS THERAPY	0	9)			64.00
	06500 RESPIRATORY THERAPY	658)			65.00
	06600 PHYSICAL THERAPY	0)			66.00
	06700 OCCUPATIONAL THERAPY	0		2			67.00
	06800 SPEECH PATHOLOGY	0		3			68.00 69.00
69.00	06900 ELECTROCARDIOLOGY	3,026		3			70.00
	07000 ELECTROENCEPHALOGRAPHY		1	2			71.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	429		(72.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	4,511		(73.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,776				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0	1 (N .			88.00
	08800 RURAL HEALTH CLINIC						89.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						90.00
	09000 CLINIC 09100 EMERGENCY	35,995		5			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,312		5			92.00
200.00		88,490		S.			200.00
201.00		00,450	`	1			201.00
201.00	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	88,490		o			202.00

	Financial Systems KENTUCKIANA MEDIC ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0176	Period: From 01/01/2016	Worksheet D-1		
				Date/Time Prep 5/31/2017 12:0	pared: 08 pm	
		Title XVIII	Hospital	PPS		
	Cost Center Description			1.00		
<u> Salatana</u>				1.00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	9,724	1.00			
2.00	Innatient days (including private room days, excluding swing-	bed and newborn days)		9,724		
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	ivate room days,	0	3.00	
3,00	do not complete this line.	,-, , , , ,				
4.00	Semi-private room days (excluding swing-bed and observation by	ed days)		9,072	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.00	
	reporting period		ļ			
.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00	
	reporting period (if calendar year, enter 0 on this line)			_	,	
.00	Total swing-bed NF type inpatient days (including private room	m days) through Decembe	31 of the cost	0	7.00	
	reporting period		17 a.E. wha	0	8.00	
.00	Total swing-bed NF type inpatient days (including private room	m days) after December	of the cost	U	6.00	
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Broggam (eyeluding	r swing-had and	5,011	9.0	
.00	notal inpatient days including private room days applicable of	o the Program (excluding	J Swilly-Ded alla	3,011	3.0	
0.00	Newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private)	room days)	0	10.00	
J.00	through December 31 of the cost reporting period (see instruc	ŭ	20101			
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o	0	11.00			
1.00	December 31 of the cost reporting period (if calendar year, e	_				
2.00						
	through December 31 of the cost reporting period		İ			
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	0	13.00			
	after December 31 of the cost reporting period (if calendar y					
L4.00	Medically necessary private room days applicable to the Progr	0				
15.00	Total nursery days (title V or XIX only)	0				
L6.00	Nursery days (title V or XIX only)		AND NOT THE RESIDENCE OF THE SECOND STATE OF T	0	16.0	
	SWING BED ADJUSTMENT	College of the Colleg		0.00	17.0	
.7.00	Medicare rate for swing-bed SNF services applicable to servic	es inrough becember 31 (or the cost	0.00	17.00	
	reporting period Medicare rate for swing-bed SNF services applicable to service	os after Docombon 31 of	the cost	0.00	18.00	
.8.00	reporting period	es after becember 31 01.	the tost	0,00	23.00	
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19.00	
	reporting period					
0.00		s after December 31 of	the cost	0.00	20.0	
	reporting period					
1.00	Total general inpatient routine service cost (see instruction	s)		12,200,619		
2.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22.0	
	5 x line 17)			_		
3,00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.0	
	x line 18)	74 C.1		^	24.0	
4.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.0	
- 00	7 x line 19)	21 of the cost manageria	n period Cline e	Λ	25.00	
5.00	Swing-bed cost applicable to NF type services after December	or the cost reporting	y periou (tine 8	0	23.00	
6 00	X line 20) Total swing-bed cost (see instructions)			0	26.0	
6.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12,200,619		
,,00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Cime 21 millus tille 20)		,00,015	1	
8.00	General inpatient routine service charges (excluding swing-be	d and observation hed c	harges)	0	28.00	
9.00	Private room charges (excluding swing-bed charges)	a and observation bed c	3-07	ō	1 .	
30.00	Semi-private room charges (excluding swing-bed charges)			0		
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	1	
32.00	of delicitat impact of a contract of the contr					
					33 0	

0.00

0.00

0.00

12,200,619

1,254.69

6,287,252

0 40.00

6,287,252 41.00

33.00

34.00

35.00

36.00 0

37.00

38.00

39.00

33.00

34.00

35.00

36.00

38.00

39.00

27 minus line 36)

PART II - HOSPITAL AND SUBPROVIDERS ONLY

Average semi-private room per diem charge (line 30 \div line 4)

Private room cost differential adjustment (line 3 x line 35)

Average per diem private room cost differential (line 34 x line 31)

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

Program general inpatient routine service cost (line 9 x line 38)

Adjusted general inpatient routine service cost per diem (see instructions)

40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)
41.00 Total Program general inpatient routine service cost (line 39 + line 40)

Average per diem private room charge differential (line 32 minus line 33)(see instructions)

General inpatient routine service cost net of swing-bed cost and private room cost differential (line

