Health Financial S	Systems	FAYETTE REGIONAL HEAL	TH SYSTEM	In Lieu	u of Form CMS-2552-	-10
This report is rea	quired by law (42 USC 1395g	g; 42 CFR 413.20(b)). Failu	re to report can resu	It in all interim	FORM APPROVED	
payments made sind	ce the beginning of the cos	st reporting period being d	eemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050	
HOSPITAL AND HOSP	ITAL HEALTH CARE COMPLEX CO	OST REPORT CERTIFICATION	Provider CCN: 150064		Worksheet S	
AND SETTLEMENT SUI	MMARY			From 10/01/2014		
					Date/Time Prepared	
					2/25/2016 4:23 pm	
PART I - COST REP	ORT STATUS					
Provi der 1.	[X] Electronically filed	cost report		Date: 2/25/20	16 Time: 4:23	рm
use only 2.	[] Manually submitted co	st report				
		report enter the number of		resubmitted this co	ost report	
4.	[F] Medicare Utilization.	Enter "F" for full or "L"	for low.		·	
Contractor 5.	[1]Cost Report Status	6. Date Received:	10.	NPR Date:		
use only	(1) As Submitted	7. Contractor No.		Contractor's Vendo		į
	(2) Settled without Audit	8. [N] Initial Report for	this Provider CCN 12.	[0]If line 5, co	lumn 1 is 4: Enter	
	(3) Settled with Audit	9. [N] Final Report for th	nis Provider CCN		es reopened = 0-9.	
	(4) Reopened					

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAYETTE REGIONAL HEALTH SYSTEM (150064) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 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.

(Si gned))					
		Offi cer	or	Admi ni strator	of	Provi der(s)
	Title					
	IIIIe					
	Date					

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-5, 314	43, 526	289, 835	-241, 249	1. 00
2.00	Subprovider - IPF	0	14, 072	0		-268, 767	2. 00
3.00	Subprovider - IRF	0	-6, 891	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	1	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	314		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
200.00	Total	0	1, 868				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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150064 Peri od: Worksheet S-2 From 10/01/2014 Part I 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1941 VIRGINIA AVENUE 1.00 PO Box: 1.00 City: CONNERSVILLE State: IN 2.00 Zip Code: 47331-County: FAYETTE 2.00 Component Name Payment System (P, CCN CBSA Provi der Date Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FAYETTE REGIONAL HEALTH 150064 99915 07/01/1966 Ν Р 0 3.00 1 SYSTEM Р 4.00 Subprovider - IPF FAYETTE REGIONAL HEALTH 15S064 99915 10/01/2013 Ν 4 Ν 4.00 SYSTEM 5.00 Subprovider - IRF FAYETTE REGIONAL HEALTH 15T064 99915 5 10/01/2003 Ν Ρ 0 5.00 SYSTEM 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF FAYETTE REGIONAL HEALTH Р 7.00 15U064 99915 06/25/2009 Ν Р 7.00 SYSTEM 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11 00 Hospi tal -Based HHA FAYETTE MEMORIAL HOME 157097 99915 01/01/1984 12.00 Ρ Ν 12.00 HEALTH Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce FMH HOME HEALTHCARE & 99915 14.00 151548 02/01/1996 14.00 HOSPI CF Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FOHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2014 09/30/2015 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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 N Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 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 Out-of 0ther In-State Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days el i gi bl e unpai d paid days days unpai d 1.00 3.00 4.00 6.00 2.00 5.00 24.00 If this provider is an IPPS hospital, enter the 0 24 00 145 324 590 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.

Health Financial Systems FAYETTE R	REGIONAL HE	ALTH SYSTEM			In Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der	CCN: 150064	Period: From 10/0	1/2014	Workshe Part I	et S-2	
				To 09/3	0/2015	Date/Ti 2/25/20		
	In-State Medicaid		Out-of State	Out-of State	Medica HMO da		ther li cai d	
	pai d days	eligible	Medi cai d	Medi cai d	Timo da	, ,	lays	
		unpai d days	paid days	el i gi bl e unpai d				
25.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4. 00	5. 00	0	. 00	25. 00
Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0						25.00
				Urban/R 1.0		2.0		
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		s at the beg	ginning of th	е	2			26. 00
27.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassification.	age) statu r "2" for	rural. If ap			2			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in	Danisa	0	F41		35. 00
				Begi nr 1. 0		Endi 2. (
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for number	r				36. 00
37.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of period	ds MDH status		0			37. 00
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38. 00
enter subsequent dates.				Y/		Υ/		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re	i)? Enter	in column 1	"Y" for yes	e 1. 0		2. (Y		39. 00
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	or "N" fo n adjustme ber 1. Ent	r no. (see i nt? Enter "\ er "Y" for y	nstructions) /" for yes or	N		N		40.00
					1. 00	2. 00	XI X 3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	nt for dis	proporti onat	te share in a	ccordance	N	l N	l N	 45. 00
with 42 CFR Section §412.320? (see instructions)								
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt.	III and Wkst	t. L-1, Pt. I	through	N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300 PPS cap 48.00 Is the facility electing full federal capital paymen					N N	N N	N N	47.00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approved	GME programs	s? Enter "Y"	for yes	N	T		56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "I th of this Y", comple	N" for no ir cost report te Worksheet	n column 1. I ting period?	f column 1 Enter "Y"				57.00
58.00 If line 56 is yes, did this facility elect cost reim	bursement	for physicia	ans' services	as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye 60.00 Are you claiming nursing school and/or allied health	s, complet	e Wkst. D-2,		e	N N			59. 00 60. 00
provider-operated criteria under §413.85? Enter "Y"	for yes o	r "N" for no IME	o. (see instr Direct GME		E	Di rect	t GME	
	1. 00	2. 00	3. 00	1.0	20	5. (20	_
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00	2.00	3.00	4.0	0.00	J. (61.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.	00				61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.	00				61. 02
ACA). (see instructions)								

			HEALTH SYSTEM			u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der		Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Pre 2/25/2016 2:2	pared:
		Y/N	IME	Direct GME	I ME	Direct GME	, p
		1. 00	2. 00	3. 00	4. 00	5. 00	
51. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0. (00		61. 03
51. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).		0.00	0.0	00		61. 04
51. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0. (00		61. 05
51. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.0	00		61. 06
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4.00	61. 10
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00		61. 20
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of FTE residents that rotated from a	tions)					62. 00 62. 01
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ıs)			
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttinas	durina this co	st reporting instructions	period? Enter	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Continue FEOM of the ACA Prop Very FTF D. 1 1 1 1		C-++:	1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			inis base yea	r is your cost r	eporting	
	Enter in column 1, if line 63 is yes, or your facilit			0.0	0.00	0. 000000	64 00
4. 00	in the base year period the number of unweighted non			0. 0	0.00	0.00000	04.0

period that begins on or arter sury 1, 2007 and before suite 30, 2010.						
Enter in column 1, if line 63 is			0.00	0. 00	0. 000000	64. 00
in the base year period, the num	mber of unweighted nor	n-primary care				
resident FTEs attributable to re	otations occurring in	all nonprovider				
settings. Enter in column 2 the	e number of unweighted	l non-primary care				
resident FTEs that trained in yo	our hospital. Enter in	column 3 the ratio				
of (column 1 divided by (column	1 + column 2)). (see	instructions)				
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		_	FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3. 00	4. 00	5. 00	

Health Financial Systems	FAYETTE RE	EGIONAL HEALTH			lı	n Lieu	of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA P	rovi der		riod: om 10/01/ o 09/30/		Workshe Part I Date/Ti 2/25/20	me Pre	pared:
	Program Name	Program (Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n	Ratio (c (col. 3 4)	+ col.	
	1.00	2.00		3. 00	4. 00		5. C		
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				0.00		0. 00	0.	000000	03. 00
4)). (see instructions)				Unwei ghted	Unwei gh	ted	Ratio (c	ol . 1/	
				FTEs Nonprovi der Si te	FTEs i Hospi ta	n	(col . 1 2)	+ col.	
Section 5504 of the ACA Current	Voor ETE Dockdonts in	Nonnrovi dor	Sotti na	1. 00	2.00		3.0		
beginning on or after July 1, 20	10	·			COST TE				
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settir ry care reside 3 the ratio of	igs. ent	0.00		0. 00	0.	000000	66. 00
	Program Name	Program (Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n	Ratio (d (col. 3 4)	+ col.	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00		3.00	4.00	0.00	5. C		67. 00
						1. 00	2. 00	3. 00	
Inpatient Psychiatric Facility P 70.00 Is this facility an Inpatient Ps		DE) or doo-	it cont	ain an IDE aut	rovi dos2				70.00
Enter "Y" for yes or "N" for no 71.00 If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	oproved GME te 004? Enter "Y lity train re (D)? Enter "Y	eaching '" for yesidents '" for ye	program in the es or "N" for n in a new teach es or "N" for n	most o. (see ing o.	Y N	N	0	70. 00
Inpatient Rehabilitation Facilit 75.00 Is this facility an Inpatient Re	habilitation Facility	(IRF), or do	es it c	ontain an IRF		Υ			75. 00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	oproved GME te ember 15, 2004 new teaching for no. Colum	eaching ? Enter program In 3: If	program in the "Y" for yes or in accordance column 2 is Y,	"N" for	N	N	0	76. 00

Health Financial Systems FAYETTE REGIONAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150064	Peri od:	eu of Form CMS- Worksheet S-	
			From 10/01/2014 To 09/30/2015		epared:
	-			1.00	
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude				N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1)(B)(iv)(I)? Enter "Y"	N	87. 00
itor yes or in tor no.			V	XI X	
Title V and XIX Services			1. 00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita	ıl services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t	he cost repor	t either in	N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ıal certificat			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			O. O N	O O O N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	n.	0.0	0.0	97. 00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all-		hod of paymen	nt N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) If			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	2 N		108. 00
	Physi cal 1, 00	Occupationa 2.00	al Speech 3.00	Respiratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	N N	N N	109. 00
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	410A Demo)for	1.00 N	110. 00
The dark size above this portion. Effect it for yes of W	. 51 110.		1. (00 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 provider	If column 2 it for long te	is "E", ente rm care (incl	rin column udes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur	,		n"N" for Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy is occurrence.	icy? Enter 1	if the policy	yis 1		118. 00
,		Premi ums	Losses	Insurance	
		1 00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00	3.00	0118.01

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE	FAYETTE REGIONAL H	Provider CCN: 150064	Peri od:	u of Form C Worksheet	
USPITAL AND HUSPITAL HEALTH CARE	COMPLEX IDENTIFICATION DATA	Provider CCN: 150064	From 10/01/2014 To 09/30/2015	Part I	Prepared
			1. 00	2.00	
Administrative and General? and amounts contained therei	d paid losses reported in a cost o If yes, submit supporting schedu n.		N	2.00	118. (
§3121 and applicable amendme "N" for no. Is this a rural Hold Harmless provision in A	qualifies for the Outpatient Hold ents? (see instructions) Enter in hospital with < 100 beds that qua ACA §3121 and applicable amendment	column 1, "Y" for yes or alifies for the Outpatient		Y	119. (120. (
Enter in column 2, "Y" for y 21.00Did this facility incur and patients? Enter "Y" for yes Transplant Center Informatic	report costs for high cost implan or "N" for no.	ntable devices charged to	Y		121.
	a transplant center? Enter "Y" for	yes and "N" for no. If	N		125.
26.00 If this is a Medicare certifin column 1 and termination	fied kidney transplant center, ent date, if applicable, in column 2.				126.
in column 1 and termination	fied heart transplant center, ente date, if applicable, in column 2. fied liver transplant center, ente				127. (
in column 1 and termination 29.00 If this is a Medicare certif	date, if applicable, in column 2. fied lung transplant center, enter		n		129.
30.00 <mark>lf this is a Medicare certif</mark>	te, if applicable, in column 2. fied pancreas transplant center, e				130.
31.00 <mark>lf this is a Medicare certif</mark>	ation date, if applicable, in colu fied intestinal transplant center, ation date, if applicable, in colu	enter the certification			131.
2.00 If this is a Medicare certifin column 1 and termination	fied islet transplant center, ente date, if applicable, in column 2.	er the certification date			132.
in column 1 and termination	fied other transplant center, ente date, if applicable, in column 2. ment organization (OPO), enter the				133.
and termination date, if app		e opo number in corumn i			134.
All Providers					
0.00 Are there any related organi chapter 10? Enter "Y" for ye are claimed, enter in column	zation or home office costs as de es or "N" for no in column 1. If y n 2 the home office chain number.	ves, and home office costs (see instructions)			140.
0.00 Are there any related organi chapter 10? Enter "Y" for ye are claimed, enter in column 1.00 If this facility is part of	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on li	ves, and home office costs (see instructions) nes 141 through 143 the I	3. 00	of the	140.
0.00 Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the hour 1.00 Name:	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00	ves, and home office costs (see instructions) nes 141 through 143 the intractor number.	3. 00	of the	141.
10.00 Are there any related organic hapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the house 11.00 Name: 12.00 Street:	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lione office contractor name and cor	ves, and home office costs (see instructions) nes 141 through 143 the intractor number.	3.00 name and address or's Number:	of the	141. 142.
0.00 Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the house 1.00 Name: 2.00 Street:	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on liome office contractor name and cor Contractor's Name: PO Box:	ves, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract	3.00 name and address or's Number:	of the	141.
0.00 Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the home office and column 1.00 Name: 2.00 Street: 3.00 City:	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on liome office contractor name and cor Contractor's Name: PO Box:	ves, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zi p Code	3.00 name and address or's Number:		141. 142. 143.
An	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and cor Contractor's Name: PO Box: State:	ves, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zi p Code	3.00 name and address or's Number:	1. 00 Y	141. 142. 143.
0.00 Are there any related organi chapter 10? Enter "Y" for ye are claimed, enter in column 1.00 If this facility is part of home office and enter the hold 1.00 Name: 2.00 Street: 3.00 City: 4.00 Are provider based physician 5.00 If costs for renal services inpatient services only? Ent no, does the dialysis facili	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and cor Contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in cuty include Medicare utilization f	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is	3.00 name and address or's Number:	1.00	141. 142. 143.
20.00 Are there any related organichapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the hold 1.00 Name: 20.00 Street: 30.00 City: 4.00 Are provider based physician 5.00 If costs for renal services inpatient services only? Enteno, does the dialysis faciliperiod? Enter "Y" for yes colon Has the cost allocation meth	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lime office contractor name and con Contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. nodology changed from the previous no in column 1. (See CMS Pub. 15	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost report?	3.00 name and address or's Number: :: 1.00 Y	1. 00 Y	141. 142. 143. 144.
0.00 Are there any related organi chapter 10? Enter "Y" for ye are claimed, enter in column 1.00 If this facility is part of home office and enter the hold 1.00 Name: 2.00 Street: 3.00 City: 4.00 Are provider based physician 5.00 If costs for renal services inpatient services only? Enter no, does the dialysis facili period? Enter "Y" for yes of 6.00 Has the cost allocation mether "Y" for yes or "N" for yes, enter the approval date	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and cor Contractor's Name: P0 Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. nodology changed from the previous no in column 1. (See CMS Pub. 15 e (mm/dd/yyyy) in column 2.	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020) If	3.00 name and address or's Number: :: 1.00 Y	1. 00 Y	141. 142. 143. 144.
0.00 Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the house of the home office and enter the house of the house	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lime office contractor name and con Contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. nodology changed from the previous no in column 1. (See CMS Pub. 15	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020) If the cost of the co	3.00 name and address or's Number: :: 1.00 Y	1.00 Y	141. 142. 143. 144. 145.
Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the hour office and enter the ho	es or "N" for no in column 1. If you 2 the home office chain number. 2.00 a chain organization, enter on lime office contractor name and concentration of the contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. Indeed line of the previous of the column 1. (See CMS Pub. 15 or (mm/dd/yyyy) in column 2. Attaistical basis? Enter "Y" for yearder of allocation? Enter "Y" for yearder of allocation? Enter "Y" for mplified cost finding method?	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost reporting sly filed cost report? 5-2, chapter 40, §4020) If the cost of "N" for no. yes or "N" for no. yes or "N" for yes or "N" for Part A Part B 1.00 2.00	3.00 name and address or's Number: :: 1.00 Y N Title V 3.00	1.00 Y 2.00 1.00 N N N Title XI 4.00	141. 142. 143. 144. 145. 146.
An are there any related organic hapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the house of the home office and enter the house of the home office and enter the house of the house of the home office and enter the house of the home office and enter the house of the home office and enter the house of the home of the house of the home of th	es or "N" for no in column 1. If you 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and corector contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. modology changed from the previous no in column 1. (See CMS Pub. 15 te (mm/dd/yyyy) in column 2. tatistical basis? Enter "Y" for yeter of allocation?	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020) If per sor "N" for no. yes or "N" for no. yes or "N" for yes or "N" for Part A Part B 1.00 2.00 exemption from the applicant for Part A and Part B.	3.00 name and address or's Number: :: 1.00 Y N Title V 3.00 ation of the lower (See 42 CFR §413	1.00 Y 2.00 1.00 N N N Title XI 4.00 er of costs	141. 142. 143. 144. 145. 146.
And there any related organic chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the h	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and cor Contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. nodology changed from the previous no in column 1. (See CMS Pub. 15 or (mm/dd/yyyy) in column 2. tatistical basis? Enter "Y" for yearder of allocation? Enter "Y" for mplified cost finding method? Enter provider that qualifies for an ear provider that	res, and home office costs (see instructions) nes 141 through 143 the intractor number. Contract Zip Code are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020) If per sor "N" for no. yes or "N" for no. yes or "N" for yes or "N" for Part A Part B 1.00 2.00 exemption from the applicant for Part A and Part B.	3.00 name and address or's Number: :: 1.00 Y N Title V 3.00 attion of the lowe	1.00 Y 2.00 1.00 N N Title XI 4.00	140. 141. 142. 143. 144. 145. 146. 147. 148. 149. X
Are there any related organi chapter 10? Enter "Y" for yeare claimed, enter in column 1.00 If this facility is part of home office and enter the ho	es or "N" for no in column 1. If yn 2 the home office chain number. 2.00 a chain organization, enter on lipme office contractor name and cor Contractor's Name: PO Box: State: are claimed on Wkst. A, line 74, ter "Y" for yes or "N" for no in column 2. nodology changed from the previous no in column 1. (See CMS Pub. 15 or (mm/dd/yyyy) in column 2. tatistical basis? Enter "Y" for yearder of allocation? Enter "Y" for mplified cost finding method? Enter provider that qualifies for an ear provider that	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? S-2, chapter 40, §4020) If ses or "N" for no. yes or "N" for no. yes or "N" for no. er "Y" for yes or "N" for Part A Part B 1.00 2.00 exemption from the applicant for Part A and Part B. N N N	3.00 name and address or's Number: :: 1.00 Y N It le V 3.00 attion of the lowe (See 42 CFR §413 N N	1.00 Y 2.00 1.00 N N N Title XI 4.00 er of costs	141. 142. 143. 144. 145. 146. 147. 148. 149. X

Health Financial Systems		ONAL HEALTH SYSTEM			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der C	CN: 15006	From 10	0/01/2014 9/30/2015	Worksheet S-: Part I Date/Time Pro 2/25/2016 2::	epared:
						2/23/2010 2	Z5 piii
						1. 00	
Mul ti campus							4
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.		s one or more campus	ses in di			N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1 00	
Health Information Technology (HI	T) inconting in the Ame	ari can Docovery and	Doi myos:	tmont Act		1.00	
167.00 s this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	05 is "Y") and is a mea	aningful user (line			the		0168. 00
168.01 If this provider is a CAH and is a exception under §413.70(a)(6)(ii)	not a meaningful user,	does this provider			shi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction		and is not a CAH (I	ine 105	is "N"), e	nter the	0. 2	5169. 00
					gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR l period respectively (mm/dd/yyyy)	peginning date and endi	ng date for the rep	porting	10/	01/2014	09/30/2015	170. 00
						1.00	_
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on WI (see instructions)						N N	171. 00

	FI NANCI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	<u>YETTE REGIONAL I</u> STIONNAIRE		CCN: 150064	Peri od: From 10/01/2014	u of Form CMS Worksheet S- Part II	-2
					To 09/30/2015		
					Y/N	Date	
	General Instruction: Enter Y for all YES resp	onses. Enter N 1	for all NO re	sponses. Ente	1.00 er all dates in t	2. 00 he	+
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS						
	Provider Organization and Operation						
0	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t				N		'
	<u> </u>	3		Y/N	Date	V/I	
0	Has the provider terminated participation in	the Medicare Pro	ogram? If	1. 00 N	2. 00	3. 00	
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column	3, "V" for				
0	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, chain home of I to the provide , or members of	fices, drug r or its the board	N			
	Terationsii ps: (see mstructrons)			Y/N	Туре	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
0	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for	r Compiled,	Y	A		1
0	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues differe		N			
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					2.00	
)	Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool? Column 2:	If yes, is th	e provider is	s N		
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	rams approved a		during the	N N		
0	Are costs claimed for Interns and Residents i	n an approved gi		al education	N		
00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr			he current	N		1
00	cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center		% Din an Ann	rayad	N		1
00	Teaching Program on Worksheet A? If yes, see		а к тп ап Арр	Toveu	IN		
						Y/N 1. 00	
	Bad Debts						
00	Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad deb	-			ost reporting	Y N	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co naymon:	ts wai vod2 lf	vos soo in	structions	N	1
	Bed Complement	ind/or co-paymen	ts warveu: II	yes, see iii	structions.		_ '
00	Did total beds available change from the pric	or cost reporting	g period? If	r -	tructions. art A	N Part B	1
		Descri p	ti on	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	10/27/2015	N	1
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 in columns			N		N	1
00	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			N		N	1
00	this 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			N		N	1
				i e	1		1

Health Financial Systems	FAYETTE REGIONAL HEAI	_TH SYSTEM	In Lieu of Form CMS-2552-		
LOCALTAL AND LOCALTAL MEALTH	CADE DELMDIDSEMENT OLIESTIONNALDE	Providor CCN: 150064	Pari ad:	Workshoot S 2	

Period: From 10/01/2014 Part II 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the N 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 Ν instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. Ν 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position KYLF SMI TH 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. BLUE AND CO 42.00 Enter the employer/company name of the cost report 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317. 713. 7957 KCSMI TH@BLUEANDCO. COM 43.00 report preparer in columns 1 and 2, respectively.