Provider CCN: 15-0176

Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/31/2017 12:08 pm

			T	o 12/31/2016	Date/Time Prep 5/31/2017 12:0	
		Title	XVIII	Hospital	PPS	0 9 111
	Cost Center Description Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost Inp	atient Days			(col. 3 x col.	
			col. 2)	4 00	4)	2000
	1.00	2.00	3,00	4,00	5.00	42.0
2.00	NURSERY (title V & XIX only)					72.0
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 0	0	0.00	0	0	43.0
4.00	CORONARY CARE UNIT	_				44.0
5.00	BURN INTENSIVE CARE UNIT					45.0
	SURGICAL INTENSIVE CARE UNIT					46.0
7.00	OTHER SPECIAL CARE (SPECIFY)		1			47.0
	Cost Center Description					
					1.00	対抗し
8.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, 1	ine 200)			7,693,290	1
9.00	Total Program inpatient costs (sum of lines 41 through 48)(see	instruction	ons)		13,980,542	49.0
	PASS THROUGH COST ADJUSTMENTS		<u> </u>		4 255 252	
0.00	Pass through costs applicable to Program inpatient routine ser	vices (from	n Wkst. D, sum	of Parts I and	1,277,053	50.0
	III)			£ 5 TT	657,124	51.0
1.00	Pass through costs applicable to Program inpatient ancillary s	ervices (ii	"OM WKSL. D, Su	m or Parts 11	037,124	31.
	and IV)				1,934,177	52.0
2.00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital relat	ed non-phy	vsician anesthe	tist and	12,046,365	1
3.00	medical education costs (line 49 minus line 52)	.cu, non pm	Jordian andsend	erse, and		
	TARGET AMOUNT AND LIMIT COMPUTATION					
4.00	Program discharges			3,,,=====	0	54.
	Target amount per discharge				0.00	55.
6.00	Target amount (line 54 x line 55)				0	
7.00	Difference between adjusted inpatient operating cost and targe	et amount (line 56 minus 1	ine 53)	0	
8.00	Bonus payment (see instructions)				0	1
9.00	Lesser of lines 53/54 or 55 from the cost reporting period end	ling 1996, ι	updated and com	pounded by the	0.00	59.
	market basket				1	
0.00	Lesser of lines 53/54 or 55 from prior year cost report, updat	ed by the r	market basket		0.00	
1.00	If line 53/54 is less than the lower of lines 55, 59 or 60 ent	er the less	ser of 50% of t	the amount by	0	61.
	which operating costs (line 53) are less than expected costs (Tines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see instructions)				0	62.
52.00	Relief payment (see instructions)	lana)			0	1
33.00	Allowable Inpatient cost plus incentive payment (see instructi	ions)				- 03.
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December	n 31 of the	a cost reportir	na neriod (See	0	64.
4.00	instructions)(title XVIII only)	21 27 01 011	e cost reporti	ig per rou (see		1
55.00	Medicare swing-bed SNF inpatient routine costs after December	31 of the	cost reporting	period (See	0	65.
,,,,,	instructions)(title XVTIT only)					
56.00	Total Medicare swing-bed SNF inpatient routine costs (line 64	plus line	65)(title XVIII	only). For	0	66.
	CAH (see instructions)				_	l
57.00		ecember 31 (of the cost rep	orting period	0	67.
	(line 12 x line 19)					
58.00		ember 31 of	the cost repor	ting period	0	68.
	(line 13 x line 20)		- (0)		0	69.
59.00	Total title V or XIX swing-bed NF inpatient routine costs (lin	16 6/ + 11N	e 68)			09.
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A	AND TCF/TID	COST (line 27)	A CONTRACTOR OF THE PROPERTY O		70.
0,00	Skilled nursing facility/other nursing facility/ICF/IID routing Adjusted general inpatient routine service cost per diem (line	ic service (2)			71.
	Program routine service cost (line 9 x line 71)	. /	-,			72.
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	line 14 v 1	ine 35)			73.
3.00 4.00		7 + line 73)			74
5.00		osts (from	Worksheet B. Pa	art II. column		75
3.00	26, line 45)			,,,		-
6.00						76.
	Program capital-related costs (line 9 x line 76)					77.
8.00	Inpatient routine service cost (line 74 minus line 77)					78
9.00	Aggregate charges to beneficiaries for excess costs (from prov	vider recor	ds)			79
0.00	Total Program routine service costs for comparison to the cost	t limitatio	n (line 78 minu	ıs line 79)	•	80
1.00	Inpatient routine service cost per diem limitation					81
2.00	Inpatient routine service cost limitation (line 9 x line 81)					82
33.00	Reasonable inpatient routine service costs (see instructions)					83
34.00	Program inpatient ancillary services (see instructions)					84
35.00	Utilization review - physician compensation (see instructions))				85
	Total Program inpatient operating costs (sum of lines 83 through	ugh 85)	tu solujujuju na nesas ne n	TWO SHOULD BE AND A STATE OF THE	1 30.50, 30.583 N. (\$0.56.400 c.c.)	86.
36.00	THAT THE COMPUTATION OF ORCEDUATION DED DACK THROUGH COST	autori Herrigile			652	□ 2 87.
36.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				1 652	/ I X /
36.00 37.00	Total observation bed days (see instructions)					
36.00 37.00 38.00					1,254.69 818,058	88

Health	Financial Systems	KENTUCKIANA MED	ICAL CENTER		In Lieu of Form CMS-2552-10			
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prep 5/31/2017 12:0	pared:	
			Title	XVIII	Hospital	PPS		
	Cost Center Description		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	50.050-4	
	COMPUTATION OF OBSERVATION BED PASS THROU	GH COST						
90.00	Capital-related cost	2,478,189	12,200,619	0.20312	0 818,058	166,164	90.00	
91.00	Nursing School cost	0	12,200,619	0.00000	0 818,058	0	91.00	
92.00	Allied health cost	0	12,200,619	0.00000	0 818,058	0	92.00	
93.00	All other Medical Education	0	12,200,619	0.00000	0 818,058	0	93.00	

		Title XIX	Hospital	5/31/2017 12:0 PPS	08 p
	Cost Center Description	TICLE XIX	NUSPICAL		-12/24
9,911,073	PART I - ALL PROVIDER COMPONENTS			1.00	Design of the last
1	INPATIENT DAYS]
00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		9,724	
00	Inpatient days (including private room days, excluding swing-b			9,724	
0	Private room days (excluding swing-bed and observation bed day	's). If you have only pr	ivatė room days,	0	3
	do not complete this line.			0.073	١.
0	Semi-private room days (excluding swing-bed and observation be		. 21 -6 -4	9,072	5
0	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 or the cost	. 0	-
0	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	o	1
٠	reporting period (if calendar year, enter 0 on this line)	m days) areer becember	or the cost	J	`
0.	Total swing-bed NF type inpatient days (including private room	ı days) through December	31 of the cost	0	7
	reporting period				
0	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
_	reporting period (if calendar year, enter 0 on this line)			440	١,
0	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	112	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days)	o	10
00	through December 31 of the cost reporting period (see instruct		oom days)	Ŭ	-
00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	1:
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			١
.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12
	through December 31 of the cost reporting period			_	١
00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	1:
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter o on this iin	days)	0	14
	Total nursery days (title V or XIX only)	am (excluding swing-bed	uuys)	ő	
	Nursery days (title V or XIX only)			0	1
	SWING BED ADJUSTMENT				1
00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	1
	reporting period		A-1	0.00	1
00	Medicare rate for swing-bed SNF services applicable to service	es atter December 31 of	tne cost	0.00	1
00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	119
•	reporting period				
00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period			10 000 510	١.,
	Total general inpatient routine service cost (see instructions			12,200,619 0	
00	Swing-bed cost applicable to SNF type services through Decembe 5×1 ine 17)	in 31 of the cost report	ing period (Tine	U.	22
ഹ	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	2:
	x line 18)		, , , , , , , , , , , , , , , , , , ,		
.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	2
00	x line 20) Total swing-bed cost (see instructions)			0	20
00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		12,200,619	1
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	_
	Private room charges (excluding swing-bed charges)			0	1
	Semi-private room charges (excluding swing-bed charges)	74		0 000000	1
	General inpatient routine service cost/charge ratio (line 27 +	- 11ne 28)		0.000000	1
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin			0.00	1
00	Private room cost differential adjustment (line 3 x line 35)	-		0	
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	12,200,619	3
	27 minus line 36)			3.31555	-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		estate de la company de la Santa de La Santa de La Santa de La Santa de La Santa de La Santa de La Santa de La La companya de la companya de la companya de la companya de la companya de la companya de la companya de la co	1,254.69	1 2
	Adjusted general inpatient routine service cost per diem (see			140,525	1
	Program general innations routing convice cost (line Q v line				1 -
.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	4(

87.00

652 1,254.69 88.00

818,058 89.00

Total observation bed days (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health Financial Systems	KENTUCKIANA MED	KENTUCKIANA MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	1	Period: From 01/01/2016 Fo 12/31/2016		pared:		
		Titl	e XIX	Hospital	PPS			
Cost Center Description	4 4 5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	2,478,189	12,200,619	0.20312	818,058	166,164	90.00		
91.00 Nursing School cost	0	12,200,619	0.00000	818,058	0	91.00		
92.00 Allied health cost	0	12,200,619	0.00000	818,058	0	92.00		
93.00 All other Medical Education	0	12,200,619	0.00000	818,058	0	93.00		

164,702

7,693,290 200.00

137,395 30,270,359

30,270,359

1.198748

92.00

201.00

202.00

91.00 09100 EMERGENCY

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

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

1.198748

610.256

610,256

92.00

201.00

202.00

0 121,106 200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200,00 201.00

202.00

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

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

			10 12/31/2010	5/31/2017 12:	
	**************************************	Title XVIII	Hospital	PPS	
				1.00	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
8088038	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	10000
	DRG Amounts Other than Outlier Payments	1986 - 1976 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 - 1986 -	A. A. A. A. A. A. A. A. A. A. A. A. A. A	0	1.
	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1	(see	6,098,537	1.
2	instructions) DRG amounts other than outlier payments for discharges occurri	ing on or after Octobe	r 1 (see	1,889,942	1.
3	instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1.
4	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1.
	October 1 (see instructions)	or a (serial ges secur) m	, 011 01 01 01	722,571	
	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			722,371	l
	Outlier payment for discharges for Model 4 BPCI (see instructi	ions)		ő	1
	Managed Care Simulated Payments	101137		1,790,252	
	Bed days available divided by number of days in the cost repor	rting period (see inst	ructions)	44.22	1
	Indirect Medical Education Adjustment				
0	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	g period ending on	0.00	5.
0	FTE count for allopathic and osteopathic programs which meet t for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add	i-on to the cap	0.00	6
0	MMA Section 422 reduction amount to the IME cap as specified u	inder 42 CEP 8412 105(E)(1)(iv)(B)(1)	0.00	7
	ACA Section 5503 reduction amount to the IME cap as specified			0.00	
_	If the cost report straddles July 1, 2011 then see instruction		(.,,(-,,(-,,(-,,		
0	Adjustment (increase or decrease) to the FTE count for allopat		rograms for	0.00	8
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7				
.	1998), and 67 FR 50069 (August 1, 2002).	to make the property of the pr	-E-41- 101 TE	0.00	
1	The amount of increase if the hospital was awarded FTE cap slotthe cost report straddles July 1, 2011, see instructions.	ots under section 5503	or the ACA, IT	0.00	8
2	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teach	ning hospital	0.00	8
-	under section 5506 of ACA. (see instructions)	Jes irom a crosea ceae.	ing nospicar	0,00	
0	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02)	(see	0.00	9
	instructions)	_			
	FTE count for allopathic and osteopathic programs in the curre	ent year from your reco	ords	0.00	\$
	FTE count for residents in dental and podiatric programs.			0.00	
	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	
	Total allowable FTE count for the penultimate year if that yea	ar ended on or after So	entember 30 1997	0.00	1
00	otherwise enter zero.	ar chaca on or areer so	epecinise, 30, 2337,	0.00	
00	Sum of lines 12 through 14 divided by 3.			0.00	15
00	Adjustment for residents in initial years of the program			0.00	
00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17
	Adjusted rolling average FTE count			0.00	
	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
	<pre>IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section</pre>	ion 422 of the MMA	hereach and solutions and		44
	Number of additional allopathic and osteopathic IME FTE reside		Sec. 412.105	0.00	23
-	(f)(1)(iv)(c).				
00	IME FTE Resident Count Over Cap (see instructions)			0.00	24
00	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or li	ne 24 (see	0.00	25
	instructions)				
	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions))		0	
00	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.03	1)		0	
ΔŢ	Disproportionate Share Adjustment	• <i>•</i> 3000)	University of the second second second second second second second second second second second second second se		1 23
00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instr	uctions)	8.66	30
00	Percentage of Medicaid patient days (see instructions)	<u></u> <u></u>		10.39	
	Sum of lines 30 and 31			19.05	
	Allowable disproportionate share percentage (see instructions))		5.13	33
~~	Disproportionate share adjustment (see instructions)			102,453	1 3/