Heal th	Financial Systems FA	YETTE REGIONAL	HEALI	H SYSTEM		In Lieu	i of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE		Provi der C	CN: 150064	Peri od:	Worksheet S-2	
						From 10/01/2014	Part II	
						To 09/30/2015		
							2/25/2016 2:2	5 pm
		Part B						
		Date						
		4.00						
	PS&R Data							
16.00	Was the cost report prepared using the PS&R	10/27/2015						16. 00
	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							
	instructions)							
17. 00	Was the cost report prepared using the PS&R							17. 00
17.00	Report for totals and the provider's records							17.00
	for allocation? If either column 1 or 3 is							
	yes, enter the paid-through date in columns							
	2 and 4. (see instructions)							
18. 00	If line 16 or 17 is yes, were adjustments							18. 00
16.00	made to PS&R Report data for additional							16.00
	claims that have been billed but are not							
	included on the PS&R Report used to file							
10.00	this cost report? If yes, see instructions.							10.00
19. 00	If line 16 or 17 is yes, were adjustments							19. 00
	made to PS&R Report data for corrections of							
	other PS&R Report information? If yes, see							
00.00	instructions.							00.00
20. 00	If line 16 or 17 is yes, were adjustments							20. 00
	made to PS&R Report data for Other? Describe							
	the other adjustments:							
21. 00	Was the cost report prepared only using the							21. 00
	provider's records? If yes, see							
	instructions.							
				0 -	_			
				3. 00	0			
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title		MANAGE	.R				41. 00
	held by the cost report preparer in columns 1	, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost r	report						42. 00
	preparer.							
43.00	Enter the telephone number and email address							43. 00
	report preparer in columns 1 and 2, respectiv	∕el y.						

 Heal th Financial
 Systems
 FAYETTE REGIONAL HEALTH SYSTEM

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider Complex Statistical Data
 Provider CCN: 150064

Component Worksheet A No. of Beds Bed Days Available No. of Beds No. of						T	09/30/2015		
Component) piii
Component									
1.00		Component	Worksheet A	No	of Reds	Red Days			
1.00		Component		140.	OI beas	,	CAIT HOURS	I TITLE V	
1.00					2 00		4 00	5 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 3 00 HMO IPF Subprovider 4 00 Color (see instructions) 5 00 Hospi tal Adul ts & Peds. Swing Bed SNF 5 00 Hospi tal Adul ts & Peds. Swing Bed SNF 6 00 Hospi tal Adul ts & Peds. Swing Bed SNF 7 01 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8 00 INTENSIVE CARE UNIT 9 00 CORONARY CARE UNIT 10 00 SURGICAL INTENSIVE CARE UNIT 11 00 SURGICAL INTENSIVE CARE UNIT 12 00 OTHER SPECIAL CARE (SPECIFY) 13 00 NURSERY 43 00 14 00 Total (see instructions) 15 00 CAH visits 16 00 CAH visits 17 00 CAH visits 18 00 CAH visits 19 00 CAH visits 19 00 OTHER LONG TEAR CAPE 19 00 SKILLED NURSING FACILITY 20 00 OTHER LONG TEAR CAPE 20 00 OTHER LONG TEAR CAPE 21 00 OTHER LONG TEAR CAPE 22 00 OTHER LONG TEAR CAPE 23 00 AMBULATORY SURGICAL CENTER (D.P.) 24 10 HOSPI CE (non-distinct part) 25 00 AMOUNT CAPE 26 00 AMBULATORY SURGICAL CENTER (D.P.) 27 00 Total (see instruction) 38 00 Employee discount days (see instructions) 40 0 0 O O O O O O O O O O O O O O O O O	1 00	Hospital Adults & Peds (columns 5 6 7 and							1 00
Hospice days)(see instructions for col. 2	1.00		00.00		07	10,000	0.00	Ĭ	1.00
For the portion of LDP room available beds) 2 00 3 00 4M0 IPF Subprovider 3 00 3 00 4M0 IPF Subprovider 3 00 4 00 400									
2.00		1 3 / 1							
3.00 HMO IPF Subprovider 4.00 MO IRF Subprovider 5.00 Hospit tal Adult ts & Peds. Swing Bed SNF 6.00 Hospit tal Adult ts & Peds. Swing Bed NF 7.00 Total Adult ts and Peds. (exclude observation beds) (see instructions) 8.00 INTRSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 DIMBN INTERSIVE CARE UNIT 11.00 SURGICAL INTERSIVE CARE UNIT 12.00 TOTAL SPECIFICAL INTERSIVE CARE UNIT 13.00 UNUSERY 14.30 0.00 UNUSERY 15.00 AUNISERY 16.00 SUBPROVIDER - IPF 17.885 0.00 0 14.00 15.00 15.80 0 15.00 15.00 16.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SUBPROVIDE	2.00								2.00
4. 00 HMO RF Subprovider	3.00								3. 00
5.00 Hospital Adults & Peds. Swing Bed SNF 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 7.00 0 8.00 0 7.00 0 8.00		•							
6.00 Hospital Adults & Peds. Swing Bed NF								ol	
7. 00 Total Adults and Peds (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 08 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE (non-distinct part) 25. 00 CMMC - CMMC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 SUBRAVI INER SUBGLOAUS (see instruction) 28. 00 Observation Bed Days 29. 00 ABBULatorial Adelivery room 30. 00 Employee di scount days (see instruction) 29. 00 Observation Bed Days 29. 00 ABBULatorial Adelivery room 30. 00 Labor & delivery days (see instructions) 30. 00 Total ancililary labor & delivery room 30. 00 Labor & delivery days (see instructions)								o	
beds) (see instructions)	7. 00				37	13, 505	0.00	0	7. 00
8. 00 INTENSIVE CARE UNIT 31.00 12 4,380 0.00 0 8. 00 9. 00 COROMARY CARE UNIT 10. 00 9. 00 10. 00 9. 00 10. 00 9. 00 11. 00 SURGI CAL INTENSIVE CARE UNIT 11. 00 11. 00 SURGI CAL INTENSIVE CARE UNIT 11. 00 12. 00 10 11. 00									
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 1	8.00		31. 00		12	4, 380	0.00	0	8.00
11. 00 SURGICAL INTENSIVE CARE (UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 43. 00 14. 00 Total (see instructions) 49 17. 885 0. 00 014. 00 13. 00 015. 00 CAH visits 015. 00	9.00	CORONARY CARE UNIT							9.00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 18. 00 UPROVIDER 19. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 ONURSING FACILITY 20. 00 NURSING FACILITY 20. 00 ONURSING FACILITY 20. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 CMHC - CORF 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 32. 00 Labor & delivery days (see instruction) 31. 00 32. 00 Labor & delivery days (see instructions) 30. 00 31. 00 Employee di scount days - IRF 31. 00 32. 01 32. 01 32. 01 32. 01	10.00	BURN INTENSIVE CARE UNIT							10.00
13. 00 NURSERY 143. 00 14. 00 Total (see instructions) 15. 00 CAH vi sits 16. 00 SUBPROVIDER - IPF 17, 885 0. 00 16. 00 18. 00 SUBPROVIDER - IPF 18. 00 19. 00 SUBPROVIDER - IRF 19. 00	11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 885 18. 00 0 14. 00 18. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IFF 19. 00 SUBPROVIDER - IRF 19. 00 16. 00 19. 00 SUBPROVIDER 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 THER LONG TERM CARE 21. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 HOSPICE 10. 00 HOSPICE 116. 00 O O O O O O O O O O O O O O O O O O	13.00		43. 00					ol	13.00
16.00 SUBPROVIDER - IPF	14.00	Total (see instructions)			49	17, 885	0.00	0	14.00
17. 00 SUBPROVIDER - IRF 41. 00 16 5,840 0 17. 00 18. 00 SUBPROVIDER 42. 00 0 0 19. 00 SUIDER 42. 00 0 19. 00 SUIDER 43. 00 19. 00 SUIDER 44. 00 0 19. 00 SUIDER 44. 00 19. 00 50. 00 19. 00 SUIDER 44. 00 19. 00 50. 00 19. 00 SUIDER 44. 00 19. 00 50. 00 19. 00 SUIDER 44. 00 19. 00 50. 00 19. 00 SUIDER 44. 00 19. 00 50. 00 19. 0	15.00	CAH visits						0	15.00
18.00 SUBPROVI DER 42.00 0 0 18.00 19.00	16.00	SUBPROVI DER - I PF	40. 00		12	4, 380		0	16.00
19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 21. 00 21. 00 22. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 10 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 26. 25 27. 00 26. 25 27. 00 27. 00 28. 00 29.	17.00	SUBPROVI DER - I RF	41. 00		16	5, 840		0	17.00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE	18.00	SUBPROVI DER	42. 00		0	0		0	18.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 41.00 HOSPICE (non-distinct part) 55.00 CMHC - CMHC 55.10 CMHC - CORF 60.00 RURAL HEALTH CLINIC 77.00 Total (sum of lines 14-26) 78.00 Observation Bed Days 79.00 Ambulance Trips 70.00 Employee discount days (see instruction) 70.10 Employee discount days - IRF 10.00 Other and the structions 10.00 CM	19.00	SKILLED NURSING FACILITY							19.00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	20.00	NURSING FACILITY							20.00
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 116. 00 0 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 32. 01 30. 00 O O O O O O O O O O O O O O O O O	21.00	OTHER LONG TERM CARE							21.00
24. 00 HOSPICE	22.00	HOME HEALTH AGENCY	101. 00					0	22.00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 00 31. 00 Total ancillary labor & delivery room outpatient days (see instructions)	23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 28. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	24.00	HOSPI CE	116. 00		0	0			24.00
25. 10	24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
26. 00 RURAL HEALTH CLINIC 88. 00 926. 05 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25 27. 00 Total (sum of lines 14-26) 77 7 28. 00 Observation Bed Days 9. 00 9. 00 Ambul ance Trips 9. 00 Employee discount days (see instruction) 9. 00 10 10 10 10 10 10 10 10 10 10 10 10	25.00	CMHC - CMHC							25.00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 77 0 26. 25 27. 00 70 10 10 10 10 10 10 10 10 10 10 10 10 10	25. 10	CMHC - CORF	99. 10					0	25. 10
27.00 Total (sum of lines 14-26) 27.00 28.00 0bservation Bed Days 0 28.00 29.00 Ambul ance Trips 29.00 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 0 0 32.00 32.01 Total ancillary labor & delivery room 0utpatient days (see instructions) 32.01 32.01 32.01 33.00 33.01 3	26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	27.00	Total (sum of lines 14-26)			77				27.00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 O 32.00 O 32.01 O 32.01	28.00	Observation Bed Days						0	28.00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 0 0 0 32.00	29.00	Ambul ance Tri ps							29.00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00 0 0 0 32.01	30.00	Employee discount days (see instruction)							30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	31.00	Employee discount days - IRF							31.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	32.00				0	0			32.00
outpatient days (see instructions)	32. 01								32. 01
33.00 LTCH non-covered days									
	33. 00	LTCH non-covered days							33.00

 Heal th Financial
 Systems
 FAYETTE REGIONAL HEALTH SYSTEM

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider Complex Statistical Data
 Provider CCN: 150064

				•		2/25/2016 2:2	5 pm
		I/P Days	3 / O/P Visits	/ Trips	Full Time	Equi val ents	
	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	1, 208	105	2, 370			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	450	070				
2. 00 3. 00	HMO and other (see instructions)	150 0	878 0				2.00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider	U	0				3. 00 4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	52	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF	52	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 260	105				7. 00
	beds) (see instructions)	,		,			
8.00	INTENSIVE CARE UNIT	442	13	745			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)		0.4	450			12.00
13. 00 14. 00	NURSERY	1 700	24 142			419. 69	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	1, 702	142		0.00	419.09	15. 00
16. 00	SUBPROVI DER - I PF	1, 529	289	·	0.00	14. 21	
17. 00	SUBPROVI DER - I RF	100	0				1
18. 00	SUBPROVI DER	o	0				
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	3, 119	656	9, 687	0. 00	16. 22	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		•		0.00	0.04	23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0	0			0. 81	24. 00 24. 10
25. 00	CMHC - CMHC	١	0				25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	l ol	0				
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0			1
27.00	Total (sum of lines 14-26)				0.00	453. 34	27. 00
28. 00	Observation Bed Days		0	657			28. 00
29. 00	Ambul ance Tri ps	794					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	39	45			32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33 00	LTCH non-covered days	o					33.00
55. 56	12.5 5546164 4435	١		ı	I .	I	, 55. 55

				To	09/30/2015	Date/Time Pre 2/25/2016 2:2	
		Full Time	<u> </u>	Di scha	arges		.
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	501	41	1, 067	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			34	245		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	501	41	1, 067	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0		46	184	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	_	0	8	17. 00
18. 00	SUBPROVI DER	0. 00	0	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

Provider CCN: 150064

					Т	o 09/30/2015	Date/Time Pre 2/25/2016 2: 2	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	22, 909, 638	0	22, 909, 638	858, 124. 00	26. 70	1.00
2. 00	Non-physician anesthetist Part		0	0	С	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	0	С	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		262, 971	0	262, 971	1, 794. 00	146. 58	4. 00
4. 01	Physicians - Part A - Teaching		4 707 724	0		0. 00 30, 856. 00	l .	
5. 00 6. 00	Physician-Part B Non-physician-Part B		4, 797, 734 0	0	4, 797, 734 C	0.00		
7. 00	Interns & residents (in an approved program)	21. 00	0	0	C	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	С	0.00	0. 00	7. 01
	programs)							
8. 00 9. 00	Home office personnel	44. 00	0	0		0. 00 0. 00		
10. 00	Excluded area salaries (see	11.00	3, 971, 658	40, 902	4, 012, 560			
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		503, 296	0	503, 296	6, 456. 00	77. 96	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12. 00
12.00	management and other management and administrative		Ŭ		Š	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		346, 038	0	346, 038	5, 747. 00	60. 21	13.00
14. 00	A - Administrative Home office salaries &		0	0				14. 00
45.00	wage-related costs							
15. 00	Home office: Physician Part A - Administrative		O	0	C	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	С	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 648, 615	0	2, 648, 615			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	C			18. 00
10.00	(see instructions)		O					
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		859, 806	0	859, 806			19. 00 20. 00
	A		-	_	_			
21. 00	Non-physician anesthetist Part B		0	0				21.00
22. 00	Physician Part A - Administrative		27, 200	0	27, 200			22. 00
22. 01	Physician Part A - Teaching		0	0				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		491, 816	0	491, 816			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	C			25. 00
24 00	OVERHEAD COSTS - DIRECT SALARIE	4. 00	171 001	83, 199	254, 200	0.774.00	20.24	26. 00
26. 00 27. 00	Employee Benefits Department Administrative & General	5. 00	171, 001 2, 162, 773			· ·		
28. 00	Administrative & General under		1, 197, 773		1, 197, 773	15, 636. 00	76. 60	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	C	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	320, 269					
31. 00 32. 00	Laundry & Linen Service Housekeeping	8. 00 9. 00	3, 549 522, 344					
33. 00	Housekeeping under contract (see instructions)	7. 00	0	0	1	0.00	l .	
34. 00	Di etary	10. 00	491, 689	-287, 278	204, 411		l .	
35. 00	Dietary under contract (see instructions)		0	0	C	0.00	0.00	35. 00
36.00	Cafeteria	11. 00	0	298, 425	298, 425			
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	510, 496	5, 563	516, 059	0. 00 11, 912. 00		37. 00 38. 00
39. 00	Central Services and Supply	14. 00	78, 186	1, 768	79, 954	4, 803. 00	16. 65	39. 00
40. 00	Pharmacy	15. 00	276, 982	3, 324	280, 306	10, 408. 00	26. 93	40.00

Health Financial Systems		F.A	YETTE REGIONAL	_ HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATI	ON			Provi der		Peri od:	Worksheet S-3	
						From 10/01/2014 To 09/30/2015		pared:
							2/25/2016 2:2	5 pm
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medi	cal	16. 00	555, 381	30, 541	585, 92	26, 295. 00	22. 28	41. 00
Records Library								
42.00 Social Service		17. 00	C	0		0.00	0.00	42.00
43.00 Other General Service		18. 00	C) 0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150064 Peri od: From 10/01/2014 To 09/30/2015 2/25/2016 2:25 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 19, 309, 677 19, 309, 677 842, 904. 00 22. 91 1.00 instructions) 2.00 Excluded area salaries (see 3, 971, 658 40, 902 4, 012, 560 200, 413. 00 20. 02 2.00 instructions) 642, 491. 00 3.00 Subtotal salaries (line 1 15, 338, 019 -40, 902 15, 297, 117 23.81 3.00 minus line 2) 4.00 Subtotal other wages & related 849, 334 849, 334 12, 203. 00 69.60 4.00 costs (see inst.) Subtotal wage-related costs 5.00 2, 675, 815 C 2, 675, 815 0.00 17.49 5.00

-40, 902

-217, 144

18, 822, 266

6, 073, 299

654, 694. 00

260, 562. 00

18, 863, 168

6, 290, 443

6.00

7.00

28. 75

23. 31

(see inst.)

instructions)

6.00

7.00

Total (sum of lines 3 thru 5)

Total overhead cost (see

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS	Provi der C		Peri od: From 10/01/2014	Worksheet S-3
				Date/Time Prepared:

PART I V - WAGE RELATED COSTS 1.00 1.0		To 09/30/2015	Date/Time Prep 2/25/2016 2:2	
PART IV - WAGE RELATED COSTS Part A - Core List			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Empl oyer Contributions 397, 284 1.00 2.00 7.00			Reported	
Part A - Core List RETIREMENT COST			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.4.00 0	1.00	401K Employer Contributions	397, 284	1.00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
5.00 401K/TSA PI an Administration fees 0 5.00 6.00 Legal /Account in g/Management Fees-Pensi on PI an 0 6.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 2, 153, 437 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan -107, 092 10.00 12.00 Accident Insurance (If employee is owner or beneficiary) -92, 766 11.00 13.00 Disability Insurance (If employee is owner or beneficiary) -134, 450 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) -134, 450 13.00 15.00 Workers' Compensation Insurance 171, 747 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 FICA-Employers Portion Only 1, 508, 489 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94, 657 19.00 20.00 State or Federal Unemployment Taxes 0 20	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
Legal / Accounting / Management Fees-Pension Plan 0 6.00		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST 8. 00 Heal th Insurance (Purchased or Self Funded) 2, 153, 437 8. 00 9. 00 10. 00 Dental , Hearing and Vision Plan -107, 092 10. 00 11. 00 Life Insurance (If employee is owner or beneficiary) -92, 766 11. 00 12. 00 Accident Insurance (If employee is owner or beneficiary) -134, 450 13. 00 13. 00 Disability Insurance (If employee is owner or beneficiary) -134, 450 13. 00 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 171, 747 15. 00 Workers' Compensation Insurance 171, 747 15. 00 Workers' Compensation Insurance 171, 747 15. 00 Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 1,508, 489 17. 00 18. 00 Wedicare Taxes - Employers Portion Only 0 18. 00 18. 00 19. 00 Unemployment Insurance 94, 657 19. 00 19. 00 Unemployment Insurance 94, 657 19. 00 19. 00 Unemployment Unsurance 94, 657 19. 00	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 2, 153, 437 8.00 9.00 Prescription Drug Plan 0 9.00 0.0	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan -107,092 10.00 11.00 Life Insurance (If employee is owner or beneficiary) -92,766 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) -134,450 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 171,747 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 FICA-Employers Portion Only 1,508,489 17.00 18.00 Medicare Taxes - Employers Portion Only 94,657 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.0		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan	8.00	Health Insurance (Purchased or Self Funded)	2, 153, 437	8. 00
11. 00	9.00		0	9. 00
11. 00	10.00	Dental, Hearing and Vision Plan	-107, 092	10.00
13. 00 Di sability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 171, 747 15. 00 Reti rement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medi care Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost	11.00		-92, 766	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Instructions) 22. 00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance 171,747 15.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 0 18.00 Unemployment Insurance 94,657 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 0 36,130 23.00 Total Wage Related cost (Sum of Lines 1 -23) 4,027,436 24.00 Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	-134, 450	13.00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES TAXES TAXES TAXES TO TO TO TO TO TO TO T	15.00	'Workers' Compensation Insurance	171, 747	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17.00 FICA-Employers Portion Only 1,508,489 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94,657 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 36,130 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 4,027,436 24.00 Part B - Other than Core Related Cost 24.00 25.00 24.0		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94,657 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 36,130 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 4,027,436 24.00 Part B - Other than Core Related Cost		TAXES		
19.00 Unempl oyment Insurance 94,657 19.00 20.00 State or Federal Unempl oyment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 36,130 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 4,027,436 24.00 Part B - Other than Core Related Cost	17.00	FICA-Employers Portion Only	1, 508, 489	17. 00
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 36,130 23.00 Total Wage Related cost (Sum of Lines 1 -23) 4,027,436 24.00 Part B - Other than Core Related Cost	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 7. Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21. 00 21. 00 22. 00 24. 00 24. 00 24. 00	19.00	Unempl oyment Insurance	94, 657	19.00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 24.00 24.00	20.00	State or Federal Unemployment Taxes	0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost Instructions (Sum of lines 1 -23)		OTHER		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 36, 130 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 4, 027, 436 24. 00 Part B - Other than Core Related Cost	21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
23.00 Tui ti on Rei mbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 23.00 4,027,436 24.00		instructions))		
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 4,027,436 24.00	22. 00	Day Care Cost and Allowances	0	22. 00
Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	36, 130	23.00
	24. 00	Total Wage Related cost (Sum of lines 1 -23)	4, 027, 436	24. 00
25. 00 OTHER 456, 860 25. 00				
	25. 00	OTHER	456, 860	25. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150064	Peri od: Worksheet S-3 From 10/01/2014 Part V Part V Date/Time Prepared: 2/25/2014 2:25 pm