O 70.93

0

70.94

70.95

-110,384

70.92

70.93

70.94

HVBP payment adjustment amount (see instructions)

HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Health	Health Financial Systems KENTUCKIANA MEDIC			In Lieu of Form CMS-2552-		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/31/2017 12:	
		Title	XVIII	Hospital	PPS	
			FF)	′ (yyyy)	Amount	7x (5 (4.15)
DATE STATE			53,000	0	1.00	White tells
70.96		n column 0		0	0	70.96
	the corresponding federal year for the period prior to 10/1)				_	
70.97				0	0	70.97
70.00	the corresponding federal year for the period ending on or af	ter 10/1)			0	70.00
70.98					-	1
	HAC adjustment amount (see instructions)	60 8 70)			20,755 9,017,818	
	Amount due provider (line 67 minus lines 68 plus/minus lines	09 & 70)			180,356	
	Sequestration adjustment (see instructions)				8,919,102	
	Interim payments Tentative settlement (for contractor use only)				0,919,102	73.00
74.00		and 73)			-81,640	
	Protested amounts (nonallowable cost report items) in accorda				89,766	
73.00	CMS Pub. 15-2, chapter 1, §115.2	nec men		•	05,700	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		CHAIL HE NOTED			
90.00		tructions)	1		0	90.00
91.00					0	91.00
92.00		uctions)			0	92.00
93.00	i •		1		0	93.00
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.00
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 instruc	tions)			0	96.00
Market (Prior to 10/1		
				1.00	2.00	200
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment	750 HOST ALE				
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	
102,00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment		ang was les Alexandre		0.000	102.00
	HRR adjustment factor (see instructions)	`		0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

Health	Financial Systems		KENTUCKIANA MED	DICAL CENTER		In Lie	u of Form CMS-2	552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider Co	F	reriod: rom 01/01/2016 o 12/31/2016	Worksheet E Part A Exhibit Date/Time Prep 5/31/2017 12:0	t 4 pared: 08 pm
					XVIII	Hospital	PPS	
		W/S E, Part A line 0	Amounts (from E, Part A) 1.00	Pre/Post Entitlement 2.00	Period Prior to 10/01 3.00	Period On/After 10/01 4.00	Total (Col 2 through 4) 5.00	
1.00	DRG amounts other than outlier payments		0	0		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,098,537	0	6,098,537		6,098,537	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October	1.02	1,889,942	Ó		1,889,942	1,889,942	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	C		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	722,571	0	650,705	71,866	722,571	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	C	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	C	0	0	3.00
4.00	Managed care simulated payments	3,00	1,790,252	0	C	0	0	4.00
	Indirect Medical Education Adj							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0		U	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0		post, at the day, and a few seconds		6.01
7.00	Indirect Medical Education Adjustment factor	27.00	0,000000	0.000000		0.00000		7.00
8.00	(see instructions) IME adjustment (see	28.00	0,000000	0.00000		0		8.00
8.01	instructions) IME payment adjustment add on	28.01	o	0		0	0	8.01
	for managed care (see instructions)			•				0.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0			0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	U)	J	9.01
	Disproportionate Share Adjustm	ent						
10.00		33.00	0.0513	0.0513	0.051	0.0513		10.00
11 00	share percentage (see instructions) Disproportionate share	34.00	102,453	0	78,214	24,239	102,453	11.00
11.00	adjustment (see instructions) Uncompensated care payments	36.00	154,029	0				
	Additional payment for high pe							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0		0	0	
13.00 14.00		47.00 48.00	8,967,532 0	0	6,943,059	2,024,473 0 0	8,967,532 0	
15.00	(see instructions)	49.00	8,967,532	C	6,943,059	2,024,473	8,967,532	15.00
16.00		50.00	1,000,616	C	841,29	159,322	1,000,616	16.00
17.00	Special add-on payments for new technologies	54.00	2,071	C		2,071	2,071	17.00
17.01 17.02	Credits received from manufacturers for replaced	68.00	0	d)	0	0	17.01 17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	o	C		0	0	18.00

			•		1	0 12/31/2016	5/31/2017 12:	
				Title	XVIII	Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	7,784,353	2,185,866	9,970,219	19.00
		W/S L, line	(Amounts from L)					
San Hill		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	639,574	0	486,944	152,630	639,574	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	(0	C	20.01
21.00	Capital DRG outlier payments	2.00	361,042	0	354,350	6,692	361,042	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	(0	C	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	(0	С	23,00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	(0	C	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,000,616	0	841,294	159,322	1,000,616	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	1000 A 100
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70.96			0.117143 911,882		911,882	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				192,044	192,044	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N			,		100.00

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2016 Part A Exhibit 5
To 12/31/2016 Date/Time Prepared: Health Financial Systems KENTUCKIANA MEDICAL CENTER
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0176

				11	0 12/31/2016	5/31/2017 12:0	
			Title	XVIII	Hospital	PPS	о ры
THE HOLE		Wkst, E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	3043344
		A. line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1.00	2.00	3.00	4.00	WHA!
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for	1.01	6,098,537	6,098,537		6,098,537	1.01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1.02	1,889,942		1,889,942	1,889,942	1.02
	discharges occurring on or after October 1						
1.03	DRG for Federal specific operating payment	1.03	0	0		0	1.03
	for Model 4 BPCI occurring prior to October						
	1	1.04				0	1.04
1.04	DRG for Federal specific operating payment	1.04	U		0		1.04
	for Model 4 BPCI occurring on or after October 1						
2.00	Outlier payments for discharges (see	2.00	722,571	650,705	71,866	722,571	2.00
2.00	instructions)	2.00	122,311	030,703	71,000	722,371	2.00
2.01	Outlier payments for discharges for Model 4	2,02	٥	0	n	o	2.01
2.01	BPCI	2.02		ŭ	•	Ĭ	2.02
3.00	Operating outlier reconciliation	2.01	o	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,790,252	1,481,283	308,969	1,790,252	4.00
	Indirect Medical Education Adjustment	15 (A.A.) 18 MAR 18 FE 19 S		mark in the large	S1 - 44 10 5 10 00 00	A CHARLEST VEHICLE	
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	0	6.00
6.01	IME payment adjustment for managed care (see	22.01	0	0	0	0	6.01
	instructions)						
	Indirect Medical Education Adjustment for the			ne MMA			
7.00	IME payment adjustment factor (see	27.00	0.000000	0.000000	0.000000	i l	7.00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	0	0	0	'l J	8.00
8.01	IME payment adjustment add on for managed	28.01	0	0	0	0	8.01
	care (see instructions)				_	ا ا	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of	29.01	ď	O ₁	U	0	9.01
	lines 6.01 and 8.01)					SCHOOL STREET	
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0.0513	0.0513	0.0513		10.00
10.00	(see instructions)	33.00	0.0313	0.0313	0.0313	1	10.00
11.00	Disproportionate share adjustment (see	34.00	102,453	78,214	24,239	102,453	11.00
TT.00	instructions)	34.00	102,433	10,221	27,233	102,133	11100
11.01	Uncompensated care payments	36.00	154,029	115,604	38,425	154,029	11.01
	Additional payment for high percentage of ESI	RD beneficiary	discharges		SIXTEMAN		
12.00		46.00	0	0	0	0	12,00
	instructions)						
13.00	Subtotal (see instructions)	47.00	8,967,532	6,943,060	2,024,472	8,967,532	13.00
14.00	Hospital specific payments (completed by SCH	48.00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15.00	Total payment for inpatient operating costs	49.00	8,967,532	6,943,060	2,024,472	8,967,532	15.00
	(see instructions)						
16.00	Payment for inpatient program capital	50.00	1,000,616	841,294			
17.00	Special add-on payments for new technologies	54.00	2,071	0	2,071	2,071	
17.01	Net organ acquisition cost			_	_		17.01
17.02	Credits received from manufacturers for	68.00	0	0	0	0	17.02
40.00	replaced devices for applicable MS-DRGs	02.00		^		ا	10 00
18.00	Capital outlier reconciliation adjustment	93.00	0	U	U	0	18.00
10.00	amount (see instructions)			7,784,354	2.185,865	9,970,219	10 00
TA'00	JOURTOIAL	I	1	1,704,334	2,100,000	9,970,219	T3'00

HOSPIT	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co	CN: 15-0176	Period: From 01/01/2016 To 12/31/2016		pared:
				XVIII	Hospital	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	5 74 (15)
20.00	Capital DRG other than outlier	1.00	639,574	486,9	44 152,630	639,574	
20.01		1.01	0		0 0	0	20.01
21.00	1	2.00	361,042	354,3	50 6,692	361,042	21.00
21.01		2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	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	0.00	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	1,000,616	841,2	159,322	1,000,616	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	District.
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	o		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	0		0 0	0	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	-110,384		0 -110,384	-110,384	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0		0	0	31.01
		The second secon			A SERVICE CONTRACTOR OF SERVICE		1 mm 200 m 200 m

0 70,99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

2.00

3.00

20,755

(Amt. to Wkst. E, Pt. A) 4.00

20,755 32.00

100.00

.00	PPS payments	2,118,999
	Outlier payment (see instructions)	10,606
00	Enter the hospital specific payment to cost ratio (see instructions)	0.000
	Line 2 times line 5	0
	Sum of line 3 plus line 4 divided by line 6	0.00
	Transitional corridor payment (see instructions)	0
	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0
	Organ acquisitions	0
	Total cost (sum of lines 1 and 10) (see instructions)	0
	COMPUTATION OF LESSER OF COST OR CHARGES	
Ì	Reasonable charges	
00	Ancillary service charges	0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0
0	Total reasonable charges (sum of lines 12 and 13)	0
	Customary charges	
0	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0
0	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0
	had such payment been made in accordance with 42 CFR §413.13(e)	
0	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000
	Total customary charges (see instructions)	0
0	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0
	instructions)	
0	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0
	instructions)	
- 1	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0
	Interns and residents (see instructions)	0
	Cost_of physicians' services in a teaching hospital (see instructions)	0
	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,129,605
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	37.1.3.5.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0
- 1	Deductibles and coinsurance (for CAH, see instructions)	0
	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	396,036
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1,733,569
	instructions)	o
00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0
	ESRD direct medical education costs (from Wkst. E-4, line 36)	1,733,569
	Subtotal (sum of lines 27 through 29)	1,733,309
	Primary payer payments	1,731,952
0	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1,731,332
	Composite rate ESRD (from Wkst. I-5, line 11)	0
	Allowable bad debts (see instructions)	ő
	Adjusted reimbursable bad debts (see instructions)	o
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ő
	Subtotal (see instructions)	1,731,952
	MSP-LCC reconciliation amount from PS&R	131
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0
	Pioneer ACO demonstration payment adjustment (see instructions)	ő
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0
	RECOVERY OF ACCELERATED DEPRECIATION	o
	Subtotal (see instructions)	1,731,821
	Sequestration adjustment (see instructions)	34,636
		1,697,184
	Interim payments Tentative settlement (for contractors use only)	0
		1
	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	Ö
0		ا
	§115.2 TO BE COMPLETED BY CONTRACTOR	TTX 1-3301-881 (-8)
, l	Original outlier amount (see instructions)	0
		0
	Outlier reconciliation adjustment amount (see instructions)	0.00
00	The rate used to calculate the Time Value of Money	0.00
UU	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	o
20		