		1	0 09/30/2015	Date/lime Prep 2/25/2016 2:25	
	Cost Center Description		Contract Labor		J pili
	oot onto book ptron		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der – I RF		0	0	4. 00
5. 00	Subprovi der - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	
12.00	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce		0	0	13.00
14. 00	Hospital-Based Health Clinic RHC		0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC				16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
	Renal Dialysis		0	0	
18. 00	Other Other		0	0	18. 00

Heal th	Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
HOME H	BEALTH AGENCY STATISTICAL DATA			CCN: 150064	Peri od: From 10/01/2014		
			Component	CCN: 157097	To 09/30/2015 Home Heal th	Date/Time Pre 2/25/2016 2:2 PPS	5 pm
					Agency I	113	
0.00	County				1. FAYETTE	00	0.00
0.00	leounty	Title V	Title XVIII	Title XIX	0ther	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5.00	
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	0 202. 00	0. (0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numbe your normal		Staff	Contract	Total	
		0		1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0. 00				3. 00
4.00	Director(s) and Assistant Director(s)		0.00	0.0	0. 00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0. (0. 00	0.00	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. (0. 00	0.00	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. (1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0			1
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (0. (13. 00 14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. (0. 00	0.00	15. 00
17. 00 18. 00	Home Health Aide Supervisor			0.0	0. 00	0.00	17. 00
	Other (specify) HOME HEALTH AGENCY CBSA CODES] 0.1		0.00	
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				5		19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			17140			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01 20. 02				50031 50035			20. 01 20. 02
20. 03 20. 04				50042 99915			20. 03 20. 04
		Full Epi Without	sodes With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3. 00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 539	216	1	19 55	1, 929	21. 00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	176, 985 362	24, 840 3	1	6, 325 19 4	221, 835 388	
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	45, 290 336	375	l .			24. 00
26. 00	Occupational Therapy Visit Charges	42, 000	1, 000	8.	, 75 1, 125	45, 000	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	Ö	0		0 0	0	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	13 2, 340	180	l .	0 1 0 180		30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	374 25, 806	25 1, 725		1 27 59 1, 863		
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 624	253	1.	46 96	3, 119	33. 00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 292, 421	0 28, 120	•	0 04 9, 993	0 347, 538	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	207			48 7	262	
37. 00	outlier) Total Number of Outlier Episodes		7		0	7	
38. 00	Total Non-Routine Medical Supply Charges	18, 325	7, 965	1, 69	380	28, 362	38. 00

Health Financial Systems FAYETTE REGIONAL	. HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	CCN: 150064	Peri od:	Worksheet S-7	
			From 10/01/2014		nanad.
			To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
	Group	SNF Days	Swing Bed SNF		J Dill
	o. oup	l cin says	Days	col . 2 + 3)	
	1.00	2.00	3. 00	4.00	
69. 00	PE2		0 (0	69. 00
70. 00	PE1		0	0	70.00
71. 00	PD2		0	0	71. 00
72. 00	PD1		0 (0	72. 00
73. 00	PC2		0 (0	73. 00
74. 00	PC1		0	0	
75. 00	PB2		0	0	
76. 00	PB1		0	0	
77. 00	PA2		0	0	
78. 00	PA1		0	0	
199. 00	AAA		0	0	
200. 00 TOTAL			0 52		200. 00
			CBSA at	CBSA on/after	
			Beginning of		
			Cost Reporting Period	the Cost Reporting	
			reirou	Period (if	
				applicable)	
			1. 00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA	ode if a rur	al facility,	99915	99915	201. 00
in effect at the beginning of the cost reporting period. Er	nter in column	2, the code			
in effect on or after October 1 of the cost reporting period	od (if applicab	ole).			
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
		1.00	2.00	Expenses?	
A notice published in the Federal Register Volume 68, No. 1	40 August 4 2			3.00	
payments beginning 10/01/2003. Congress expected this incre					
expenses. For lines 202 through 207: Enter in column 1 the					
column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" for					
with direct patient care and related expenses for each cate					
202. 00 Staffing			0.00		202. 00
203.00 Recrui tment			0.00		203.00
204.00 Retention of employees			0.00		204. 00
205. 00 Trai ni ng			0.00)	205. 00
206. 00 OTHER (SPECIFY)			0.00	l .	206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3))	1	0		207. 00

Health Financial Systems	F.A	YETTE REGIONAL	_ HEAL	TH SYSTEM	1	In Lie	eu of Form CMS-2	2552-10
HOSPITAL IDENTIFICATION DATA					CCN: 150064 t CCN: 151548	Peri od: From 10/01/2014 To 09/30/2015		pared:
						Hospi ce I		
	Unduplicated Days							
	Title XVIII	Title XIX	Ti tl	e XVIII	Title XIX	ALL Other	Total (sum of	

						Hospi ce i		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	1, 197	0	0	0	0	1, 197	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	1, 197	0	0	0	0	1, 197	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0	0	0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0.00	0.00	0.00	0.00	0.00	0.00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	31	0	0	0	0	31	9. 00

Heal th	Financial Systems FAYETTE REGIONAL HEALT	TH SYSTEM		In Li€	eu of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der (CCN: 150064	Peri od:	Worksheet S-10	0			
				From 10/01/2014 To 09/30/2015	Date/Time Pre	narod:			
				10 09/30/2013	2/25/2016 2: 2				
					1. 00				
	Uncompensated and indigent care cost computation								
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lin	ne 202 column	8)	0. 390167	1.00			
0.00	Medicaid (see instructions for each line)				4 400 000	0.00			
2.00	Net revenue from Medicaid				4, 190, 239	2. 00 3. 00			
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental	2		4. 00					
5.00	If line 4 is "no", then enter DSH or supplemental payments from I		Tolli Wedi Card	•	406, 776	1			
6. 00	Medicaid charges	wear car a			15, 494, 317				
7. 00	Medicaid cost (line 1 times line 6)				6, 045, 371	7. 00			
8.00	Difference between net revenue and costs for Medicaid program (1)	ine 7 minu	s sum of lin	es 2 and 5; if	1, 448, 356	8. 00			
	< zero then enter zero)								
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ich line)						
9.00	Net revenue from stand-alone SCHIP				0				
10.00	Stand-al one SCHIP charges				0				
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1: 11:	1: 0	: 6 41	0				
12. 00	Difference between net revenue and costs for stand-alone SCHIP (lenter zero)	line II mi	nus line 9;	ir < zero then	0	12. 00			
	Other state or local government indigent care program (see instru	uctions fo	r each line)						
13. 00	Net revenue from state or local indigent care program (Not included in the inc)	0	13.00			
14. 00	Charges for patients covered under state or local indigent care		•	,	Ö	14. 00			
	10)								
15. 00	State or local indigent care program cost (line 1 times line 14)				0				
16. 00	Difference between net revenue and costs for state or local indig	gent care	program (lin	e 15 minus line	0	16. 00			
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)								
17. 00	Private grants, donations, or endowment income restricted to fund	ding chari	ty care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of hos					18.00			
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			s (sum of lines	1, 448, 356				
. ,	8, 12 and 16)	rnar gont	oar o program	o (ou ooo	1, 1,0,000	.,			
			Uni nsured	Insured	Total (col. 1				
		-	pati ents	pati ents	+ col . 2)				
20.00	Tatal initial abligation of matients are account for about the case (-+ 6.11	1.00	2. 00	3. 00	20.00			
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire		2, 256, 86	9 0	2, 256, 869	20. 00			
21. 00	Cost of initial obligation of patients approved for charity care		880, 55	6	880, 556	21. 00			
200	times line 20)	(000,00		000,000	200			
22.00	Partial payment by patients approved for charity care			0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		880, 55	6 0	880, 556	23. 00			
0.1.00					1. 00	0.1.00			
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a length o	f stay limit		24. 00			
25. 00	imposed on patients covered by Medicaid or other indigent care pulf line 24 is "yes," charges for patient days beyond an indigen	h of stav limit	0	25. 00					
26 00									
26. 00 27. 00	[Medicare bad debts for the entire hospital complex (see instruction	Tons)							
26. 00 27. 00 28. 00	Medicare bad debts for the entire hospital complex (see instruction) Non-Medicare and non-reimbursable Medicare bad debt expense (line		s line 27)		8, 067, 022				
27. 00		e 26 minus	,	28)		28. 00			
27. 00 28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	e 26 minus	,	28)	8, 067, 022	28. 00 29. 00			

Heal th	Financial Systems	FAYETTE REGIONAL I	HEALTH SYSTEM		In Lie	eu of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
					From 10/01/2014 Fo 09/30/2015	Date/Time Pre	pared:
						2/25/2016 2: 2	
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	0.00	0.00	4.00	col . 4)	
	OFNEDAL CERVILOE COCT OFNEDO	1.00	2. 00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		2 512 110	2 512 11/		2 512 110	1 00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT	171 001	2, 513, 110			2, 513, 110	
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	171, 001	4, 238, 051				
7. 00	00700 OPERATION OF PLANT	2, 162, 773 320, 269	5, 845, 005 2, 208, 826				
7. 00	00701 OPERATION OF PLANT	320, 209	2, 200, 020	1	831, 801		1
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 549	129, 742	1			
9. 00	00900 HOUSEKEEPING	522, 344	123, 597			· ·	1
10. 00	01000 DI ETARY	491, 689	361, 144				
11. 00	01100 CAFETERI A	0	00.,	002,000			
13. 00	01300 NURSING ADMINISTRATION	510, 496	25, 867	536, 363			
14. 00	01400 CENTRAL SERVICES & SUPPLY	78, 186	909, 727				
15. 00	01500 PHARMACY	276, 982	3, 754, 168		· ·		
	01600 MEDICAL RECORDS & LIBRARY	555, 381	835, 212			1	1
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	•				
30.00	03000 ADULTS & PEDI ATRI CS	1, 271, 348	253, 669	1, 525, 01	7 -335, 093	1, 189, 924	30.00
31.00	03100 INTENSIVE CARE UNIT	660, 628	227, 056	887, 684	7, 729	895, 413	31.00
40.00	04000 SUBPROVI DER - I PF	665, 829	713, 590	1, 379, 419	7, 679	1, 387, 098	40. 00
41.00	04100 SUBPROVI DER - I RF	76, 632	75, 326	151, 958	1, 174	153, 132	41.00
42.00	04200 SUBPROVI DER	0	0)	0	0	
43.00	04300 NURSERY	0	0	(349, 866	349, 866	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	722, 734	1, 002, 411	1, 725, 14!	8, 419	1, 733, 564	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 012, 962	1, 511, 930	2, 524, 892	19, 968	2, 544, 860	1
57. 00	05700 CT SCAN	0	0	(0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	(2) [2]	1 001 000	1 717 /1:	1 14 1/1	1 701 770	59.00
60.00	06000 LABORATORY	626, 521	1, 091, 090	1, 717, 61	14, 161	1, 731, 772	1
60. 01	06001 BLOOD LABORATORY	251 024	47.074	399, 912	1 0/5	402 077	60. 01
65.00	06500 RESPIRATORY THERAPY	351, 936	47, 976	1	-		
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	564, 908	133, 645 7, 971				1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 677	7, 971	153, 648	1, 746	155, 394 0	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0		66, 678	·	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		00,070	00,078	73.00
74. 00	07400 RENAL DIALYSIS		0			0	1
7 1. 00	OUTPATIENT SERVICE COST CENTERS	1 9		`	<u> </u>		7 1. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0) (0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		0	0	89. 00
91.00	09100 EMERGENCY	1, 002, 404	914, 779	1, 917, 183	11, 586	1, 928, 769	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	04040 CLI NI C	6, 854, 423	1, 758, 861	8, 613, 28	79, 659	8, 692, 943	93. 00
	04954 BI C	621, 906	569, 221	1, 191, 12	7, 247	1, 198, 374	
	04953 UCI C	0	0	(0	0	
	04955 CI C	0	0	(0	0	
	04956 RI C	0	0	(0	0	1
93. 05	04950 PODI ATRY	9, 863	60, 263	70, 120	5 103	70, 229	93. 05
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	332, 796	21, 414	354, 210	3, 861	358, 071	05 00
	09910 CORF	332, 740	21,414	354, 210	3,001	338,071	1
	10100 HOME HEALTH AGENCY	759, 981	117, 726	877, 70	7 -29, 578		
101.00	SPECIAL PURPOSE COST CENTERS	707,701	117,720	017,70	27,070	010, 127	101.00
109.00	10900 PANCREAS ACQUISITION	0	0		0	0	109. 00
	11000 INTESTINAL ACQUISITION	O	0) (0	0	110.00
111.00	11100 SLET ACQUISITION	0	0) (0	0	111. 00
116.00	11600 HOSPI CE	O	48, 102	48, 102	38, 683	86, 785	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	20, 773, 218	29, 499, 479	50, 272, 69	7 14, 575	50, 287, 272	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00
	19100 RESEARCH	0	0) (0		191. 00
	19101 FMH DIAGNOSTIC CENTE	189, 047	9, 996				
	19102 WELLNESS	86, 987	108, 546				
	19200 PHYSICIANS' PRIVATE OFFICES	11, 407	4, 847			· ·	192. 00
	19201 RFE	0	19	l .		•	192. 01
	19202 MARKETI NG	63, 878	316, 755	380, 633	-40, 075		
	19203 FOUNDATION	0	0]	0		192. 03
	19204 BROOKVI LLE CLINI C		0				192. 04 192. 05
	19205 ATOD 19206 HEART CENTER		0]			192. 05
	19206 HEART CENTER 19207 WVCP	1, 506, 899	609, 241	2, 116, 140	17, 312	1	
192. U/	19207 WVCP 19210 OCCUPATI ONAL MED	23, 872	609, 241	1			192. 07
. /2. 00	12.3 OGGGI ATT GIANE MED	1 23,012	044	24, 310	201	1 24, 111	11,72,00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ()F EXPENSES	Provi der		Peri od:	Worksheet A	
			_	rom 10/01/2014	D 1 (T' D	
				o 09/30/2015	Date/Time Pre 2/25/2016 2:2	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
192. 09 19209 HOME MEDICAL EQUIPMENT	0	0	(0	0	192. 09
192. 10 19211 HOSPI TALI ST	254, 330	884, 825	1, 139, 155	3, 105	1, 142, 260	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	22, 909, 638	31, 434, 352	54, 343, 990	0	54, 343, 990	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150064 Peri od:

Peri od: Worksheet A From 10/01/2014 To 09/30/2015 Date/Ti me Prepared:

<u>2/25/2016 2:25 pm</u> Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT -612, 699 1, 900, 411 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 492, 251 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -148, 958 7, 516, 508 5.00 00700 OPERATION OF PLANT -2, 402 7 00 1, 706, 285 7 00 7.01 00701 OPERATION OF PLANT 831, 801 7.01 0 00800 LAUNDRY & LINEN SERVICE 8.00 0 133, 396 8.00 9.00 00900 HOUSEKEEPI NG 0 657, 727 9.00 01000 DI ETARY 10.00 0 346, 362 10.00 01100 CAFETERI A -209, 087 308, 531 11.00 11.00 13 00 01300 NURSING ADMINISTRATION -2, 108 539, 818 13.00 01400 CENTRAL SERVICES & SUPPLY 923, 003 14 00 14 00 15.00 01500 PHARMACY -950, 016 3, 084, 458 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY -9, 267 1, 411, 867 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 1, 189, 924 31.00 03100 INTENSIVE CARE UNIT 0 895, 413 31.00 04000 SUBPROVI DER - I PF 0 40.00 1, 387, 098 40.00 0 04100 SUBPROVI DER - I RF 41.00 41.00 153, 132 04200 SUBPROVI DER 42.00 0 42 00 04300 NURSERY 349, 866 43.00 43.00 ANCILLARY SERVICE COST CENTERS -759,003 50.00 05000 OPERATING ROOM 974, 561 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 544, 860 54.00 0 05700 CT SCAN 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 60.00 1, 731, 772 60.00 0 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 403, 977 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY -97, 196 608, 143 66.00 06901 CARDI AC REHAB 69.01 0 155, 394 69.01 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 66,678 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 C 07400 RENAL DIALYSIS 74.00 74.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 91 00 09100 EMERGENCY -724, 465 1, 204, 304 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 CLI NI C -5, 425, 929 3, 267, 014 93.00 93.00 93. 01 04954 BIC -228, 918 93.01 969.456 04953 UCI C 93 02 93 02 0 Ω 93.03 04955 CI C 0 0 93.03 93.04 04956 RI C 0 0 93.04 04950 PODI ATRY 93.05 70, 229 93.05 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES -32, 054 326, 017 95.00 99. 10 |09910 CORF 99.10 101.00 10100 HOME HEALTH AGENCY 848, 129 101.00 0 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 111.00 0 0 116. 00 11600 HOSPI CE 86, 785 116. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS -9, 202, 102 41, 085, 170 118.00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 191. 00 19100 RESEARCH 191. 00 191. 01 19101 FMH DIAGNOSTIC CENTE 0 202, 010 191. 01 0 191. 02 19102 WELLNESS 196, 529 191. 02 192.00 19200 PHYSICIANS' PRIVATE OFFICES 17, 113 192. 00 192. 01 19201 RFE 192. 01 192. 02 19202 MARKETI NG 0000000 340, 558 192. 02 192. 03 19203 FOUNDATI ON 192.03 C 192. 04 19204 BROOKVILLE CLINIC Ω 192. 04 192. 05 19205 ATOD 192. 05 0 192.06 19206 HEART CENTER 192.06 192, 07 19207 WVCP 192. 07 2, 133, 452 192. 08 19210 OCCUPATIONAL MED 24, 777 192. 08 192. 09 19209 HOME MEDICAL EQUIPMENT 192.09 192. 10 19211 HOSPI TALI ST 192. 10 1 142 260

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CCN:	150064 Peri od:	Worksheet A
			From 10/01/2014	
			To 09/30/2015	Date/Time Prepared:
				2/25/2016 2:25 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	·	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	-9, 202, 102	45, 141, 888		200. 00

Provider CCN: 150064

					2/25/2016	2: 25 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	11. 00	298, 425	219, 193		1. 00
			298, 425	219, 193		
	B - NURSERY					
1.00	NURSERY	43.00	318, 628	31, 238		1.00
1.00	0		318, 628	31, 238		1.00
	C - COACH RECLASS		310, 020	31, 230		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	83, 199	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	125, 310	0		2.00
3.00	OPERATION OF PLANT	7.00	11, 393	0		3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	11, 393	0		4. 00
5.00	HOUSEKEEPI NG	9.00	11, 786	0		5. 00
6.00	DI ETARY	10.00	11, 147	0		6. 00
7.00	NURSING ADMINISTRATION	13.00	5, 563	0		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	1, 768	0		8. 00
9. 00	PHARMACY	15. 00	3, 324	0		9. 00
10. 00	MEDICAL RECORDS & LIBRARY	16. 00	30, 541	0		10. 00
11. 00	ADULTS & PEDIATRICS	30. 00	14, 773	0		11. 00
12.00	INTENSIVE CARE UNIT	31. 00	7, 729	0		12. 00
13.00	SUBPROVI DER - I PF	40. 00	7, 679	0		13. 00
14.00	SUBPROVI DER - I RF	41. 00	1, 174	0		14. 00
15.00	OPERATING ROOM	50.00	8, 419	0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	19, 968	0		16. 00
17.00	LABORATORY	60.00	14, 161	0		17. 00
18.00	RESPI RATORY THERAPY	65.00	4, 065	0		18. 00
19.00	PHYSI CAL THERAPY	66.00	6, 786	0		19. 00
20. 00	CARDI AC REHAB	69. 01	1, 746	O		20. 00
21. 00	EMERGENCY	91.00	11, 586	O		21. 00
22. 00	CLINIC	93. 00	79, 659	Ö		22. 00
23. 00	BIC	93. 01	7, 247	Ö		23. 00
24. 00	PODI ATRY	93. 05	103	Ö		24. 00
25. 00	AMBULANCE SERVICES	95.00	3, 861	Ö		25. 00
26. 00	HOME HEALTH AGENCY	101.00	9, 105	Ö		26. 00
27. 00	FMH DIAGNOSTIC CENTE	191. 01	2, 967	Ö		27. 00
28. 00	WELLNESS	191. 02	996	o		28. 00
29. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	859	Ö		29. 00
30.00	MARKETING	192.00	764	o		30.00
31. 00	WVCP	192.07	17, 312	0		31. 00
32. 00	OCCUPATI ONAL MED	192.08	261	0		32.00
33. 00		192. 08	3, 105			33. 00
33.00	HOSPITALIST			0		33.00
	U I		508, 461	U		
1 00	D - MARKETI NG	F 00	7 101	22 (50		1 00
1. 00	ADMI NI STRATI VE & GENERAL		<u>7, 181</u>	33,658		1. 00
	0		7, 181	33, 658		
	E - HOSPI CE					
1.00	HOSPICE	11600	3 <u>8, 6</u> 83	<u>o</u>		1. 00
	0		38, 683	0		
	F - HOSPITAL UTILITIES					
1.00	OPERATION_OF_PLANT	<u>7.</u> 01	0	83 <u>1, 8</u> 01		1. 00
	0		0	831, 801		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	66, 678		1. 00
	PATI ENTS					
	0			66, 678		
500.00	Grand Total: Increases		1, 171, 378	1, 182, 568		500.00
						•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150064