81,640

Contractor

Number

1.00

8,837,462

6.01

6.02

7.00

8.00

1,697,185

NPR Date

(Mo/Day/Yr)

2.00

Health Financial Systems KENTUCKIANA MEDICAL CENTER In Lieu of Form CMS-2552-10 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0176 Period: From 01/01/2016 Worksheet E-1 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 5/31/2017 12:08 pm Title XVIII Hospital PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4.00 1.00 2.00 3.00 1,697,184 1.00 1.00 Total interim payments paid to provider 8,919,102 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 3.01 3.02 0 0 3.02 3.03 3.03 0 O 0 3.04 3.04 3.05 0 3.05 Provider to Program 0 3.50 3.50 ADJUSTMENTS TO PROGRAM 3.51 0 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3,99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 4,00 Total interim payments (sum of lines 1, 2, and 3.99) 8,919,102 1,697,184 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.00 5.00 Program to Provider 5.01 0 5.01 0 TENTATIVE TO PROVIDER 0 5.02 0 5.02 5.03 0 0 5.03 Provider to Program 0 5.50 5.50 TENTATIVE TO PROGRAM o 0 5.51 5.51 0 5.52 5.52 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines O 5.99 5.99 5.50 - 5.986.00 6.00 Determined net settlement amount (balance due) based on

the cost report. (1)

8.00 Name of Contractor

SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM

Total Medicare program liability (see instructions)

6.01

6.02

7.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0176	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Pre 5/31/2017 12:	pared:	
Transferoiteac		Title XVIII	Hospital	PPS	las and a second	
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N Comments of the comments of	140 (1984) 5655 (1984)			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			98,388,590	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			110,036	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00	
8.00	Calculation of the HIT incentive payment (see instructions)			355,707	8.00	
9.00	Sequestration adjustment amount (see instructions)			7,114	9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		348,593	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			364,862		
	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	15)	-16,269	32.00	

PRT VIT - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES	CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0176	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Pre 5/31/2017 12:	pared:	
PART VIT - CALCULATION OF RETMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES	FEST CONTRACTOR		Title XIX	Hospital		,	
PART VII - CALCULATION OF RETMOURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						235	
COMPUTATION OF NET COST OF COVERED SERVICES 0 0 88,490 2.00 2.00 30,00	-455 S/68635				2.00	1450	
1.00			ERVICES FOR TITLES V OR $oldsymbol{x}$	IX SERVICES			
Medical and other services 88,490 2.00 30.00							
3.00 Organ acquisition (certified transplant centers only)				0			
Subtotal (sun of lines 1, 2 and 3) 88,490 4.00 6.00 0.0					88,490		
Inpatient primary payer payments 0 0 6.00							
0				1	88,490		
Subtotal (Tine 4 less sum of lines 5 and 6)				0			
COMPUTATION OF LESSER OF COST OR CHARGES S.00					-		
Reasonable Charges 8.00 9.00 9.00 10	7.00			_ 0	88,490	7.00	
8.00 Noutine service charges 576,793 8.00 10							
Ancillary service charges 610,255 372,102 9.00	0 00		Approved the state of the state				
10.00 Organ acquisition charges, net of revenue 10.00							
11.00 Incentive from target amount computation 1,187,049 372,102 12.00 12.				610,256	372,102		
12.00 Total reasonable charges (sum of lines 8 through 11) 1,187,049 372,102 12.00				0			
CUSTOMARY CHARGES				1 107 040	272 102	1	
3.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00	12.00			1,187,049	3/2,102	12.00	
basis	13 00					12 00	
Amounts that would have been realized from patients liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 17.00	13,00	hasis	or services on a charge	۷	U	13.00	
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 10.00 10.000000 1.187,049 372,102 16.00 10.000000 1.187,049 372,102 16.00 10.000000 1.187,049 372,102 16.00 10.000000 1.187,049 372,102 17.00 10.0000000 1.187,049 11.0000000000000000000000000000000000	14.00		or navment for services o	n 0	0	14 00	
15.00		a charge basis had such payment been made in accordance with	42 CER 8413 13(e)		U	17.00	
16.00 Total customary charges (see instructions) 1,187,049 372,102 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,187,049 283,612 17.00 11ne 4) (see instructions) 0 0 0 18.00 16.00 16.00 16.00 17.00	15.00		72 CIN 3 (13) 13 (C)	0.000000	0.000000	15 00	
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,187,049 1,187,0	16.00		1				
line 4) (see instructions)	17.00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds			1	
16) (see instructions)		line 4) (see instructions)	•				
16) (see instructions)	18.00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lin	e 0	0	18.00	
20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 20.00		16) (see instructions)					
Cost of covered services (enter the lesser of line 4 or line 16) Responsible Res				0	0	19.00	
PROSPECTIVE PAYMENT AMOUNT = Lines 22 through 26 must only be completed for PPS providers. 359,794 112,784 22.00					0	20.00	
22.00 Other than outlier payments 359,794 112,784 22.00 23.00 23.00 24.00 24.00 25.00 24.00 25.00 26	21.00				88,490	21.00	
23.00 Outlier payments 0 0 23.00	22.00						
24.00 25.00 Capital exception payments (see instructions) 24.00 25.00 Capital exception payments (see instructions) 0 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 26.00 25.00 25.00 26.00					-		
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT COMPUTATION OF REIMBURSEMENT SETTLEMENT Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 31.00 32.00 Coinsurance 36.00 Allowable bad debts (see instructions) 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 379,794 201,274 38.00 38.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 36.00 37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 30.00 Total amount payable to the provider (sum of lines 38 and 39) 359,794 112,784 40.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 25.00 25.00 25.00 0 0 28.00 0 0 20.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1 4	0		
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Utilization review 34.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 35.00 Subtotal (line 36 ± line 37) 37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 Total amount payable to the provider (sum of lines 38 and 39) 30.00 Total amount payable to the provider (sum of lines 38 and 39) 30.00 Allowable dad provider/program (line 40 minus line 41) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 359,794 112,784 27.00 36.00 O 0 28.00 359,794 201,274 31.00 30.00 31.00 32.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 33.00 33.00 34.00 359,794 201,274 36.00 35.00 36.00 36.00 36.00 37.00 3							
27.00 Subtotal (sum of lines 22 through 26) 359,794 112,784 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 359,794 201,274 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 359,794 201,274 31.00 Deductibles 0 0 0 32.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 Utilization review 0 0 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 36.00 37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 0 -88,490 37.00 39.00 Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) 0 39.00 41.00 Interim payments 8alance due provider/program (line 40 minus line 41) 70 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00							
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) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT		The same same same same same same same sam			•		
Titles V or XIX (sum of lines 21 and 27) 359,794 201,274 29.00					,		
COMPUTATION OF REIMBURSEMENT SETTLEMENT				750 704	. •		
30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 31.00 31.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 33.	23.00			359,794	201,274	29.00	
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 359,794 201,274 31.00 32.00 32.00 33.00 Coinsurance	30.00		1997 to National Control of the Control of Association and Control of State of the Control of State of the Control of State of the Control of State of the Control of State of		^	20.00	
32.00 Deductibles 0 0 32.00 33.00 34.00 35.00					•		
33.00 Coinsurance 0 0 33.00 34.00 34.00 35.00 0 0 34.00 35.00 0 0 0 35.00 0 0 0 35.00 0 0 0 35.00 0 0 0 35.00 0 0 0 0 35.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
34.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 36.00 37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 10 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 34.00 359,794 201,274 36.00 36.00 359,794 112,784 38.00 359,794 112,784 41.00 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,					- 1		
35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 36.00 37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,							
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 359,794 201,274 36.00 37.00 38.00 Subtotal (line 36 ± line 37) 38.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				ام	U		
37.00 ADUST TO O/P PPS REIMBURSEMENT AMOUN 0 -88,490 37.00 38.00 359,794 112,784 38.00 39.00 0 0 0 0 0 0 0 0 0					201 274		
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	37.00	ADUST TO O/P PPS REIMBURSEMENT AMOUN					
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 39.00 39.00 359,794 112,784 40.00 0 42.00 0 43.00				359 794			
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40.00 359,794 41.00 0 42.00 42.00 43.00			333,,34	116,704			
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			359 794	112 784			
42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00							
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	42.00	1					
chapter 1, §115.2			ance with CMS Pub 15-2.				
		chapter 1, §115.2	•		-		