						2/25/2016	2:25 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
Α	A - CAFETERIA						
00 <u>D</u>	DI ETARY	<u>10.</u> 00	298, 425	21 <u>9, 1</u> 93	0		1.
0)		298, 425	219, 193			
В	B - NURSERY						
00 A	DULTS & PEDIATRICS	30.00	318, 628	31, 238	0		1.
0	$\overline{}$		318, 628	31, 238			İ
C	- COACH RECLASS		2.0, 220				
	DMI NI STRATI VE & GENERAL	5. 00	508, 461	0	0		1.
00	ISMIT WE GENERALE	0.00	0	0			2.
00		0.00	0	0	0		3.
		0.00	0	0			1
00							4.
00		0.00	0	0			5.
00		0.00	0	0			6.
00		0. 00	0	0			7.
00		0.00	0	0			8.
00		0.00	0	0			9.
. 00		0.00	0	0			10.
. 00		0.00	0	0	0		11.
. 00		0.00	0	0	0		12.
00		0.00	0	0	0		13.
. 00		0.00	o	0	0		14.
00		0.00	o	0			15.
00		0.00	0	0			16
00		0.00	o	0			17
. 00		0.00	o	0	0		18
. 00		0.00	0	0			19.
. 00		0.00	0	0			20.
			- 1				
. 00		0.00	0	0			21.
. 00		0.00	0	0			22.
. 00		0.00	0	0			23.
. 00		0.00	0	0			24.
. 00		0.00	0	0			25.
. 00		0.00	0	0			26.
. 00		0.00	0	0			27.
. 00		0.00	0	0			28.
00		0.00	0	0	0		29.
00		0.00	0	0	0		30.
00		0.00	0	0	0		31.
00		0.00	o	0	0		32.
00		0.00	ol	0	o		33.
0			508, 461	- — — <u> </u>			
ח) - MARKETING		555, 151				
	MARKETI NG	192. 02	7, 181	33, 658	0		- 1.
	WHICE CLING		7, 181	33, 658			''
0	HOSPI CE		7, 101	33, 036			
		101 00	20 400	^			1
	IOME_HEALTH_AGENCY	1 <u>01.</u> 00	38, 683	⁰ 0	0		1.
Ю			38, 683	0			
	- HOSPITAL UTILITIES						
0	PERATION OF PLANT		•	83 <u>1, 8</u> 01			1.
0)		0	831, 801			
G	G - IMPLANTABLE DEVICES						
o C	CENTRAL SERVICES & SUPPLY	14. 00	0	66, 678	0		1.
0				66, 678			1
\ 00 to	Grand Total: Decreases		1, 171, 378	1, 182, 568			500.

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150064 Peri od: Worksheet A-7 From 10/01/2014 Part I Date/Time Prepared: 09/30/2015 2/25/2016 2:25 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 850, 637 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 55, 418, 068 3.00 74, 329 74, 329 45.633 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 24, 773, 019 369, 688 369, 688 90, 589 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 82, 041, 724 444, 017 444, 017 136, 222 8.00 9.00 Reconciling Items 0 9.00 82, 041, 724 Total (line 8 minus line 9) 444, 017 136, 222 10.00 0 444, 017 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1,850,637 0 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 0 3.00 55, 446, 764 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00

25, 052, 118

82, 349, 519

82, 349, 519

0

0

0

0

6.00

7.00

8.00

9.00

10.00

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

9.00

Heal th	Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 10/01/2014 To 09/30/2015		pared:
						2/25/2016 2:2	
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a				
1.00	NEW CAP REL COSTS-BLDG & FIXT	975, 506	0	1, 537, 60	4 0	0	1. 00
3.00	Total (sum of lines 1-2)	975, 506	0	1, 537, 60	4 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	ŭ ,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 ai	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 513, 110				1. 00
3.00	Total (sum of lines 1-2)	0	2, 513, 110				3. 00

Heal th	n Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2014 Fo 09/30/2015		pared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed 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 COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	55, 446, 764		55, 446, 76			1.00
3.00	Total (sum of lines 1-2)	55, 446, 764		55, 446, 76			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		937, 054		1.00
3.00	Total (sum of lines 1-2)	0	0	(937, 054	0	3.00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			•		
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 537, 604	0		-574, 247	1, 900, 411	1.00
3.00	Total (sum of lines 1-2)	1, 537, 604			-574, 247		3. 00
		,		•			

| Peri od: | Worksheet A-8 | From 10/01/2014 | To 09/30/2015 | Date/Time Prepared: Provider CCN: 150064

					o 09/30/2015	Date/Time Prep 2/25/2016 2:25	
				Expense Classification on To/From Which the Amount is			рііі
	Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FIXT	1.00		1. 00
2. 00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		О		0.00	0	7. 00
8. 00	21) Tellevision and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -5, 654, 847		0.00		9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00		11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00 14. 00	transactions (chapter 10) Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00		15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	А	-9, 267	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00 0. 00		20. 00 21. 00
22. 00	, , ,		0		0.00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00		27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30. 00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31. 00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00

					0 09/30/2013	2/25/2016 2: 2	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 00	INTEREST EXPENSE	В	-574, 247	NEW CAP REL COSTS-BLDG &	1.00	14	33. 00
				FIXT			
38.00	MISC SVC/SPLY CLEAR-OTHER REV	В	-156	ADMINISTRATIVE & GENERAL	5.00	0	38. 00
39.00	PFS BILLING SVC -OTHER REV	В	-521	ADMINISTRATIVE & GENERAL	5.00	0	39. 00
40.00	VENDOR REBATE/REFUND-OTHER REV	В	-8, 095	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00	PURCHASE DISC EARNED-OTHER REV	В	11, 668	ADMINISTRATIVE & GENERAL	5.00	0	41. 00
42.00	CASH SHORT & OVER-OTHER REV	В	25	ADMINISTRATIVE & GENERAL	5.00	0	42. 00
43.00	CAFETERIA SALES-OTHER REV	В	-207, 556	CAFETERI A	11.00	0	43.00
45. 01	CAFÉ VEND MACHIN-OTHER REV	В	-1, 531	CAFETERI A	11. 00	0	45. 01
45. 02	EDUCATION & TRAINING-OTHER REV	В	-2, 108	NURSING ADMINISTRATION	13.00	0	45. 02
45. 03	EMPLOYEE DRUG SALES-OTHER REV	В	-89, 350	PHARMACY	15. 00	0	45. 03
45.05	PHARMACY REBATES - OTHER	В	-390	PHARMACY	15. 00	0	45. 05
45. 07	OCCUPATION MED-OTHER REV	В	-570	PHYSI CAL THERAPY	66.00	0	45. 07
45. 08	PHY TH SCHOOL REV-OTHER REV	В	-95, 096	PHYSI CAL THERAPY	66.00	0	45. 08
45. 09	PHYSICAL NIGHT-OTHER REV	В	-1, 530	PHYSI CAL THERAPY	66.00	0	45. 09
45. 10	HELPLINE -OTHER REV	В		AMBULANCE SERVICES	95.00	0	45. 10
45. 11	THA DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 11
45. 12	ANESTHESIA OFFSET-CRNA	l A		OPERATING ROOM	50.00	0	45. 12
45. 13	TELEVI SI ON	A	-16, 607	ADMINISTRATIVE & GENERAL	5. 00	0	45. 13
45. 14	TELEVISION ELECTRICITY	A		OPERATION OF PLANT	7. 00	0	45. 14
45. 15	24TH ST OLD DEPRECIATION	A		NEW CAP REL COSTS-BLDG &	1.00	9	45. 15
			,	FIXT		·	
45. 16	24TH ST NEW DEPRECIATION	A	-20, 106	NEW CAP REL COSTS-BLDG &	1.00	9	45. 16
			,	FLXT			
45. 18	PHYSICIAN RECRUITMENT	l A	-134, 396	ADMINISTRATIVE & GENERAL	5. 00	0	45. 18
45. 19	340B REVENUE	A		PHARMACY	15. 00		
45. 20	ER PURCHASED SERVICES	A		EMERGENCY	91. 00		45. 20
50. 00	TOTAL (sum of lines 1 thru 49)		-9, 202, 102				50.00
-	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	res in this col	umn nertain to	n CMS Pub 15-1	1		

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

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

 B. Amount Received if cost cannot be determined.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 10/01/2014 To 09/30/2015 Date/Time Prepared: Provider CCN: 150064

							To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			I denti fi er	Remuneration	Component	Component		ider Component	
								Hours	
	1. 00		2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		CLINIC		5, 513, 192	5, 323, 541	189, 651			1. 00
2.00	93. 01	1		296, 043	222, 723	73, 320	1		
3.00	0.00			0	0	C	0	0	3. 00
4.00	0. 00			0	0	C	0	0	4. 00
5.00	0.00			0	0	C	0	0	5. 00
6.00	0.00			0	0	C	0	0	6. 00
7.00	0.00			0	0	C	0	0	7. 00
8.00	0.00			0	0	C	0	0	8. 00
9.00	0.00			0	0	C	0	0	9. 00
10.00	0.00			0	0	C	0	0	10.00
200.00				5, 809, 235	5, 546, 264	262, 971			200. 00
	Wkst. A Line #	Cost	Center/Physi ci an	Unadjusted RCE		Cost of	Provi der	Physician Cost	
			l denti fi er	Limit	Unadjusted RCE			of Malpractice	
					Li mi t	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
4.00	1. 00	01.1.111.0	2. 00	8.00	9.00	12. 00	13. 00	14. 00	1 00
1.00		CLINIC		87, 263			-		
2.00	93. 01			67, 125			-		2. 00
3.00	0.00			0	0		-		3. 00
4.00	0.00	1		0	0	_	٠,	ı .	4. 00
5.00	0.00			0	0	(-		5. 00
6.00	0.00	1		0	0	(0	ı .	6. 00
7.00	0.00			0	0	(0	0	7. 00
8.00	0.00	1		0	0			0	8. 00
9.00	0.00			0	0		ή	0	9. 00
10.00	0. 00			154 200	7 710		0	0	10.00
200.00	Wkst. A Line #	0+	C	154, 388 Provi der		RCE	0	0	200. 00
	WKST. A LINE #	Cost	Center/Physician I denti fier		Adjusted RCE	-	Adjustment		
			rdentrirer	Component Share of col.	Limit	Di sal I owance			
				14					
	1. 00		2. 00	15. 00	16. 00	17. 00	18.00		
1. 00		CLINIC		0					1. 00
2.00	93. 01	віс		0	67, 125		228, 918		2. 00
3.00	0.00			0	0				3. 00
4.00	0.00			0	0	C	0		4. 00
5.00	0.00			0	0		o o		5. 00
6.00	0.00			0	0	C	0		6. 00
7.00	0.00			0	0	C	0		7. 00
8.00	0.00			0	0	C	0		8. 00
9.00	0.00			0	0	C	0		9. 00
10.00	0.00			0	0	C	0		10. 00
200.00				0	154, 388	108, 583	5, 654, 847		200. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10 Provi der CCN: 150064 COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 10/01/2014 Part I Date/Time Prepared: 09/30/2015 2/25/2016 2:25 pm CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses NEW BLDG & **EMPLOYEE** Subtotal FLXT for Cost BENEFITS & GENERAL DEPARTMENT Allocation (from Wkst A col. 7) 1.00 4.00 5. 00 4A GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 1, 900, 411 1, 900, 411 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 492, 251 7, 383 4, 499, 634 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 7, 516, 508 118, 039 354, 881 7, 989, 428 7, 989, 428 5.00 00700 OPERATION OF PLANT 548, 286 7 00 1, 706, 285 777, 489 65, 872 2, 549, 646 7 00 00701 OPERATION OF PLANT 7.01 831,801 C 831, 801 178, 874 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 133, 396 2, 279 726 136, 401 29, 332 8.00 00900 HOUSEKEEPI NG 657, 727 9, 379 106, 085 773, 191 166, 270 9.00 9.00 01000 DI ETARY 399, 583 346, 362 12, 623 40, 598 85, 928 10 00 10.00 11.00 01100 CAFETERI A 308, 531 19, 491 59, 271 387, 293 83, 285 11.00 01300 NURSING ADMINISTRATION 539, 818 102, 496 642, 314 13.00 138, 126 13.00 01400 CENTRAL SERVICES & SUPPLY 923, 003 12, 469 15, 880 951, 352 204, 583 14.00 14.00 3, 084, 458 12, 066 55, 672 15.00 01500 PHARMACY 3, 152, 196 677, 861 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 411, 867 18, 085 116, <u>3</u>71 1, 546, 323 16.00 16.00 332, 527 INPATIENT ROUTINE SERVICE COST CENTERS 1, 189, 924 70, 505 30.00 03000 ADULTS & PEDIATRICS 192, 156 1, 452, 585 312, 370 30.00 31.00 03100 INTENSIVE CARE UNIT 895, 413 43, 116 132.744 1,071,273 230, 371 31 00 36, 638 40.00 04000 SUBPROVIDER - IPF 1, 387, 098 133, 767 1, 557, 503 334, 932 40.00 41.00 04100 SUBPROVIDER - IRF 153, 132 44, 230 15, 453 212, 815 45, 765 41.00 04200 SUBPROVI DER 42.00 42.00 0 04300 NURSERY 349, 866 43.00 23, 695 63, 283 436, 844 93, 941 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 974, 561 115, 552 145, 216 1, 235, 329 265, 650 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 544, 860 102, 966 205, 152 2, 852, 978 613, 516 54.00 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 0 0 59 00 06000 LABORATORY 60.00 1, 731, 772 33, 134 127, 247 1, 892, 153 406, 896 60.00 60.01 06001 BLOOD LABORATORY 60.01 105, 426 06500 RESPIRATORY THERAPY 403.977 15, 569 70, 706 490, 252 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 608, 143 34, 211 113, 545 755, 899 162, 552 66.00 06901 CARDI AC REHAB 69.01 155, 394 13, 838 29, 280 198, 512 42, 689 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 Ω 07200 I MPL. DEV. CHARGED TO PATIENTS 0 14, 339 72.00 66,678 66, 678 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 91.00 09100 EMERGENCY 1, 204, 304 38, 471 201, 391 1, 444, 166 310, 559 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 93.00 04040 CLI NI C 3, 267, 014 123, 891 1, 377, 184 4, 768, 089 1,025,361 93.00 04954 BIC 969, 456 124, 957 1, 094, 413 235, 347 93.01 93.01 93.02 04953 UCI C 93.02 C 0 93.03 O 04955 CIC 0 Ω 0 0 93 03 93.04 04956 RI C 0 Ω 93.04 04950 PODI ATRY 93.05 70, 229 1, 979 72, 208 15, 528 93.05 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 326, 017 0 66.864 392, 881 84.487 99. 10 09910 CORF 0 0 101.00 10100 HOME HEALTH AGENCY 993, 196 848, 129 0 145, 067 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 86, 785 116. 00 11600 HOSPI CE 94, 468 7.683 SUBTOTALS (SUM OF LINES 1-117) 41, 085, 170 1, 685, 119 4, 071, 526 40, 441, 770 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191. 00 19100 RESEARCH 0 Ω O 0 191. 01 19101 FMH DIAGNOSTIC CENTE 202, 010 38, 136 240, 146

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 150064	Peri od: Worksheet B From 10/01/2014 Part I To 09/30/2015 Date/Time Prepared:

						2/25/2016 2: 2	5 pm
			CAPITAL RELATED COSTS				
Cos	st Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)					
		0	1. 00	4. 00	4A	5. 00	
192. 06 19206 HEA	ART CENTER	0	4, 376	0	4, 376	941	192. 06
192. 07 19207 WVC	CP	2, 133, 452	97, 843	302, 727	2, 534, 022	544, 926	192. 07
192. 08 19210 OCC	CUPATIONAL MED	24, 777	0	4, 793	29, 570	6, 359	192. 08
192.09 19209 HOM	ME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 19211 HOS	SPI TALI ST	1, 142, 260	0	51, 130	1, 193, 390	256, 631	192. 10
194. 00 07950 OTH	HER NONREIMBURSABLE COST CENTERS	0	73, 897	0	73, 897	15, 891	194. 00
200.00 Cro	oss Foot Adjustments				0		200. 00
201.00 Neg	gative Cost Centers		0	0	0	0	201. 00
202. 00 TOT	TAL (sum lines 118-201)	45, 141, 888	1, 900, 411	4, 499, 634	45, 141, 888	7, 989, 428	202. 00

Provider CCN: 150064

| Period: | Worksheet B | From 10/01/2014 | Part I | Date/Time Prepared: | 2/25/2016 2:25 pm

					2/25/2016 2: 2	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT	LINEN SERVICE			
	7. 00	7. 01	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS		I				4 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL	2 007 022					5.00
7.00 00700 0PERATI ON OF PLANT 7.01 00701 0PERATI ON OF PLANT	3, 097, 932					7. 00 7. 01
8.00 00800 LAUNDRY & LINEN SERVICE	6, 183					8.00
9. 00 00900 HOUSEKEEPI NG	25, 448			978, 555		9. 00
10. 00 01000 DI ETARY	34, 250				566, 959	10.00
11. 00 01100 CAFETERI A	52, 886			17, 824	0	11.00
13. 00 01300 NURSING ADMINISTRATION	02,000	20,007	l o	17, 52	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	33, 834	_		11, 403	0	14. 00
15. 00 01500 PHARMACY	32, 739			11, 034	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	49, 071	26, 313	0		0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	177071	20,010		10,000		
30. 00 03000 ADULTS & PEDIATRICS	191, 309	102, 587	40, 697	64, 476	234, 539	30.00
31. 00 03100 INTENSIVE CARE UNIT	116, 991	62, 735			42, 113	31. 00
40. 00 04000 SUBPROVI DER - I PF	99, 413		0	· ·	60, 534	40.00
41. 00 04100 SUBPROVI DER - RF	120, 013		9, 942	40, 448	3, 907	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	64, 294	34, 477	0	21, 669	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	313, 538	168, 132	14, 540	105, 671	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	279, 389	149, 819	21, 553	94, 162	0	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	89, 906	48, 211	0	30, 301	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	42, 246			14, 238	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	92, 827		·		0	66. 00
69. 01 06901 CARDI AC REHAB	37, 549		1, 357	12, 655	0	69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	U	0	74. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0		0	O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	89. 00
91. 00 09100 EMERGENCY	104, 387	55, 976	28, 438	35, 181	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	104, 367	33, 970	20, 430	33, 101	U	92.00
93. 00 04040 CLI NI C	345, 371	42, 748	101	106, 057	0	93. 00
93. 01 04954 BI C	267, 615		101	90, 194	0	93. 01
93. 02 04953 UCI C	207,010	0	l ő	,0,1,1	0	93. 02
93. 03 04955 CI C	0	0	l ő	0	0	93. 03
93. 04 04956 RI C	0	0	0	0	0	93. 04
93. 05 04950 PODI ATRY	0	Ö	l o	o	0	
OTHER REIMBURSABLE COST CENTERS				-1		
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	4, 880	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	_					
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 399, 259	947, 305	172, 127	787, 613	341, 093	118. 00
NONREI MBURSABLE COST CENTERS		_	_		_	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
191. 01 19101 FMH DI AGNOSTI C CENTE	114 400	0	0	0		191. 01
191. 02 19102 WELLNESS	114, 498		2 504	38, 589		191. 02
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	72, 114	38, 670	2, 584	24, 304		192.00
192. 01 19201 RFE	1/ 422	0.010	0	E E20		192. 01
192. 02 19202 MARKETI NG 192. 03 19203 FOUNDATI ON	16, 432			5, 538		192. 02 192. 03
192. 03 19203 FOUNDATION 192. 04 19204 BROOKVI LLE CLINI C	17, 755			5, 984		192. 03
192. 05 19204 BROOKVILLE CLINIC						192. 04
192.06 19206 HEART CENTER	11, 874	6, 367		4, 002		192. 05
192. 00 19200 HEART CENTER 192. 07 19207 WVCP	265, 487	0, 307	520		225, 866	
192. 08 19210 OCCUPATI ONAL MED	203, 467		J20	00, 030		192. 07
192. 09 19209 HOME MEDICAL EQUIPMENT		1	l 0			192. 09
192. 10 19211 HOSPI TALI ST	0	1	l o	l ol		192. 10
-1			1	<u> </u>		1 10

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 150064	From 10/01/2014	Worksheet B Part I Date/Time Prepared: 2/25/2016 2:25 pm

						2/25/2010 2:2	o piii
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	PLANT	LINEN SERVICE			
		7. 00	7. 01	8. 00	9. 00	10.00	
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	200, 513	0	0	24, 487	0	194. 00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	3, 097, 932	1, 010, 675	175, 231	978, 555	566, 959	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2014 Part I
To 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm Provider CCN: 150064

			10	09/30/2015	2/25/2016 2: 2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	15.00	14.00	13.00	10.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 OPERATION OF PLANT						7. 01
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	569, 647					11. 00
13. 00 01300 NURSING ADMINISTRATION	10, 842	791, 282				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	4, 333	0	1, 223, 648			14. 00
15. 00 01500 PHARMACY	11, 937	29, 293	0	3, 932, 616		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	23, 799	0	0	0	1, 994, 571	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 (10	00.700		ما	00.070	00.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	40, 649 26, 324		0	0	80, 079 38, 822	30. 00 31. 00
40. 00 04000 SUBPROVI DER - PF	26, 324		0	0	68, 329	40.00
41. 00 04100 SUBPROVI DER - I RF	4, 461	10, 945	0	Ö	3, 747	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	o	0	42. 00
43. 00 04300 NURSERY	11, 470	28, 158	0	o	8, 234	43.00
ANCILLARY SERVICE COST CENTERS	,					
50. 00 05000 OPERATI NG ROOM	41, 667	102, 233	0	0	151, 080	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 (10	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	39, 618	97, 190	0	U	382, 743 0	54. 00 57. 00
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	Ö	0	59. 00
60. 00 06000 LABORATORY	27, 726	68, 033	0	Ö	294, 223	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	o	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	20, 439	50, 139	0	O	54, 963	65. 00
66. 00 06600 PHYSI CAL THERAPY	18, 031	44, 235	0	0	34, 218	66. 00
69. 01 06901 CARDI AC REHAB	5, 868	1	0	0	5, 826	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	1, 223, 648	0	52, 931	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3, 932, 616	0 192, 954	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	0		0	3, 732, 010	172, 734	74.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		7 11 00
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
91. 00 09100 EMERGENCY	33, 672	0	0	0	221, 762	91.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 93. 00 04040 CLINIC	88, 849		0		220 001	92.00
93. 00 04040 CLI NI C 93. 01 04954 BI C	88, 849	0	0	U O	220, 081 43, 521	93. 00 93. 01
93. 02 04953 UCI C	0	0	0	0	43, 521	93. 01
93. 03 04955 CI C	0	Ö	Ö	ő	0	93. 03
93. 04 04956 RI C	0	o	0	o	0	93. 04
93. 05 04950 PODI ATRY	510	0	0	0	1, 221	93. 05
OTHER REIMBURSABLE COST CENTERS	I					
95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF	17, 987		0	0	18, 480	
101. 00 10100 HOME HEALTH AGENCY	30, 033	"	0	0	0 14, 919	99. 10
SPECIAL PURPOSE COST CENTERS	30,033	73,000	U _I	<u> </u>	14, 717	101.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	ol	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	o	0	О	0	110. 00
111.00 11100 ISLET ACQUISITION	0	o	0	o	0	111. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	484, 527	791, 282	1, 223, 648	3, 932, 616	1, 892, 207	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				ما	0	100 00
191.00 19100 RESEARCH	0		0	0		190. 00 191. 00
191. 01 19101 FMH DI AGNOSTI C CENTE	0	0	0	Ö		191. 01
191. 02 19102 WELLNESS	0	o	0	o		191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	О	0	o	18, 450	192. 00
192. 01 19201 RFE	0	0	0	0		192. 01
192. 02 19202 MARKETI NG	1, 847		0	0		192. 02
192. 03 19203 FOUNDATION	2,008	0	0	0		192. 03
192. 04 19204 BROOKVI LLE CLI NI C 192. 05 19205 ATOD	0		0	0		192. 04 192. 05
192.06 19206 HEART CENTER			0	O O		192. 05
192. 07 19207 WVCP	79, 173	l ol	n	ol O	83, 399	
192. 08 19210 OCCUPATI ONAL MED	0	l ől	Ö	ő		192. 08
192. 09 19209 HOME MEDICAL EQUIPMENT	0	o	0	o		192. 09
			<u> </u>	'		

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 150064	From 10/01/2014	Worksheet B Part I Date/Time Prepared: 2/25/2016 2:25 pm

					2/25/2016 2:2	5 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13. 00	14.00	15. 00	16. 00	
192. 10 19211 HOSPI TALI ST	2, 092	0	0	0	0	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	569, 647	791, 282	1, 223, 648	3, 932, 616	1, 994, 571	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150064

						2/25/2016 2:	: 25 pm
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post			
				Stepdown Adjustments			
			24. 00	25. 00	26. 00		
	GENER	AL SERVICE COST CENTERS	24.00	25.00	20.00		_
1.00		NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500	ADMINISTRATIVE & GENERAL					5. 00
7.00	00700	OPERATION OF PLANT					7. 00
7. 01	00701	OPERATION OF PLANT					7. 01
8.00		LAUNDRY & LINEN SERVICE					8. 00
9.00		HOUSEKEEPI NG					9. 00
10. 00		DI ETARY					10. 00
11. 00		CAFETERI A					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON					13. 00
14.00	1	CENTRAL SERVICES & SUPPLY					14. 00
15.00		PHARMACY MEDICAL RECORDS & LIBRARY					15. 00 16. 00
16. 00		I ENT ROUTINE SERVICE COST CENTERS					16.00
30. 00		ADULTS & PEDIATRICS	2, 619, 024	0	2, 619, 024		30.00
31. 00		INTENSIVE CARE UNIT	1, 707, 478	0	1, 707, 478		31. 00
40. 00		SUBPROVIDER - IPF	2, 245, 064	Ö	2, 245, 064		40. 00
41.00		SUBPROVIDER - IRF	516, 399	0	516, 399		41.00
42.00	04200	SUBPROVI DER	0	O	0		42. 00
43.00	04300	NURSERY	699, 087	0	699, 087		43. 00
		LARY SERVICE COST CENTERS					
50.00	1	OPERATING ROOM	2, 397, 840	0	2, 397, 840		50. 00
52. 00		DELIVERY ROOM & LABOR ROOM		0	0		52. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	4, 530, 968	0	4, 530, 968		54. 00
57. 00		CT SCAN	0	0	0		57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58. 00 59. 00
60.00		CARDI AC CATHETERI ZATI ON LABORATORY	2, 857, 449	0	2, 857, 449		60.00
60. 00	1	BLOOD LABORATORY	2,037,449	0	2, 037, 449		60. 00
65. 00		RESPI RATORY THERAPY	800, 357	ő	800, 357		65. 00
66. 00	1	PHYSI CAL THERAPY	1, 207, 315	0	1, 207, 315		66. 00
69. 01		CARDI AC REHAB	338, 988	О	338, 988		69. 01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 276, 579	0	1, 276, 579		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	81, 017	0	81, 017		72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	4, 125, 570		4, 125, 570		73. 00
74. 00		RENAL DIALYSIS	0	0	0		74. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0		88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
91. 00	1	EMERGENCY	2, 234, 141	Ö	2, 234, 141		91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	2,201,111	Ö	2, 201, 111		92. 00
93. 00		CLINIC	6, 596, 657	0	6, 596, 657		93. 00
93. 01	04954		1, 731, 090	0	1, 731, 090		93. 01
93. 02	04953	UCI C	0	0	0		93. 02
93. 03			0	0	0		93. 03
93. 04				0			93. 04
93. 05		PODI ATRY	89, 467	0	89, 467		93. 05
05 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	557, 979	0	557, 979		95. 00
99. 10			337, 777	0	337, 777		99. 10
	1	HOME HEALTH AGENCY	1, 330, 274	o	1, 330, 274		101. 00
		AL PURPOSE COST CENTERS	1,000,271	Ψ,	1,000,271		
109.00	10900	PANCREAS ACQUISITION	0	0	0		109. 00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110. 00
		ISLET ACQUISITION	0	0	0		111. 00
		HOSPI CE	118, 857	0	118, 857		116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38, 061, 600	0	38, 061, 600		118. 00
100.00		I MBURSABLE COST CENTERS		٥	0		100.00
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0	0	0		190. 00 191. 00
	1	FMH DIAGNOSTIC CENTE	291, 948	0	291, 948		191. 00
		WELLNESS	413, 110	0	413, 110		191. 02
	1	PHYSICIANS' PRIVATE OFFICES	212, 167	Ö	212, 167		192. 00
192. 01			23	o	23		192. 01
	1	MARKETI NG	467, 646	o	467, 646		192. 02
		FOUNDATI ON	43, 218	o	43, 218		192. 03
		BROOKVILLE CLINIC	0	0	0		192. 04
192.05			0	0	0		192. 05
		HEART CENTER	27, 560		27, 560		192. 06
192. 07	19207	WVCF	3, 821, 431	0	3, 821, 431		192. 07

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15	0064 Peri od: Worksheet B From 10/01/2014 Part I To 09/30/2015 Date/Time Prepared:

				2/25/2016 2: 2	5 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25. 00	26. 00		
192. 08 19210 OCCUPATI ONAL MED	36, 284	0	36, 284		192. 08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0		192. 09
192. 10 19211 H0SPI TALI ST	1, 452, 113	0	1, 452, 113		192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	314, 788	0	314, 788		194. 00
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers	0	o	0		201.00
202.00 TOTAL (sum lines 118-201)	45, 141, 888	o	45, 141, 888		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FAYETTE REGIONAL HEALTH SYSTEM Provider CCN: 150064

					10	09/30/2015	Date/lime Prep 2/25/2016 2:2	
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
			0	1.00	2A	4. 00	5. 00	
4 00		AL SERVICE COST CENTERS	1		T			4 00
1. 00 4. 00 5. 00 7. 00 7. 01	00400 00500 00700	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT	0 0 0	7, 383 118, 039 777, 489	118, 039 777, 489	7, 383 582 108 0	118, 621 8, 141 2, 656	1. 00 4. 00 5. 00 7. 00 7. 01
8. 00 9. 00 10. 00	00800	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	0	2, 279 9, 379 12, 623	9, 379	1 174 67	436 2, 469 1, 276	8. 00 9. 00 10. 00
11. 00 13. 00 14. 00	01100	CAFETERIA NURSI NG ADMINI STRATI ON CENTRAL SERVI CES & SUPPLY	0	19, 491 0 12, 469	19, 491 0	97 168 26	1, 276 1, 237 2, 051 3, 038	11. 00 13. 00 14. 00
15. 00 16. 00	01500 01600	PHARMACY MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	0	12, 066 18, 085	12, 066	91 191	10, 065 4, 937	15. 00 16. 00
30. 00		ADULTS & PEDIATRICS	0	70, 505	70, 505	315	4, 638	30. 00
31. 00 40. 00 41. 00	03100	INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF	0	43, 116 36, 638 44, 230	43, 116 36, 638	218 220 25	3, 421 4, 973 680	31. 00 40. 00 41. 00
42. 00 43. 00	04200 04300	SUBPROVI DER NURSERY LARY SERVI CE COST CENTERS	0	23, 695	0	0 104	0 1, 395	42. 00 43. 00
50. 00 52. 00	05000	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	115, 552		238	3, 944 0	50. 00 52. 00
54. 00 57. 00	05400 05700	RADI OLOGY-DI AGNOSTI C CT SCAN	0	102, 966 0	102, 966 0	337 0	9, 110 0	54. 00 57. 00
58. 00 59. 00 60. 00	05900	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION LABORATORY	0	0 0 33, 134	0	0 0 209	0 0 6, 042	58. 00 59. 00 60. 00
60. 01 65. 00 66. 00	06500	BLOOD LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0 15, 569 34, 211		0 116 186	0 1, 565 2, 414	60. 01 65. 00 66. 00
69. 01 71. 00	06901 07100	CARDIAC REHAB MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13, 838 0	13, 838 0	48 0	634 0	69. 01 71. 00
72. 00 73. 00 74. 00	07300	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0 0	0	0 0 0	213 0 0	72. 00 73. 00 74. 00
		TIENT SERVICE COST CENTERS	1		1 -			
88. 00 89. 00 91. 00	08900	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER EMERGENCY	0 0	0 0 38, 471	0	0 0 331	0 0 4, 611	88. 00 89. 00 91. 00
92. 00 93. 00 93. 01		OBSERVATION BEDS (NON-DISTINCT PART) CLINIC BIC	0	123, 891		2, 258 205	15, 217 3, 494	
93. 02 93. 03	04953 04955	UCI C CI C	0	0	0	0	0	93. 02 93. 03
93. 04 93. 05	-	PODIATRY PODIATRY REIMBURSABLE COST CENTERS	0	0	0	3	0 231	93. 04 93. 05
95. 00 99. 10 101. 00	09910	AMBULANCE SERVICES CORF HOME HEALTH AGENCY	0	1	0	110 0 238	1, 254 0 3 171	95. 00 99. 10 101. 00
		AL PURPOSE COST CENTERS					5, . 7 1	
110.00	11000	PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET ACQUISITION	0	0	0	0	0	109. 00 110. 00 111. 00
	11600	HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0	1, 685, 119	0 1, 685, 119	13 6, 679	302	116. 00
	19000	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0	0		0		190. 00 191. 00
191. 01 191. 02	19101 19102	FMH DIAGNOSTIC CENTE WELLNESS PHYSICIANS' PRIVATE OFFICES	0	0 0 26, 577	0 0 26, 577	63 29	767 683	191. 01 191. 02 192. 00
192. 01 192. 02	19201 19202	RFE MARKETI NG	0	0 6, 056	0 6, 056	4 0 19	0 1, 143	192. 01 192. 02
	19204	FOUNDATION BROOKVILLE CLINIC	0	6, 543 0 0	0	0	0	192. 03 192. 04 192. 05
		HEART CENTER	0	4, 376	-	0	14	192. 06

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Peri od: Worksheet B From 10/01/2014 Part II To 09/30/2015 Date/Time Prepared:

					2/25/2016 2: 2	5 pm
		CAPI TAL				
Cost Center Description	Directly	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
cost center bescription	Assigned New	FLXT	Subtotal	BENEFITS	& GENERAL	
	Capi tal			DEPARTMENT	G 02.12.012	
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
192. 07 19207 WVCP	0	97, 843	97, 843	497	8, 091	192. 07
192. 08 19210 OCCUPATI ONAL MED	0	0	0	8	94	192. 08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 19211 HOSPI TALI ST	0	0	0	84	3, 810	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	73, 897	73, 897	0	236	194. 00
200.00 Cross Foot Adjustments			0			200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	1, 900, 411	1, 900, 411	7, 383	118, 621	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FAYETTE REGIONAL HEALTH SYSTEM Provider CCN: 150064

			Τ̈́	o 09/30/2015	Date/Time Pre 2/25/2016 2:2	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Э ріп
	7. 00	PLANT 7. 01	LINEN SERVICE 8.00	9.00	10. 00	
GENERAL SERVICE COST CENTERS	7.00	7. 0.	0.00	7. 00	10.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	785, 738					7. 00
7. 01 00701 OPERATION OF PLANT	0	,				7. 01
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	1, 568 6, 455		4, 293			8. 00 9. 00
10. 00 01000 DI ETARY	8, 687	48			23, 343	10.00
11. 00 01100 CAFETERI A	13, 414	75	c	337	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0		0	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	8, 582 8, 304			216	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	12, 446	l .			0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	48, 522 29, 673					30. 00 31. 00
40. 00 04000 SUBPROVI DER - 1 PF	25, 214				1, 734 2, 492	40.00
41. 00 04100 SUBPROVI DER - I RF	30, 439	l .	244		161	41.00
42. 00 04200 SUBPROVI DER	0	_	1	_	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	16, 307	91	C	410	0	43.00
50. 00 05000 OPERATI NG ROOM	79, 524	439	356	1, 999	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	_		1	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	70, 862	l .	528 1	1	0	54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)				_	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00 06000 LABORATORY	22, 803	l .	C	1	0	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	10, 715	0 60		_	0	60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY	23, 544		453		Ö	66.00
69. 01 06901 CARDI AC REHAB	9, 524	53			0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		1	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	~	ή	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0	C	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			-	0	88. 00 89. 00
91. 00 09100 EMERGENCY	26, 476	_	697	1	Ö	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 00 04040 CLI NI C 93. 01 04954 BI C	87, 597 67, 876	l .	2	2, 007 1, 706	0 0	93. 00 93. 01
93. 02 04953 UCI C	07,870	0		0	0	93. 02
93. 03 04955 CI C	0	0	C	0	0	93. 03
93. 04 04956 RI C	0	_	C	0	0	93. 04
93. 05 O4950 PODIATRY OTHER REIMBURSABLE COST CENTERS	0	0	[0	0	93. 05
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	0					99. 10 101. 00
SPECIAL PURPOSE COST CENTERS	0	0	120) 0	0	101.00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0	-	109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	C	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 116. 00 11600 HOSPI CE	0	0		0		111. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	608, 532	2, 489	4, 217	14, 900		
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0		1		190. 00 191. 00
191. 01 19101 FMH DI AGNOSTI C CENTE		0		0		191. 00
191. 02 19102 WELLNESS	29, 040	0	C	730		191. 02
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	18, 290	l .		460		192.00
192. 01 19201 RFE 192. 02 19202 MARKETI NG	4, 168	_		0 105		192. 01 192. 02
192. 03 19203 FOUNDATION	4, 503		Č	113		192. 03
192. 04 19204 BROOKVI LLE CLI NI C	0		C	0		192. 04
192. 05 19205 ATOD 192. 06 19206 HEART CENTER	3, 012	0 17		0 76		192. 05 192. 06
192.00 19200 HEART CENTER 192.07 19207 WVCP	67, 336	l .	13			192.06
192. 08 19210 OCCUPATI ONAL MED	0	Ō	C	0	0	192. 08
192. 09 19209 HOME MEDI CAL EQUI PMENT	0	0		0		192. 09
192. 10 19211 H0SPI TALI ST	0	0	1 (<u> </u>	0	192. 10

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150064	Peri od: Worksheet B From 10/01/2014 Part II To 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm

						2/25/2016 2:2	5 pm
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	PLANT	LINEN SERVICE			
		7. 00	7. 01	8. 00	9. 00	10.00	
194.0007950	OTHER NONREIMBURSABLE COST CENTERS	50, 857	0	0	463	0	194. 00
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	785, 738	2, 656	4, 293	18, 513	23, 343	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

| Peri od: | Worksheet B | From 10/01/2014 | Part II | Date/Time Prepared: | 2/25/2016 2:25 pm |

			10	09/30/2015	2/25/2016 2: 2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 O0701 OPERATION OF PLANT						7. 01
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	34, 651					11. 00
13. 00 01300 NURSING ADMINISTRATION	659	2, 878				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	264	0	24, 643			14.00
15. 00 01500 PHARMACY	726	107	0	31, 614	07.400	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 448	0	0	U _I	37, 489	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 473	363	0	ما	1, 505	30.00
31. 00 03100 NTENSI VE CARE UNI T	1, 601	235	0	0	729	31.00
40. 00 04000 SUBPROVI DER - 1 PF	1, 601	235	0	0	1, 284	40.00
41. 00 04100 SUBPROVI DER - I RF	271	40	0	0	70	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	698	102	0	0	155	43. 00
ANCILLARY SERVICE COST CENTERS				-,		
50. 00 05000 OPERATING ROOM	2, 535	372	0	0	2, 839	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 410	353	0	0	7, 204	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	1, 687	247	0	0	5, 528	60. 00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	1, 243	182	0	0	1, 033	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 097	161	0	0	643	66.00
69. 01 06901 CARDI AC REHAB	357	52	0	0	109	69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	0	24, 643	0	994	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	21 414	2 425	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	0		0	31, 614	3, 625 0	74.00
OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	<u> </u>	<u> </u>		74.00
88. 00 08800 RURAL HEALTH CLINIC	0	ol	0	O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l ol	Ö	0	0	89. 00
91. 00 09100 EMERGENCY	2, 048	o	0	0	4, 167	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					•	92.00
93. 00 04040 CLI NI C	5, 404	o	0	O	4, 135	93. 00
93. 01 04954 BI C	0	0	0	0	818	93. 01
93. 02 04953 UCI C	0	0	0	0	0	93. 02
93. 03 04955 CI C	0	0	0	0	0	93. 03
93. 04 04956 RI C	0		0	0	0	93. 04
93. 05 04950 PODI ATRY	31	0	0	0	23	93. 05
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	1 004	1/1		ما	247	05.00
99. 10 09910 CORF	1, 094 0	1	0	0	347 0	95. 00 99. 10
101.00 10100 HOME HEALTH AGENCY	1, 827	۱ ۱	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	1,627	∠08	U	<u> </u>	280	101.00
109. 00 10900 PANCREAS ACQUISITION	0	n	Ω	nl	n	109. 00
110. 00 11000 NTESTI NAL ACQUISITION	l 0	ا م	n	n		110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	o	0	0		111. 00
116. 00 11600 H0SPI CE	0	ol	ō	o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	29, 474	2, 878	24, 643	31, 614	35, 565	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
191. 01 19101 FMH DIAGNOSTIC CENTE	0	이	0	0		191. 01
191. 02 19102 WELLNESS	0	이	0	0		191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
192. 01 19201 RFE	0	0	0	0		192. 01
192. 02 19202 MARKETI NG	112		0	0		192. 02
192. 03 19203 FOUNDATION	122		0	0		192. 03 192. 04
192. 04 19204 BROOKVI LLE CLI NI C 192. 05 19205 ATOD			0	0		192. 04
192. 06 19206 HEART CENTER			0	0		192. 05
192. 00 19200 HEART CENTER 192. 07 19207 WVCP	4, 816		0	0	1 567	192. 00
192. 08 19210 OCCUPATI ONAL MED	4,010		0	0	1, 307	192. 07
192. 09 19209 HOME MEDICAL EQUIPMENT	0		Ö	o o		192. 09
		٠	٩	<u>al</u>		