In Lieu of Form CMS-2552-10
Worksheet G

Health Financial Systems

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

KENTUCKIANA MEDICAL CENTER

Provider CCN: 15-0176 fund-type accounting records, complete the General Fund column

Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

nly)					Date/Time Pre 5/31/2017 12:	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3,00	4.00	
	CURRENT ASSETS		AGUS CONSTRUCTO			1
.00	Cash on hand in banks	760,886		1 (0	
.00	Temporary investments	0	C	0	0	1 -
.00	Notes receivable	0	C	0	0	1 .
.00	Accounts receivable	14,489,595		0	0	1
.00	Other receivable	1,011,955		0	. 0	1
.00	Allowances for uncollectible notes and accounts receivable	-11,268,566		0	0	F
.00	Inventory	572,828		U	. 0	
.00	Prepaid expenses	303,625		0	0	1
.00	Other current assets	73,645	0	0	0	1
0.00	Due from other funds	U 043 000	U	U O	0	1 -
1.00	Total current assets (sum of lines 1-10)	5,943,968		U U U U U U U U U U U U U U U U U U U	0	1
2.00	FIXED ASSETS Land	0	l o	O	0	۱,
3.00	Land improvements	0		t I	0	
4.00	Accumulated depreciation	0	,		0	1
5.00	Buildings	1 670 010		0	0	
5.00	Accumulated depreciation	1,620,018 -160,854		0	0	
7.00	Leasehold improvements	-100,034			. 0	
	Accumulated depreciation	0		0	0	1 -
9.00	Fixed equipment	639,027		0	0	1
	Accumulated depreciation		1		0	
1.00	Automobiles and trucks	-334,916		0	0	1
	Accumulated depreciation	0	0	0	0	_
3.00	Major movable equipment	13,693,416		0	0	
4.00	Accumulated depreciation				0	1
	Minor equipment depreciable	-5,465,211		. 0	0	1
6.00	Accumulated depreciation	0			0	1
7.00	HIT designated Assets	0	١		0	1
8.00	Accumulated depreciation	0			0	
9.00	Minor equipment-nondepreciable	0	"		0	1
0.00	Total fixed assets (sum of lines 12-29)	9,991,480		0	0	
0.00	OTHER ASSETS	9,991,460				3
1.00	Investments	0	0	l ol	0	3:
2.00	Deposits on leases	0	١	١	0	4
3.00	Due from owners/officers	0	,	ا	Ö	1
4.00	Other assets	4,452,466		ام	0	1 .
5.00	Total other assets (sum of lines 31-34)	4,452,466		١	ő	1 -
6.00	Total assets (sum of lines 11, 30, and 35)	20,387,914			0	
0.00	CURRENT LIABILITIES	20,367,314				٦,
7.00	Accounts payable	3,740,944	0	0	0	3:
8.00	Salaries, wages, and fees payable	720,760		١	o o	1
9.00	Payroll taxes payable	24,750		ا	ő	1
0,00	Notes and loans payable (short term)	15,621,489		0	0	
1.00	Deferred income	13,021,403	١	١	0	1
2.00	Accelerated payments	0	Ĭ	١	v	4
3.00	Due to other funds	0	١	0	0	1
4.00	Other current liabilities	0	,	٥	0	4
5.00	Total current liabilities (sum of lines 37 thru 44)	20,107,943	i o	0	o 0	1 .
	LONG TERM LIABILITIES	20,101,545	iersissias inicialent			1 7
6.00	Mortgage payable	٥	0	o	0	4
7.00	Notes payable	0	0		0	
8.00	Unsecured loans	0	0	ار	0	1
	Other long term liabilities	40,593,147	0	0	0	
0.00	Total long term liabilities (sum of lines 46 thru 49)	40,593,147			0	
L.00	Total liabilities (sum of lines 45 and 50)	60,701,090		1 -1	0	
	CAPITAL ACCOUNTS	23,731,090		Contract Contract		1 -
2.00	General fund balance	-40,313,176		1,111	nggana nana paggang	5
3.00	Specific purpose fund	.0,313,170	0			5
1.00	Donor created - endowment fund balance - restricted		ĺ	اما		5.
5.00	Donor created - endowment fund balance - unrestricted			١		5
5.00	Governing body created - endowment fund balance			ا		5
7.00	Plant fund balance - invested in plant			١	0	
3.00	Plant fund balance - reserve for plant improvement,				0	1
0,00	replacement, and expansion				U	'د
9.00	Total fund balances (sum of lines 52 thru 58)	-40,313,176	0	ام	0	5
0.00		20,387,914		1	0	1
						יט ו