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150064	From 10/01/2014	Worksheet B Part II Date/Time Prepared: 2/25/2016 2:25 pm

					2/25/2016 2:2	5 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
192. 10 19211 HOSPI TALI ST	127	0	0	0	0	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	34, 651	2, 878	24, 643	31, 614	37, 489	202. 00

Provider CCN: 150064

				'	o 09/30/2015 Date/lime Pr 2/25/2016 2:	
	Cost Center Description	Subtotal	Intern &	Total	= = = =	
		F	Residents Cost			
			& Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7.00
7. 01 8. 00	OO701 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE					7. 01 8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15.00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS					16. 00
30. 00	03000 ADULTS & PEDIATRICS	140, 464	ol	140, 464		30.00
31. 00	03100 INTENSIVE CARE UNIT	82, 002	0	82, 002		31. 00
	04000 SUBPROVI DER - I PF	73, 291	o	73, 291		40.00
41.00	04100 SUBPROVI DER - I RF	77, 094	0	77, 094		41.00
42.00	04200 SUBPROVI DER	0	0	0		42. 00
43.00	04300 NURSERY	42, 957	0	42, 957		43. 00
	ANCI LLARY SERVI CE COST CENTERS					4
50.00	05000 OPERATING ROOM	207, 798	0	207, 798		50.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0 195, 945	0	0 195, 945		52. 00 54. 00
57. 00	05700 CT SCAN	195, 945	0	195, 945		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	O	Ö	0		59. 00
60.00	06000 LABORATORY	70, 350	0	70, 350		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	30, 752	0	30, 752		65. 00
66. 00	06600 PHYSI CAL THERAPY	63, 432	0	63, 432		66. 00
69. 01	O6901 CARDI AC REHAB O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	24, 887	0	24, 887		69. 01 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATTENTS	25, 637 213	o	25, 637 213		72.00
	07300 DRUGS CHARGED TO PATIENTS	35, 239	Ö	35, 239		73. 00
	07400 RENAL DIALYSIS	0	Ö	0		74. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
91.00	09100 EMERGENCY	77, 614	0	77, 614		91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	240, 623	0	240, 623		92. 00 93. 00
	04954 BI C	74, 099	o	74, 099		93. 00
	04953 UCI C	0	0	74,077		93. 02
	04955 CI C	0	Ö	0		93. 03
93. 04	04956 RI C	0	0	0		93. 04
93. 05	04950 PODI ATRY	288	0	288		93. 05
05.00	OTHER REIMBURSABLE COST CENTERS	0.044	٥	0.044	T	- or on
	09500 AMBULANCE SERVICES 09910 CORF	2, 966	0	2, 966 0		95. 00 99. 10
	10100 HOME HEALTH AGENCY	5, 904	ol Ol	5, 904		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	3, 704	<u> </u>	3, 704		=101.00
109.00	10900 PANCREAS ACQUISITION	0	0	0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0		110. 00
111.00	11100 ISLET ACQUISITION	0	0	0		111. 00
	11600 HOSPI CE	392	0	392		116. 00
118.00		1, 471, 947	0	1, 471, 947		118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	0		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
	19101 FMH DIAGNOSTIC CENTE	833	0	833		191. 00
	19102 WELLNESS	30, 482	Ö	30, 482		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	45, 990	o	45, 990		192. 00
	19201 RFE	0	0	0		192. 01
	19202 MARKETI NG	11, 626	0	11, 626		192. 02
	19203 FOUNDATION	11, 327	0	11, 327		192. 03
	19204 BROOKVI LLE CLI NI C	0	0	0		192. 04
	19205 ATOD 19206 HEART CENTER	7, 495	0	7, 495		192. 05 192. 06
	19200 HEART CENTER	191, 128	0	7, 495 191, 128		192. 06
	1 1 - 1 - 1 - 1		<u> </u>	.,., 120	I	

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150064	From 10/01/2014	Worksheet B Part II Date/Time Prepared:

			'	2/25/2016 2:	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
192. 08 19210 OCCUPATI ONAL MED	109	0	109		192. 08
192. 09 19209 HOME MEDICAL EQUIPMENT	0	0	C		192. 09
192. 10 19211 HOSPI TALI ST	4, 021	0	4, 021		192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	125, 453	0	125, 453	3	194. 00
200.00 Cross Foot Adjustments	0	0	C		200. 00
201.00 Negative Cost Centers	0	0	C		201. 00
202.00 TOTAL (sum lines 118-201)	1, 900, 411	0	1, 900, 411		202. 00

		AYETTE REGIONAL				U OT FORM CMS	
COSTA	ILLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet B-1 Date/Time Pre 2/25/2016 2:2	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	409, 516	00 /55 400				1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 591 25, 436	22, 655, 438 1, 786, 803		37, 152, 460		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	167, 540	331, 662		2, 549, 646	246, 026	7.00
7. 01	00701 OPERATION OF PLANT	0	001,002	Ö		0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	491	3, 654	- C	136, 401	491	8. 00
9.00	00900 HOUSEKEEPI NG	2, 021	534, 130	1	,	2, 021	
10.00	01000 DI ETARY 01100 CAFETERI A	2, 720	204, 411	1	,	2, 720	
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 200	298, 425 516, 059	1	387, 293 642, 314	4, 200 0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 687	79, 954			2, 687	
15. 00	01500 PHARMACY	2, 600	280, 306		3, 152, 196	2, 600	
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 897	585, 922	C	1, 546, 323	3, 897	16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	45 400	0/7 400		4 450 505	45.400	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	15, 193 9, 291	967, 493 668, 357			15, 193 9, 291	
40. 00	04000 SUBPROVI DER - I PF	7, 895	673, 508	l .		7, 895	1
41. 00	04100 SUBPROVI DER - I RF	9, 531	77, 806	l .		9, 531	
42. 00	04200 SUBPROVI DER	0	0	C		0	
43. 00	04300 NURSERY	5, 106	318, 628	C	436, 844	5, 106	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	24, 900	731, 153	C	1, 235, 329	24, 900	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	24, 700	731, 133			24, 700	
54.00	05400 RADI OLOGY-DI AGNOSTI C	22, 188	1, 032, 930	C	2, 852, 978	22, 188	
57. 00	05700 CT SCAN	0	0	C	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C		0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	7, 140	640, 682			7, 140	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	7, 140	040, 062	0	1, 092, 153	7, 140	60.00
65. 00	06500 RESPI RATORY THERAPY	3, 355	356, 001		490, 252	3, 355	
66.00	06600 PHYSI CAL THERAPY	7, 372	571, 694	- c	755, 899	7, 372	66. 00
69. 01	06901 CARDI AC REHAB	2, 982	147, 423	1	198, 512	2, 982	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	_	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		,	0	73.00
74. 00	07400 RENAL DIALYSIS	o	0	ď		0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		0	
	09100 EMERGENCY	0 8, 290	0 1, 013, 990	1	0 1, 444, 166	0 8 290	89. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,270	1,013,770		1, 444, 100	0, 270	92.00
		26, 697	6, 934, 082	C	4, 768, 089	27, 428	1
93. 01	04954 BI C	0	629, 153	C	1, 094, 413	21, 253	1
93. 02 93. 03	04953 UCI C	0	0		0	0	1
	04955 CI C 04956 RI C	0	0		0	0	
	04950 PODI ATRY	0	9, 966	d	72, 208	0	
	OTHER REIMBURSABLE COST CENTERS					_	
95.00	09500 AMBULANCE SERVI CES 09910 CORF	0	336, 657	C		0	
	10100 HOME HEALTH AGENCY	0	730, 403				101. 00
	SPECIAL PURPOSE COST CENTERS	-	, , , , , , ,	_			
	10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0		0		110. 00 111. 00
	111600 HOSPI CE	0	38, 683		94, 468		116.00
118.00		363, 123	20, 499, 935	1			
	NONREI MBURSABLE COST CENTERS						
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1910 RESEARCH	0	0	C			190. 00 191. 00
	19101 FMH DIAGNOSTIC CENTE		192, 014	1	240, 146		191. 01
	19102 WELLNESS	O	87, 983		214, 003		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	5, 727	12, 266	C	46, 126		192. 00
	19201 RFE	0	0	0	19		192. 01
	19202 MARKETI NG 19203 FOUNDATI ON	1, 305 1, 410	57, 461		358, 026 6, 543		192. 02 192. 03
	19204 BROOKVILLE CLINIC	1,410	0	o o			192. 04
	19205 ATOD	ō	0				192. 05
		<u> </u>			·		

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150064	Period: Worksheet B-1 From 10/01/2014
		To 09/30/2015 Date/Time Prepared:

				T	09/30/2015	Date/Time Pre 2/25/2016 2:2	
		CAPITAL RELATED COSTS				, , , , , , , , , , , , , , , , , , , ,	, p
	Cost Center Description	NEW BLDG &	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS SALARI ES)		COST)	FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
192.06 19206	HEART CENTER	943	0	0	4, 376	943	192. 06
192. 07 19207	7 WVCP	21, 084	1, 524, 211	0	2, 534, 022	21, 084	192. 07
192. 08 19210	OCCUPATIONAL MED	0	24, 133	0	29, 570	0	192. 08
192. 09 19209	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 19211	I HOSPI TALI ST	0	257, 435	0	1, 193, 390	0	192. 10
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	15, 924	0	0	73, 897	15, 924	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 900, 411	4, 499, 634		7, 989, 428	3, 097, 932	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	4. 640627	0. 198612		0. 215044	12. 591889	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		7, 383		118, 621	785, 738	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000326		0. 003193	3. 193719	205. 00
·						•	-

COST A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 10/01/2014	Worksheet B-1	
					To 09/30/2015		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	2/25/2016 2: 2 CAFETERI A	5 pm
	р	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	SERVED)	HOURS)	
		7. 01	8.00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT	140 400					7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	149, 680 491	69, 092				8.00
9.00	00900 HOUSEKEEPI NG	2, 021	0	230, 584			9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 720 4, 200	6, 817	2, 720 4, 200		640, 117	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 200		4, 200		12, 183	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 687	0	2, 687		4, 869	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 600 3, 897	0	2, 600 3, 89		13, 414 26, 743	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3,047		3, 04	0	20, 743	10.00
30.00	03000 ADULTS & PEDIATRICS	15, 193			·	45, 678	1
31. 00 40. 00	03100 NTENSIVE CARE UNIT 04000 SUBPROVIDER - PF	9, 291	5, 851	9, 29 ² 7, 895		29, 580 29, 567	1
41. 00	04100 SUBPROVI DER - I RF	9, 531	3, 920				1
42. 00	04200 SUBPROVI DER	0	0	(ا ا	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 106	0	5, 10	5 0	12, 889	43.00
50. 00	05000 OPERATING ROOM	24, 900	5, 733	24, 900	0	46, 821	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	22, 188	8, 498	22, 188	0	44, 519 0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	7, 140	0	7, 140	0	31, 156	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	3, 355		3, 355	5 0	22, 967	
66. 00	06600 PHYSI CAL THERAPY	7, 372	7, 291	7, 372	0	20, 262	66. 00
69. 01 71. 00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 982	535	2, 982		6, 594 0	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			-	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0		, 0. 00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	74.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(-	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 290	11, 213	8, 290	0	37, 838	91.00
	04040 CLINIC	6, 331	40	24, 99	0	99, 841	93. 00
	04954 BI C	0	0			Ŭ	
93. 02	04953 UCI C 04955 CI C	0	0	(0	93. 02 93. 03
	04956 RI C	0	ő	Ò	o o	Ö	
93. 05	04950 PODI ATRY	0	0	(0	573	93. 05
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	0	(0	20, 212	95. 00
	09910 CORF	0		Ò			1
101.00	10100 HOME HEALTH AGENCY	0	1, 924		0	33, 748	101. 00
109 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	0	(0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	Ö	Ò	o o	0	110. 00
	11100 I SLET ACQUI SI TI ON	0	0	(0		111.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	140, 295	67, 868	185, 59	36, 496		116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	1.10/270	0.7000	1.007.07	337 170	311, 137	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190.00
	19100 RESEARCH 19101 FMH DIAGNOSTIC CENTE	0			0		191. 00 191. 01
191. 02	19102 WELLNESS	0	0	9, 093		0	191. 02
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RFE	5, 727	1, 019	5, 727	0		192. 00 192. 01
	2 19201 RFE	1, 305		1, 305	5 0		192. 01
192. 03	19203 FOUNDATI ON	1, 410	l e	1, 410	0	2, 256	192. 03
	19204 BROOKVI LLE CLI NI C 19205 ATOD	0	0	(-		192. 04 192. 05
	19206 HEART CENTER	943		943	-		192. 05
192.07	7 19207 WVCP	0	205	20, 745	24, 167	88, 967	192. 07
192. 08	3 19210 OCCUPATIONAL MED	0	0	() 0	0	192. 08

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150064	Period: Worksheet B-1

				To	09/30/2015	Date/Time Pre 2/25/2016 2:2	
Cost Center Des	cription	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	HOURS)	
		FEET)	LAUNDRY)				
		7. 01	8. 00	9. 00	10.00	11. 00	
192.09 19209 HOME MEDICAL EQ	UI PMENT	0	0	0	0	0	192. 09
192. 10 19211 HOSPI TALI ST		0	0	0	0	2, 351	192. 10
194. 00 07950 OTHER NONREI MBU	RSABLE COST CENTERS	0	0	5, 770	0	0	194. 00
200.00 Cross Foot Adju	stments						200. 00
201.00 Negative Cost C	enters						201. 00
202.00 Cost to be allo	cated (per Wkst. B,	1, 010, 675	175, 231	978, 555	566, 959	569, 647	202. 00
Part I)							
203.00 Unit cost multi	plier (Wkst. B, Part I)	6. 752238	2. 536198	4. 243811	9. 346043	0. 889911	203. 00
204.00 Cost to be allo	cated (per Wkst. B,	2, 656	4, 293	18, 513	23, 343	34, 651	204.00
Part II)							
205.00 Unit cost multi	plier (Wkst. B, Part	0. 017745	0. 062135	0. 080287	0. 384798	0. 054132	205. 00
11)							

Control Cont			FAYETTE REGIONAL				u of Form CMS-2552-	<u>-10</u>
Cost Center Description	COST	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150064	Period: From 10/01/2014	Worksheet B-1	
Cost Center Description						To 09/30/2015		
ADMINISTRATION SERVICES & CHOOK) RECORDER & SUPPLY CHOOK) RECORDER & SUPPLY CHOOK CHOOKES)		Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDI CAL	2/25/2016 2: 25 pill	
		, , , , , , , , , , , , , , , , , , ,		SERVICES &		RECORDS &		
CHEMBAL SERVICE DOT CENTERS 13.00 14.00 15.00 16.00			(ETE: C)					
THE STATE SERVICE COST CHITES			(FIE 3)	(100%)		,		
1.00 00100 MEDICAP REL COSTS-BLIDG & IT NIT 0.00			13.00	14. 00	15. 00			
4 00 00000 DEPLOYEE ERREFT TS DEPARTMENT						T		
5.00 0.0000 AZMINI STRATIVE & GENERAL		1						
7.00								
B. 00 DOSCO ALRIGNEY A. LININ STRATT ON 19.00 10.00 10.00 ETARY 11.00		00700 OPERATION OF PLANT						
9.00 0.000 DISCRETEN INC 10.00 11.00								
10.00 01000 DETARY								
13.00 01300 MURSING ADM IN STRATION 17.423 12.00 100 15.								
14.00 01400 CHITARI, SERVICES & SURPIV 0 0 0 111, 866, 338 15.00 15.								
15.00 1500 PHABMACY 10.00 10.00 111,866,388 10.00			1	100				
16. 00 0.600 REDICAL RECORDS & LIBRARY 0 0 0 111, 866, 388 16. 00			١		1	00		
30.00 3000 ADULTS & PEDIATRICS 2,196 0 0 4,491,228 30,00			1	-	·			
31.00								
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000			1					
41.00 04.00 (SUBPROVIDER - IRF 241 0 0 210,152 41.00 42.00 4				0				
43.00	41. 00		1	0				
ANCIL LARY SERVICE COST CENTRES 50. 00 60. 00 60. 0			1	- 1		٥		
50.00	43.00		620	0		0 461, 826	43.	00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 55.00	50. 00		2, 251	0		0 8, 473, 353	50.	00
57.00	52.00		1	0				
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 59. 00			2, 140	0		0 21, 466, 599	· · · · · · · · · · · · · · · · · · ·	
59 00 05900 CARDIAC CATHETER IZATION 0 0 0 0 50 00 00 00			0	0		0		
60.00 060000 LABORATORY 1, 498				0		0 0		
65.00 06.500 RESPIRATORY THERRAPY 1, 104 0 0 3, 082, 620 65.00	60.00	06000 LABORATORY	1, 498	0		0 16, 501, 546		
66.00 06-600 PHYSICAL THERAPY			١	0		0 0		
69. 01 06901 CARDIAC REHAB 317			1 1	0				
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			1	0				
73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 100 10,821,858 73. 00			- 1			0 2, 968, 641		
74 00 0 0 0 0 0 0 0 0			- 1	-	1.	0 0		
DUTPATE BY SERVICE COST CENTERS			1		'			
89. 00 08900 FOEDRALLY QUALIFIED HEALTH CENTER 0 0 0 0 12, 437, 582 91. 00			-1	-				
91.00 09100 EMERGENCY 0 0 0 12, 437, 582 91, 00 92.00 09200			1					
92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 04040 CLINIC 04954 BI C 0 0 0 0 0 12, 343, 319 93. 00 93. 01 04954 BI C 0 0 0 0 0 0 0 0 93. 02 04953 BI C 0 0 0 0 0 0 0 0 0			1	_				
93. 00 04040 CLI NI C 0 0 0 12, 343, 319 93. 00 93. 01 04954 BI C 0 0 0 0 2, 440, 901 93. 01 93. 02 04953 UC 0 0 0 0 0 0 93. 02 93. 03 04955 CL 0 0 0 0 0 0 0 93. 03 04955 CL 0 0 0 0 0 0 93. 04 04956 RI C 0 0 0 0 0 0 93. 05 04950 PODI ATRY 0 0 0 0 0 95. 00 05900 AMBURANCE SERVI CES 972 0 0 0 1, 036, 445 95. 00 99. 10 09910 CORF 0 0 0 0 0 836, 725 101. 00 99. 10 09910 CORF 0 0 0 0 0 836, 725 101. 00 99. 10 0100 HOME HEALTH AGENCY 1, 622 0 0 0 836, 725 101. 00 99. 10 0100 1000 NAURLAGE SERVI CES 972 0 0 0 0 0 109. 00 110. 00 10100 NTESTI NAL ACQUI SITI ON 0 0 0 0 0 110. 00 110. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 111. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 111. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 17, 423 100 100 106, 125, 235 118. 00 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 01 19101 FMH DI AGNOSTI C CENTE 0 0 0 0 0 191. 00 191. 01 19101 FMF DI AGNOSTI C CENTE 0 0 0 0 0 192. 00 192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 03 192. 01 19201 RFE 0 0 0 0 0 0 192. 03 192. 04 19204 BROOKVI LLE CLI NI C 0 0 0 0 0 192. 03 192. 04 19204 BROOKVI LLE CLI NI C 0 0 0 0 0 192. 05 192. 04 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 05 19205 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 0 192. 05			J J	U		0 12, 437, 362		
93. 02			0	0		0 12, 343, 319		
93. 03 04955 CI C 0 0 0 0 0 0 93. 03 93. 04 04956 RI C 0 0 0 0 0 0 93. 04 93. 05 04950 PODI ATRY 0 0 0 0 68, 484 93. 05 95. 00 09500 AMBULANCE SERVI CES 972 0 0 1, 036, 445 95. 00 99. 10 09910 CORF 0 0 0 0 836, 725 101. 00 101. 00 10100 HOME HEALTH AGENCY 1, 622 0 0 836, 725 101. 00 109. 00 10900 PANGREAS ACQUISISTI ON 0 0 0 0 0 110. 00 11000 INTESTI NAL ACQUISISTI ON 0 0 0 0 0 111. 00 11100 ISLET ACQUISISTI ON 0 0 0 0 0 116. 00 116.00 HOSPI CE 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1-117) 17, 423 100 100 106, 125, 235 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 191. 01 19101 FMH DIAGNOSTIC CENTE 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CIANS' PRI VATE OFFICES 0 0 0 0 0 0 192. 01 19201 RFE 0 0 0 0 0 0 192. 02 192. 03 19203 FOUNDATION 0 0 0 0 0 192. 04 19204 BRROKVI LLE CLINIC 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 19206 19206 HEART CENTER 0 0 0 0 0 192. 06 19206			0	0		0 2, 440, 901		
93. 04 04956 R1 C			0	0		0		
93. 05 04950 PODI ATRY 0 0 0 68,484 93. 05 OTHER REI MBURSABLE COST CENTERS 972 0 0 1, 036, 445 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 1, 622 0 0 0 836, 725 101. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 110. 00 110. 01 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 111. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 111. 00 11000 INTESTI NAL SUM OF LINES 1-117) 17, 423 100 100 106, 125, 235 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 17, 423 100 100 106, 125, 235 118. 00 191. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 191. 01 19101 FMH DI AGNOSTI C CENTE 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 192. 01 19201 RFE 0 0 0 0 0 0 192. 00 192. 03 19203 FOUNDATI ON 0 0 0 0 0 192. 00 192. 04 19204 BROKVI LLE CLI NI C 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 00 192. 06 1				0		0 0		
95. 00 09500 AMBULANCE SERVICES 972 0 0 0 1,036,445 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 99. 10 101.000 10100 HOME HEALTH AGENCY 1,622 0 0 0 836,725 101. 00 101.00 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000	93. 05	04950 PODI ATRY	0	0		0 68, 484	93.	05
99. 10 09910 CORF 0 0 0 0 0 0 836,725 101.00 101.00 10100 HOME HEALTH AGENCY 1,622 0 0 0 836,725 101.00	05.00		072	0		0 1 02/ 445	0.5	00
101. 00 10100 HOME HEALTH AGENCY 1,622 0 0 836,725 101. 00 SPECI AL PURPOSE COST CENTERS			1				· · · · · · · · · · · · · · · · · · ·	
109. 00		l l	-1					
110. 00 11000 INTESTI NAL ACQUISITION 0 0 0 0 0 1110. 00 111. 00								
111. 00			0	0		0 0		
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 17, 423 100 100 106, 125, 235 118. 00 100 106, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100 100, 125, 235 118. 00 100 100 100 100, 125, 235 118. 00 100 100 100, 125, 235 118. 00 100 100, 125, 235 118. 00 100 100, 125, 235 120, 200 120, 2			0	0		0 0		
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00			o	0		0 228, 513		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 191. 00 191. 00 191. 01 19101 FMH DI AGNOSTI C CENTE 0 0 0 0 191. 01 191. 01 191. 02 19102 WELLNESS 0 0 0 0 0 191. 02 19200	118.00		17, 423	100	1	00 106, 125, 235	118.	00
191. 00 19100 RESEARCH	100.00			0		0 0	100	00
191. 01 19101 FMH DI AGNOSTI C CENTE			0	0		0 0		
192. 00			Ö	0		0 8, 991		
192. 01 19201 RFE			0	0		0 0		
192. 02 19202 MARKETI NG 0 0 0 0 192. 02 19203 FOUNDATI ON 0 0 0 0 192. 03 19203 FOUNDATI ON 0 0 0 0 192. 03 19204 BROOKVI LLE CLI NI C 0 0 0 0 0 192. 04 192. 05 19205 ATOD 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 0 192. 06			0	0		0 1, 034, 789		
192. 03 19203 FOUNDATION				O O		0		
192. 04 19204 BROOKVI LLE CLINI C 0 0 0 0 192. 04 192. 05 19205 ATOD 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06				0		o o		
192. 06 19206 HEART CENTER 0 0 0 0 192. 06	192. 04	19204 BROOKVILLE CLINIC	0	O		0 0		
			0	0		0 0		
, and the second			0	O O		0 4 677 436		
		1 1 11-11	, 9	<u> </u>		., ., ., , , ,	1.72.	