18.00

19,00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0176 Period: From 01/01/2016 Worksheet G-1 Date/Time Prepared: 5/31/2017 12:08 pm То 12/31/2016 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 5.00 3.00 4.00 -8,300,173 1.00 Fund balances at beginning of period 1.00 -32,013,003 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 3.00 Total (sum of line 1 and line 2) -40,313,176 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 0 5.00 0 6.00 0 6.00 0 7.00 0 0 7.00 0 8.00 0 8,00 9.00 0 9.00 Total additions (sum of line 4-9) 10.00 0 10.00 11.00 Subtotal (line 3 plus line 10) -40,313,176 11.00 12.00 OTHER CHANGES IN CAPITAL 0 12.00 13.00 0 13.00 0 14.00 ROUNDING 0 0 14.00 15.00 15.00 0 16.00 16.00 0 17.00 0 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 19.00 Fund balance at end of period per balance -40,313,176 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 6.00 7.00 8.00 1.00 Fund balances at beginning of period 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) 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 6.00 7.00 7.00 8.00 8.00 9.00 9,00 Total additions (sum of line 4-9) 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 OTHER CHANGES IN CAPITAL 12.00 13,00 13.00 14.00 ROUNDING 14.00 15.00 15.00 16.00 16.00 17.00 17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 15-0176		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 12:	nared:
	Cost Center Description		Inpatient	Outpatient	Total	1975
<u> </u>	DART T. DATICAL DESCRIPTION		1.00	2.00	3,00	Jacob (Sala)
	PART I - PATIENT REVENUES					
1 00	General Inpatient Routine Services Hospital					
1.00 2.00	1 •		15,653,50	08	15,653,508	
3.00	SUBPROVIDER - IPF SUBPROVIDER - IRF			ŀ		2.00
4.00	SUBPROVIDER - IRF					3.00
5.00	Swing bed - SNF					4.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY				0	1
8.00	NURSING FACILITY			0	0	
9.00	OTHER LONG TERM CARE			١	0	
10.00	Total general inpatient care services (sum of lines 1-9)		15,653,50	10	15 652 500	9.00
	Intensive Care Type Inpatient Hospital Services	11 TO 11 THE R. P. LEWIS CO.	15,035,30	70	15,653,508	10.00
11.00	INTENSIVE CARE UNIT	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	T T	o	0	11.00
	CORONARY CARE UNIT			١	U	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
	OTHER SPECIAL CARE (SPECIFY)		ĺ			15.00
	Total intensive care type inpatient hospital services (sum o 11-15)	f lines		0	0	
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	15,653,50	18	15,653,508	17.00
18.00	Ancillary services	-,	50,769,90	1 3	77,131,083	
19.00	Outpatient services		653,35		5,604,000	
	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY			0	ō	22.00
	AMBULANCE SERVICES					23.00
	CMHC			o	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)					25.00
	HOSPICE					26.00
27.00	PROFESSIONAL FEES			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 to Wkst.	67,076,77	2 31,311,819	98,388,591	28.00
20.00	PART II - OPERATING EXPENSES	dia anglikaran ing	449 galagia (5.44, 5.44			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			41,904,351		29.00
30.00				0		30.00
32.00				0	ĺ	31.00
33.00				U		32.00
34.00				U		33.00
35.00						34.00
36.00	Total additions (sum of lines 30-35)			را ا		35.00
37.00	DEDUCT (SPECIFY)			0		36.00
38.00	SESSET (SIECELTY					37.00
39.00						38.00
40.00				0		39.00
41.00		,		0		40.00
	Total deductions (sum of lines 37-41)			ا ا		41.00
	Total operating expenses (sum of lines 29 and 36 minus line to Wkst. G-3, line 4)	12)(transfer		41,904,351		42.00 43.00

0 23.00

0 28.00

-32,013,003 29.00

24.00

25.00

26.00

27.00

1,139,462

1,354,115

-32,013,003

23,00

24.00

25.00

27.00

28.00

Governmental appropriations

Total (line 5 plus line 25)

OTHER EXPENSES (SPECIFY)

Total other income (sum of lines 6-24)

Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

MISC & OTHER INCOME

0 17.00

17.00 | Current year exception offset amount (see instructions)