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet B-1 Date/Time Pre	
					2/25/2016 2: 2	5 pm

				10	09/30/2015		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2/25/2016 2:2	5 piii
		ADMI NI STRATI ON		(100%)	RECORDS &		
			SUPPLY		LI BRARY		
		(FTE' S)	(100%)		(GROSS		
					CHARGES)		
		13. 00	14. 00	15. 00	16. 00		
192. 08 19210	OCCUPATIONAL MED	0	0	0	19, 937		192. 08
192. 09 19209	HOME MEDICAL EQUIPMENT	0	0	0	0		192. 09
192. 10 19211	HOSPI TALI ST	0	0	0	0		192. 10
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	791, 282	1, 223, 648	3, 932, 616	1, 994, 571		202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	45. 415944	12, 236. 480000	39, 326. 160000	0. 017830		203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 878	24, 643	31, 614	37, 489		204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 165184	246. 430000	316. 140000	0.000335		205. 00
	11)						

In Lieu of Form CMS-2552-10

Period:	Worksheet C	
From 10/01/2014	Part	
To 09/30/2015	Date/Time Prepared:	2/25/2016 2:25 pm

Total Cost Cost Center Description						10 077 007 2010	2/25/2016 2: 2	5 pm
Total Cost Cost Center Description				Ti tl	e XVIII	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS Adj Disallowance		·				Costs		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		·	(from Wkst. B,			Di sal I owance		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00			Part I, col.					
INPATI ENT ROUTINE SERVI CE COST CENTERS 2, 619, 024 2, 619, 024 0 2, 619, 024 30. 00 03000 ADULTS & PEDI ATRI CS 2, 619, 024 1, 707, 478 0 0, 0 0 0 0 0 0 0 0			26)					
30. 00			1.00	2.00	3. 00	4. 00	5. 00	
31.00 03100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS						
40. 00 04000 SUBPROVI DER - I PF	30.00		2, 619, 024		2, 619, 02	4 0	2, 619, 024	30. 00
41. 00	31.00		1, 707, 478		1, 707, 47	8 0	1, 707, 478	31. 00
42. 00 04200 SUBPROVI DER 0 0 04300 NURSERY 699,087 699,087 0 0 699,087 43. 00 43. 00 04300 NURSERY 699,087 699,087 0 699,087 43. 00 43. 00 04300 NURSERY 609,087 699,087 43. 00 43. 00 0500 DEL VERY SERVICE COST CENTERS 50. 00 0500 DEL VERY ROOM & LABOR ROOM 0 0 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 4,530,968 4,530,968 0 4,530,968 54. 00 55. 00 05700 CT SCAN 0 0 0 0 0 0 0 58. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 2,857,449 2,857,449 0 2,857,449 0 0,2857,449 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40.00	04000 SUBPROVI DER - I PF	2, 245, 064		2, 245, 06	4 0	2, 245, 064	40. 00
43. 00	41.00		516, 399		516, 39	9 0	516, 399	41. 00
ANCILLARY SERVICE COST CENTERS	42.00		0			0 0	0	42.00
SOLO OSCION OPERATING ROOM Color Col	43.00		699, 087		699, 08	7 0	699, 087	43.00
SOLO OSCION OPERATING ROOM Color Col		ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 530, 968 4, 530, 968 0 4, 530, 968 54. 00 57. 00 05700 CT SCAN 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 2, 857, 449 2, 857, 449 0 2, 857, 449 60. 00 0	50.00		2, 397, 840		2, 397, 84	0 0	2, 397, 840	50.00
57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 60. 00 06000 LABORATORY 2, 857, 449 2, 857, 449 0 2, 857, 449 60. 00 60. 01 06001 BLOOD LABORATORY 0	52.00		0			0 0	0	52.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 60. 00 06000 LABORATORY 2, 857, 449 2, 857, 449 0 2, 857, 449 60. 00 60. 01 06001 BLOOD LABORATORY 0 <	54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 530, 968		4, 530, 96	8 0	4, 530, 968	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 2, 857, 449 2, 857, 449 0 2, 857, 449 60. 00 60. 01 06001 BLOOD LABORATORY 0	57.00	05700 CT SCAN	0			0 0	0	57.00
60. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58. 00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 65. 00 06500 RESPIRATORY THERAPY 800, 357 0 800, 357 0 800, 357 0 66. 00 06600 PHYSI CAL THERAPY 1, 207, 315 0 1, 207, 315 0 69. 01 06901 CARDI AC REHAB 338, 988 338, 988 0 338, 988 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 276, 579 1, 276, 579 0 1, 276, 579 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 81, 017 81, 017 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 74. 00 0000 0000 0000 0000 0000 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00000 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 000000 0 0 800, 357 0 0 0 0 0 800, 357 0 0 0 0 800, 357 0 0 0 0 800, 357 0 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 0 800, 357 0 0 800, 357 0 0 0 800, 300, 357 0 0 800, 300, 357 0 0 800, 300, 357 0 800, 300, 357 0 0 0 800, 300, 357 0 0 800, 300, 300, 300, 300, 300, 300, 300,	59.00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 800, 357 0 800, 357 0 800, 357 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 207, 315 0 1, 207, 315 0 1, 207, 315 0 69. 01 06901 CARDI AC REHAB 338, 988 338, 988 0 338, 988 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 276, 579 1, 276, 579 0 1, 276, 579 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 81, 017 81, 017 0 81, 017 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 00TPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 800, 357 0 800, 357 0 0 1, 207, 315 0 1, 207, 310 0 1, 207, 315	60.00	06000 LABORATORY	2, 857, 449		2, 857, 44	9 0	2, 857, 449	60.00
66. 00 06600 PHYSI CAL THERAPY 1, 207, 315 0 1, 207, 315 0 1, 207, 315 66. 00 69. 01 06901 CARDI AC REHAB 338, 988 338, 988 0 338, 988 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 276, 579 1, 276, 579 0 1, 276, 579 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 81, 017 81, 017 0 81, 017 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 00 00 0 0 00 00 0	60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
69. 01 06901 CARDI AC REHAB 338, 988 338, 988 0 338, 988 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 276, 579 1, 276, 579 0 1, 276, 579 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 81, 017 81, 017 0 81, 017 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 73. 00 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	800, 357	0	800, 35	7 0	800, 357	65. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 276, 579 1, 276, 579 0 1, 276, 579 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 81, 017 81, 017 0 81, 017 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 73. 00 074. 00 0740 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0	66.00	06600 PHYSI CAL THERAPY	1, 207, 315	0	1, 207, 31	5 0	1, 207, 315	66. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 81,017 81,017 0 81,017 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 4,125,570 4,125,570 0 4,125,570 73. 00 0 0 0 0 0 0 0 0 0	69. 01	06901 CARDI AC REHAB	338, 988		338, 98	8 0	338, 988	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 125, 570 4, 125, 570 0 4, 125, 570 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 276, 579		1, 276, 57	9 0	1, 276, 579	71. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	81, 017		81, 01	7 0	81, 017	72. 00
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 89. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	4, 125, 570		4, 125, 57	0	4, 125, 570	73. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00	74.00		0			0 0	0	74.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00		OUTPATIENT SERVICE COST CENTERS						
	88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
91 00 09100 EMERGENCY 2 234 141 2 234 141 01 00 2 234 141 01 00			0			0 0	0	89. 00
	91.00	09100 EMERGENCY	2, 234, 141		2, 234, 14	1 0	2, 234, 141	91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 565, 940 565, 940 565, 940 92. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	565, 940		565, 94	0	565, 940	92.00
93. 00 04040 CLI NI C 6, 596, 657 6, 596, 657 102, 388 6, 699, 045 93. 00	93.00	04040 CLI NI C	6, 596, 657		6, 596, 65	7 102, 388	6, 699, 045	93. 00
93. 01 04954 B I C 1, 731, 090 1, 731, 090 6, 195 1, 737, 285 93. 01	93. 01		1, 731, 090		1, 731, 09	0 6, 195	1, 737, 285	93. 01
93. 02 04953 UCI C 0 0 0 93. 02	93. 02	04953 UCI C	0			0 0	0	93. 02
93. 03 04955 CI C 0 0 0 93. 03	93. 03	04955 CI C	0			0 0	0	93. 03
93. 04 04956 RI C 0 0 0 93. 04	93. 04	04956 RI C	0			0 0	0	93. 04
93. 05 04950 PODI ATRY 89, 467 89, 467 0 89, 467 93. 05	93. 05		89, 467		89, 46	7 0	89, 467	93. 05
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVI CES 557, 979 557, 979 0 557, 979 95. 00			557, 979		557, 97	9 0	557, 979	
99. 10 09910 CORF 0 0 99. 10			0			0	0	99. 10
101. 00 10100 HOME HEALTH AGENCY 1, 330, 274 1, 330, 274 1, 330, 274 101. 00	101.00		1, 330, 274		1, 330, 27	4	1, 330, 274	101. 00
SPECIAL PURPOSE COST CENTERS								
109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00			0			-		
110. 00 11000 I NTESTINAL ACQUISITION 0 0 110. 00			0		1	-		
111.00 1SLET ACQUISITION 0 0 111.00			0			·		
116. 00 11600 HOSPI CE 118, 857 116. 00								
200. 00 Subtotal (see instructions) 38, 627, 540 0 38, 627, 540 108, 583 38, 736, 123 200. 00		,		0				
201.00 Less Observation Beds 565, 940 565, 940 565, 940 565, 940 201.00		1 1						
202. 00 Total (see instructions) 38, 061, 600 0 38, 061, 600 108, 583 38, 170, 183 202. 00	202.00	Total (see instructions)	38, 061, 600	0	38, 061, 60	0 108, 583	38, 170, 183	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet C |
| From 10/01/2014 | Part |
| To 09/30/2015 | Date/Time Prepared: | 2/25/2016 2:25 pm | Provider CCN: 150064

						2/25/2016 2:2	5 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'		•	+ col. 7)	Ratio	Inpati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 033, 512		4, 033, 51	2		30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 853, 380		1, 853, 38			31. 00
40. 00	04000 SUBPROVI DER - I PF	3, 559, 251		3, 559, 25			40. 00
41. 00	04100 SUBPROVI DER - I RF	210, 152		210, 15			41. 00
42. 00	04200 SUBPROVI DER	210, 102			0		42. 00
43. 00	04300 NURSERY	461, 826		461, 82	-		43. 00
43.00	ANCILLARY SERVICE COST CENTERS	401,020		401, 02	o _l		43.00
50.00	05000 OPERATING ROOM	1, 472, 906	7, 000, 447	8, 473, 35	3 0. 282986	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,472,700	7,000,447		0. 202700	0. 000000	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 441, 942	19, 874, 478			0. 000000	54. 00
57. 00	05700 CT SCAN	1, 441, 742	17,074,470	21, 310, 42	0. 000000	0. 000000	57.00
58. 00	1		0		0.00000	0. 000000	58.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0				
	05900 CARDI AC CATHETERI ZATI ON	2 422 200	14 0/0 150	1/ 501 54	0.000000	0.000000	
60.00	06000 LABORATORY	2, 432, 388	14, 069, 158	16, 501, 54		0.000000	60.00
60. 01	06001 BLOOD LABORATORY	1 222 225	0		0.000000	0. 000000	60. 01
65. 00	06500 RESPI RATORY THERAPY	1, 028, 325	2, 030, 469			0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	338, 013	1, 581, 114			0. 000000	66. 00
69. 01	06901 CARDI AC REHAB	0	326, 753			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	994, 322	1, 828, 795			0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 590	126, 934			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	2, 773, 544	8, 048, 314			0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0. 000000	0. 000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
91.00	09100 EMERGENCY	1, 127, 386	11, 310, 196	12, 437, 58		0. 000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	783, 543	783, 54	0. 722283	0.000000	92.00
93.00	04040 CLI NI C	1, 400	4, 605, 796	4, 607, 19	6 1. 431816	0.000000	93. 00
93. 01	04954 BI C	175	2, 116, 306	2, 116, 48	0. 817910	0.000000	93. 01
93. 02	04953 UCI C	0	0		0. 000000	0.000000	93. 02
93.03	04955 CI C	0	0		0. 000000	0.000000	93. 03
93.04	04956 RI C	0	0		0. 000000	0.000000	93. 04
93.05	04950 PODI ATRY	o	1, 030	1, 03	0 86. 861165	0. 000000	93. 05
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					
95.00	09500 AMBULANCE SERVICES	0	1, 036, 445	1, 036, 44	5 0. 538359	0.000000	95. 00
	09910 CORF	o	0		0		99. 10
101.00	10100 HOME HEALTH AGENCY	o	836, 725	836, 72	5		101. 00
	SPECIAL PURPOSE COST CENTERS	<u>, </u>					
109.00	10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0		0		110. 00
	11100 SLET ACQUISITION		0		ol		111. 00
	11600 HOSPI CE		228, 513	228, 51	3		116. 00
200.00		21, 747, 112	75, 805, 016				200. 00
201. 00			, , 0 . 0	,,			201. 00
202.00	· · · · · · · · · · · · · · · · · · ·	21, 747, 112	75, 805, 016	97, 552, 12	8		202. 00
50	, , , , , , , , , , , , , , , , , , , ,		. 2, 500, 510	, 552, 12	-1	ı	

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1500	From 10/01/2014	Worksheet C Part I Date/Time Prepared: 2/25/2016 2:25 pm

				2/25/2016 2:25 pr	m
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					0. 00
31. 00 03100 INTENSIVE CARE UNIT					1. 00
40. 00 04000 SUBPROVI DER - I PF					0. 00
41. 00 04100 SUBPROVI DER - I RF					1. 00
42. 00 04200 SUBPROVI DER					2. 00
43. 00 04300 NURSERY				43	3. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 282986				0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				2. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 212558				4. 00
57. 00 05700 CT SCAN	0. 000000			57	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58	3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59	9. 00
60. 00 06000 LABORATORY	0. 173163			60	0. 00
60. 01 06001 BLOOD LABORATORY	0. 000000			60	0. 01
65. 00 06500 RESPIRATORY THERAPY	0. 261658			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 629096			66	5. 00
69. 01 06901 CARDI AC REHAB	1. 037444			69	9. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 452188			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 556726			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 381226			73	3. 00
74.00 07400 RENAL DIALYSIS	0. 000000			74	1. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC				88	3. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					9. 00
91. 00 09100 EMERGENCY	0. 179628			91	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 722283			92	2. 00
93. 00 04040 CLI NI C	1. 454040			93	3. 00
93. 01 04954 BI C	0. 820837			93	3. 01
93. 02 04953 UCI C	0. 000000			93	3. 02
93. 03 04955 CI C	0. 000000			93	3. 03
93. 04 04956 RI C	0. 000000			93	3. 04
93. 05 04950 PODI ATRY	86. 861165			93	3. 05
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 538359			95	5. 00
99. 10 09910 CORF				99	9. 10
101.00 10100 HOME HEALTH AGENCY				101	1.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION				109	9. 00
110.00 11000 INTESTINAL ACQUISITION				110	0. 00
111.00 11100 ISLET ACQUISITION				111	1.00
116. 00 11600 HOSPI CE				116	5. 00
200.00 Subtotal (see instructions)				200	0. 00
201.00 Less Observation Beds				201	1.00
202.00 Total (see instructions)				202	2. 00
				•	

Peri od: Worksheet C From 10/01/2014 Part I To 09/30/2015 Date/Time Prepared:

					10 09/30/2013	2/25/2016 2: 2	
			Ti t	le XIX	Hospi tal	Cost	
	·		·		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	.1 _1		
30.00	03000 ADULTS & PEDI ATRI CS	2, 619, 024		2, 619, 02		2, 619, 024	
31.00	03100 I NTENSI VE CARE UNI T	1, 707, 478		1, 707, 47		1, 707, 478	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	2, 245, 064		2, 245, 06		2, 245, 064 516, 399	
41.00	04200 SUBPROVI DER	516, 399		516, 39	0 0	510, 399	1
	04300 NURSERY	699, 087		699, 08	۳ _ا ۳۱	699, 087	
43.00	ANCI LLARY SERVI CE COST CENTERS	077,007		077,00	7 0	077,007	43.00
50. 00	05000 OPERATING ROOM	2, 397, 840		2, 397, 84	0 0	2, 397, 840	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2,077,010		2,077,01	o o	2, 377, 310	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 530, 968		4, 530, 96	-	4, 530, 968	
57. 00	05700 CT SCAN	0		1, 222, 12	ol ol	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			o o	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0			o o	0	59. 00
60.00	06000 LABORATORY	2, 857, 449		2, 857, 44	9 0	2, 857, 449	60.00
60. 01	06001 BLOOD LABORATORY	0			0 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	800, 357	0	800, 35	7 0	800, 357	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 207, 315	0	1, 207, 31	5 0	1, 207, 315	66. 00
69. 01	06901 CARDI AC REHAB	338, 988		338, 98		338, 988	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 276, 579		1, 276, 57	9 0	1, 276, 579	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	81, 017		81, 01		81, 017	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 125, 570		4, 125, 57		4, 125, 570	
74. 00	07400 RENAL DIALYSIS	0			0 0	0	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00	08800 RURAL HEALTH CLINIC	0		1	0 0	0	
89. 00 91. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	2, 234, 141		2, 234, 14	0 1 0	0 2, 234, 141	89. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	565, 940		2, 234, 14		2, 234, 141 565, 940	
	04040 CLINIC	6, 596, 657		6, 596, 65		6, 699, 045	
	04954 BI C	1, 731, 090		1, 731, 09		1, 737, 285	
	04953 UCI C	1, 731, 070		1, 731, 07	0, 173	1, 737, 203	93. 02
	04955 CI C	0				0	93. 03
	04956 RI C	0				0	93. 04
	04950 PODI ATRY	89, 467	•	89, 46	7 0	89, 467	1
	OTHER REIMBURSABLE COST CENTERS			, , ,	-1		
95.00	09500 AMBULANCE SERVICES	557, 979		557, 97	9 0	557, 979	95. 00
99. 10	09910 CORF	0			0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	1, 330, 274		1, 330, 27	4	1, 330, 274	101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0			0		109. 00
	11000 INTESTINAL ACQUISITION	0			0		110. 00
	11100 SLET ACQUI SI TI ON	0			0		111. 00
	11600 HOSPI CE	118, 857		118, 85		118, 857	
200.00		38, 627, 540				38, 736, 123	
201.00		565, 940		565, 94		565, 940	
202. 00	Total (see instructions)	38, 061, 600	0	38, 061, 60	0 108, 583	38, 170, 183	1202.00

Provider CCN: 150064 Peri od: Worksheet C From 10/01/2014 Part I To 09/30/2015 Date/Time Prepared:

					10 09/30/2013	2/25/2016 2: 2	
			Ti t	le XIX	Hospi tal	Cost	
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 033, 512		4, 033, 51			30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 853, 380		1, 853, 38			31. 00
40. 00	04000 SUBPROVI DER - I PF	3, 559, 251		3, 559, 25			40. 00
41. 00	04100 SUBPROVI DER - I RF	210, 152		210, 15			41. 00
42. 00	04200 SUBPROVI DER	0			0		42. 00
43. 00	04300 NURSERY	461, 826		461, 82	6		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 470 00/	7 000 447	0 470 05	0 000001	0.00000	F0 00
50.00	05000 OPERATING ROOM	1, 472, 906	7, 000, 447				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1 441 040	10 074 470		0.000000	0.000000	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	1, 441, 942	19, 874, 478			0. 000000 0. 000000	
57.00		0	0			0. 000000	
59.00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION		0		0.000000 0.000000	0.000000	
60.00	06000 LABORATORY	2, 432, 388	14, 069, 158	16, 501, 54		0.000000	
60. 00	06001 BL00D LABORATORY	2, 432, 300	14,009,136	10, 501, 54	0. 173163	0.000000	
65. 00	06500 RESPIRATORY THERAPY	1, 028, 325	2, 030, 469	3, 058, 79		0.000000	
66. 00	06600 PHYSI CAL THERAPY	338, 013	1, 581, 114			0. 000000	
69. 01	06901 CARDI AC REHAB	330,013	326, 753			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	994, 322	1, 828, 795	1		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 590	126, 934			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 773, 544	8, 048, 314			0. 000000	
74. 00	07400 RENAL DI ALYSI S	0	0,0.0,0.1		0.000000	0. 000000	
	OUTPATIENT SERVICE COST CENTERS		-	I.			
88. 00	08800 RURAL HEALTH CLINIC	0	0		0. 000000	0.000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000	0.000000	89. 00
91.00	09100 EMERGENCY	1, 127, 386	11, 310, 196	12, 437, 58	2 0. 179628	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	783, 543	783, 54	3 0. 722283	0.000000	92. 00
93.00	04040 CLI NI C	1, 400	4, 605, 796	4, 607, 19	6 1. 431816	0. 000000	93. 00
93. 01	04954 BI C	175	2, 116, 306	2, 116, 48	0. 817910	0. 000000	93. 01
93. 02	04953 UCI C	0	0		0. 000000	0. 000000	93. 02
93. 03	04955 CI C	0	0		0. 000000		
93. 04	04956 RI C	0	0		0. 000000		
93. 05	04950 PODI ATRY	0	1, 030	1, 03	0 86. 861165	0. 000000	93. 05
	OTHER REIMBURSABLE COST CENTERS	,					
95. 00	09500 AMBULANCE SERVICES	0	1, 036, 445			0. 000000	
99. 10	09910 CORF	0	0	1	0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	836, 725	836, 72	5		101. 00
400.00	SPECIAL PURPOSE COST CENTERS			ı	al		
	10900 PANCREAS ACQUISITION	0	0	1	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	1	0		110.00
	11100 I SLET ACQUI SI TI ON	0	220 512		0		111. 00
200.00	11600 HOSPI CE	21 747 110	228, 513	1			116. 00 200. 00
200.00		21, 747, 112	75, 805, 016	97, 552, 12	٥		200.00
201.00		21, 747, 112	75, 805, 016	97, 552, 12	Ω		201.00
202.00	p protai (See Mistructions)	21, 141, 112	75, 605, 016	77, 552, 12	o _l	I	1202.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/25/2016 2:25 pm	

				77 007 2010	2/25/2016 2: 25 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVI DER - I PF				40. 00
41.00	04100 SUBPROVI DER - I RF				41. 00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00	05700 CT SCAN	0. 000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60.00	06000 LABORATORY	0. 000000			60.00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 01	06901 CARDI AC REHAB	0. 000000			69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000			74. 00
	OUTPATIENT SERVICE COST CENTERS	•			
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
93.00	04040 CLI NI C	0. 000000			93.00
93. 01	04954 BI C	0. 000000			93. 01
93. 02	04953 UCI C	0. 000000			93. 02
93. 03	1 1	0. 000000			93. 03
93. 04	04956 RI C	0. 000000			93. 04
93. 05	04950 PODI ATRY	0. 000000			93. 05
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95.00	09500 AMBULANCE SERVICES	0. 000000			95.00
	09910 CORF				99. 10
101.00	10100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION				109. 00
	11000 INTESTINAL ACQUISITION				110. 00
	11100 I SLET ACQUISITION				111. 00
	11600 HOSPI CE				116.00
200.00	1 1				200. 00
201.00					201. 00
	1 1				202. 00
202.00	1 1				

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	ı	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	API TAL COSTS	Provi der		Period: From 10/01/2014 To 09/30/2015		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	S					
30.00 ADULTS & PEDIATRICS	140, 464	620	139, 84	4 3, 027	46. 20	30. 00
31.00 INTENSIVE CARE UNIT	82, 002		82, 00	2 745	110.07	31.00
40. 00 SUBPROVI DER - I PF	73, 291	C	73, 29	1 2, 173	33. 73	40.00
41. 00 SUBPROVI DER - I RF	77, 094	l c	77, 09	4 163	472. 97	41.00
42. 00 SUBPROVI DER	0	l c		0	0.00	42.00
43. 00 NURSERY	42, 957		42, 95	7 450	95. 46	43.00
200.00 Total (lines 30-199)	415, 808		415, 18	6, 558		200. 00
Cost Center Description	I npati ent	Inpati ent		•		
·	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	S					
30. 00 ADULTS & PEDIATRICS	1, 208	55, 810)			30. 00
31.00 INTENSIVE CARE UNIT	442	48, 651				31.00
40. 00 SUBPROVI DER - I PF	1, 529	51, 573	3			40.00
41. 00 SUBPROVI DER - I RF	100					41.00
42. 00 SUBPROVI DER	0	,	1			42.00
43. 00 NURSERY	0	l d				43. 00
200.00 Total (lines 30-199)	3, 279	203, 331				200.00
	1 3,2,,	200,001	1			1-30.00

Health Financial Systems F.	AYETTE REGIONAL	HEAL	TH SYSTEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet D Part II Date/Time Pre 2/25/2016 2:2	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	(from	n Wkst. C,		Program	Capital Costs (column 3 x column 4)	

					2/25/2016 2:2	5 pm
			tle XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal		es Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst.	C, to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col	. (col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	207, 798	8, 473, 3	53 0. 024524	453, 724	11, 127	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.000000	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	195, 945	21, 316, 4	20 0. 009192	1, 215, 237	11, 170	54.00
57. 00 05700 CT SCAN	0		0.000000	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.000000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.000000	0	0	59. 00
60. 00 06000 LABORATORY	70, 350	16, 501, 5	46 0. 004263	1, 543, 791	6, 581	60.00
60. 01 06001 BLOOD LABORATORY	0		0. 000000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	30, 752	3, 058, 7	94 0. 010054	703, 253	7, 071	65. 00
66. 00 06600 PHYSI CAL THERAPY	63, 432	1, 919, 1	27 0. 033053	86, 894	2, 872	66.00
69. 01 06901 CARDI AC REHAB	24, 887	326, 7		. 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 637	2, 823, 1	17 0. 009081	412, 939	3, 750	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	213					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	35, 239			1, 105, 104	3, 598	73.00
74. 00 07400 RENAL DIALYSIS	0		0.000000		0	74.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0		0.000000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 000000		0	89. 00
91. 00 09100 EMERGENCY	77, 614	12, 437, 5			5, 292	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	30, 487	783, 5			0	92.00
93. 00 04040 CLI NI C	240, 623				69	93.00
93. 01 04954 BI C	74, 099		•			93. 01
93. 02 04953 UCI C	0	_,,	0.000000		0	93. 02
93. 03 04955 CI C	0		0.000000		0	93. 03
93. 04 04956 RI C	0		0.000000		0	93. 04
93. 05 04950 PODI ATRY	288	1, C			0	93. 05
OTHER REIMBURSABLE COST CENTERS		1,0	3.2.7012			1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 077, 364	85, 332, 3	24	6, 375, 913	51, 544	

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	l	In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 10/01/2014 To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
			e XVIII	Hospi tal PP		
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0 0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0)	0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0)	0 0	0	42.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30-199)	0	0)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 027	0.00	1, 20	8 0		30.00
31.00 03100 INTENSIVE CARE UNIT	745	0.00	44	2 0		31.00
40. 00 04000 SUBPROVI DER - 1 PF	2, 173	0.00	1, 52	9 0		40.00
41. 00 04100 SUBPROVI DER - RF	163	0.00	10	0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		o o		42.00
43. 00 04300 NURSERY	450	0.00		o o		43.00
200.00 Total (lines 30-199)	6, 558		3, 27	9 0		200.00
	•	•	•	•		•

Health Financial Systems	FAYETTE REGIONAL HEA	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared:

				'	0 07/30/2013	2/25/2016 2: 2	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
	ANOLUL ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS			1			F0 00
	O5000 OPERATI NG ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	00.00
		0	0		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	57. 00
	1 1	0	0			0	58. 00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0			0	59. 00 60. 00
	06001 BLOOD LABORATORY	0	0			0	60.00
	06500 RESPIRATORY THERAPY	0	0			0	65. 00
	06600 PHYSI CAL THERAPY	0	0			0	66. 00
	06901 CARDI AC REHAB	0	0			0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	71.00
	07300 DRUGS CHARGED TO PATIENTS						73. 00
	07400 RENAL DIALYSIS	0				0	74.00
74.00	OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	74.00
88 00	08800 RURAL HEALTH CLINIC	0	1		0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				o o	89. 00
	09100 EMERGENCY	0	0			o o	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			o o	92. 00
	04040 CLINIC	0	0			o o	93. 00
	04954 BI C	0	0			o o	93. 01
	04953 UCI C	0	0	0	0	o o	93. 02
	04955 CI C	0	0		0	0	93. 03
	04956 RI C	0	0	0	0	0	93. 04
	04950 PODI ATRY	0	Ö	l d	Ö	Ō	93. 05
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	0	0	C	0	0	200. 00

Heal th	Financial Systems	FAYETTE REGIONAL	HFALTH S	/STFM		ln lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS			i der	CCN: 150064	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Pre 2/25/2016 2:2	pared:
		_			e XVIII	Hospi tal	PPS	
	Cost Center Description	Total			Ratio of Cost		Inpati ent	
		Outpati ent			to Charges	Ratio of Cost	Program	
		Cost (sum of		col .	(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)		7)	(col . 6 ÷ col .		
		4)	7.00		0.00	7)	40.00	
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	6. 00	7. 00		8. 00	9. 00	10.00	
F0 00	ANCILLARY SERVICE COST CENTERS		0 47	2 050	0.0000	0 000000	450.704	F0 00
50.00	05000 OPERATING ROOM		8, 47	3, 353			453, 724	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	1	420	0.00000			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN		21, 31	5, 420	0. 00000 0. 00000		1, 215, 237	54.00
57. 00 58. 00	05700 CT SCAN			0	0. 00000		0	57. 00 58. 00
59.00	05900 CARDIAC CATHETERIZATION			0	0. 00000		0	59.00
60.00	06000 LABORATORY) 16, 50°	1 544			1, 543, 791	60.00
60. 00	06000 LABORATORY		16, 50	1, 546 0	0. 00000		1, 543, 791	60.00
65. 00	06500 RESPIRATORY THERAPY		3, 058				_	65. 00
66. 00	06600 PHYSI CAL THERAPY		1, 91		0.00000			
69. 01	06901 CARDI AC REHAB			5, 127 5, 753				69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2, 82					
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS			5, 524				
73. 00	07300 DRUGS CHARGED TO PATIENTS		•				1, 105, 104	73.00
74.00	07400 RENAL DIALYSIS		1	າ, ວວວ ດ	0.00000		1, 105, 104	
74.00	OUTPATIENT SERVICE COST CENTERS		4	- 0	0.00000	0.00000	0	74.00
88. 00	08800 RURAL HEALTH CLINIC		1	0	0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	0	0.00000		·	89.00
91. 00	09100 EMERGENCY		12, 43	7 582			848, 007	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			3, 543			040,007	92.00
93. 00	04040 CLINIC		4,60				ľ	
93. 00	04954 BI C		2, 110		0.00000			
93. 02	04953 UCI C		j -, 110	2, 101 N	0. 00000			93. 02
93. 03	04955 CI C		ál	0	0. 00000		n	93. 03
93. 04	04956 RI C		ól –	0	0. 00000		n	93. 04
93. 05	04950 PODI ATRY			1. 030			Ö	1
	OTHER RELABILE COCT OFFITERS		1	., 500	3. 00000	3, 000000		1

85, 332, 324

6, 375, 913 200. 00

95.00

93. 05 04950 PODI ATRY
OTHER REI MBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES

Total (lines 50-199)

200.00

Health Financial Systems	LTH SYSTEM	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared:

				2/25/2016 2:2		25 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 067, 680	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 590, 312	2 0			54.00
57. 00 05700 CT SCAN	0	0	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0			59. 00
60. 00 06000 LABORATORY	0	2, 383, 572	2 0			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0			60. 01
65. 00 06500 RESPIRATORY THERAPY	0	948, 860	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	220				66. 00
69. 01 06901 CARDI AC REHAB	0	192, 581	0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	450, 114	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	22, 794	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 105, 715	0			73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0			74. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
91. 00 09100 EMERGENCY	0	2, 281, 926	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	519, 335	0			92. 00
93. 00 04040 CLI NI C	0	1, 271, 606	0			93. 00
93. 01 04954 BI C	o	55, 440	0			93. 01
93. 02 04953 UCI C	o	O	0			93. 02
93. 03 04955 CI C	o	0	0			93. 03
93. 04 04956 RI C	o	0	0			93. 04
93. 05 04950 PODI ATRY	o	0	0			93. 05
OTHER REIMBURSABLE COST CENTERS	<u>.</u>		•			1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	o	19, 890, 155	0			200. 00

Health Financial Systems		FAYETTE REGIONAL HEA	LTH SYSTEM	H SYSTEM In Lieu of F			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provi der CCN: 150064	Peri od: From 10/01/2014			

				rom 10/01/2014 To 09/30/2015	Part V Date/Time Pre 2/25/2016 2:2	pared: 5 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
	1.00		(see inst.)	(see inst.)		
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.00000/	0.0/7./00		<u> </u>	FOF 404	F0 00
50. 00 05000 OPERATING ROOM	0. 282986		1	1 1	585, 124	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 212558				1, 400, 824	54.00
57. 00 05700 CT SCAN	0. 000000				0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	l .			0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				0	59.00
60. 00 06000 LABORATORY	0. 173163				412, 746	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 261658		•		248, 277	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 629096				138	66.00
69. 01 06901 CARDI AC REHAB	1. 037444				199, 792	69. 01 71. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0. 452188 0. 556726				203, 536	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS			1	0 07	12, 690	72.00
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0. 381226 0. 000000		1	26, 087	1, 183, 979 0	74.00
OUTPATIENT SERVICE COST CENTERS	0.000000	ı u	,)l U	U	74.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000		1		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
91. 00 09100 EMERGENCY	0. 179628		,		409, 898	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 722283		•		375, 107	92.00
93. 00 04040 CLINIC	1. 431816		•		1, 820, 706	93. 00
93. 01 04954 BI C	0. 817910				45, 345	
93. 02 04953 UCI C	0. 000000			ál ől	0	93. 02
93. 03 04955 CI C	0. 000000			ol ol	0	93. 03
93. 04 04956 RI C	0. 000000				0	93. 04
93. 05 04950 PODI ATRY	86. 861165			-	0	93. 05
OTHER REIMBURSABLE COST CENTERS				-1		
95. 00 09500 AMBULANCE SERVI CES	0. 538359					95. 00
200.00 Subtotal (see instructions)		19, 890, 155		26, 087	6, 898, 162	200.00
201.00 Less PBP Clinic Lab. Services-Program				ol		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		19, 890, 155	i (26, 087	6, 898, 162	202. 00

Health Financial Systems		FAYETTE REGIONAL HEA	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 150064	Peri od: From 10/01/2014	Worksheet D
				T 00 (00 (0015	

						To 09/30/2015	Date/Time Pro 2/25/2016 2:2	epared: 25 pm
				Ti tl	e XVIII	Hospi tal	PPS	
		Cos	sts					
	Cost Center Description	Cost		Cost				
		Rei mbursed	Rei	mbursed				
		Servi ces	Serv	ices Not				
		Subject To	Sub	ject To				
		Ded. & Coins.		& Coins.				
		(see inst.)		e inst.)				
		6. 00		7. 00				
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0		0				50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0		0				52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		0				54. 00
	05700 CT SCAN	0		0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0		0				59. 00
60. 00	06000 LABORATORY	0		0				60.00
60. 01	06001 BLOOD LABORATORY	0		0				60. 01
65. 00	06500 RESPI RATORY THERAPY	0		0				65. 00
	06600 PHYSI CAL THERAPY	0		0				66. 00
69. 01	06901 CARDI AC REHAB	0		0				69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		9, 945				73. 00
74. 00	07400 RENAL DIALYSIS	0		0				74. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0		0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89. 00
91. 00	09100 EMERGENCY	0		0				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0				92.00
93. 00	04040 CLI NI C	0		0				93. 00
93. 01	04954 BI C	0		0				93. 01
93. 02	04953 UCI C	0		0				93. 02
93. 03	04955 CI C	0		0				93. 03
93. 04	04956 RI C	0		0				93. 04
93. 05	04950 PODI ATRY	0		0				93. 05
İ	OTHER REIMBURSABLE COST CENTERS							
95. 00	09500 AMBULANCE SERVICES	0						95. 00
200.00	Subtotal (see instructions)	0		9, 945				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0						201. 00
	Only Charges							
202. 00	Net Charges (line 200 +/- line 201)	0		9, 945				202. 00

		HEALTH SYSTEM			eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L C0515	Provi der	CCN: 150064	Peri od: From 10/01/2014	Worksheet D Part II	
		Component	CCN: 15S064	To 09/30/2015	Date/Time Pre 2/25/2016 2:2	pared: 5 pm
Title XVIII Subprovider -					PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	207, 798				1	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	_	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	195, 945	21, 316, 420			525	1
57.00 05700 CT SCAN	0	0	0. 00000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00 06000 LABORATORY	70, 350	16, 501, 546			715	
60. 01 06001 BLOOD LABORATORY	0	-	0. 00000		0	
65. 00 06500 RESPIRATORY THERAPY	30, 752				29	
66. 00 06600 PHYSI CAL THERAPY	63, 432				930	
69. 01 06901 CARDI AC REHAB	24, 887				0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 637				21	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	213				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	35, 239				1, 384	1
74. 00 07400 RENAL DIALYSIS	0	0	0. 00000	00	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0.0000		0	89. 00
91. 00 09100 EMERGENCY	77, 614				396	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, , , , , , ,			0	
93. 00 04040 CLI NI C	240, 623				l	93. 00
93. 01 04954 BI C	74, 099	2, 116, 481	0. 0350°		0	
93. 02 04953 UCI C	0	0	0. 00000		0	
93. 03 04955 CI C	0	0	0. 00000		0	93. 03
93. 04 04956 RI C	0	0	0. 00000		0	
93. 05 04950 PODI ATRY	288	1, 030	0. 2796	12 0	0	93. 05
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	1, 046, 877	85, 332, 324	l	746, 599	4, 002	200. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-255 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150064 Period: Worksheet D	52-10
THROUGH COSTS From 10/01/2014 Part IV Component CCN: 15S064 To 09/30/2015 Date/Time Prepar	red:
2/25/2016 2:25 p	
Title XVIII Subprovider - PPS	
IPF	
Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost	
Anesthetist Medical (sum of col 1	
Cost Education Cost through col.	
4)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
	0.00
	2. 00
	4. 00
	7. 00
	8. 00
	9. 00
	0.00
	0. 01
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 6	5. 00
	6. 00
	9. 01
	1. 00
	2. 00
	3.00
	4. 00
OUTPATIENT SERVICE COST CENTERS	
	38. 00
	39. 00
	91. 00
	2. 00
	93.00
	93. 01
	93. 02
	93. 03
	93. 04
	93. 05
OTHER REIMBURSABLE COST CENTERS	
	5. 00
200.00 Total (lines 50-199) 0 0 0 0 20	00.00

Heal th	Financial Systems F.	AYETTE REGIONAL	. HEALTH SYSTEM	<u> </u>	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	COSTS		Component		From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre 2/25/2016 2:2	
			Ti tl	e XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	TANGLEL ARY OF BUILDE COOK OF STATERS	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS		0 470 050			0.7	
50. 00	05000 OPERATING ROOM	0				27	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0.00000		0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 316, 420			57, 101	54.00
57. 00	05700 CT SCAN	0	0	0.00000		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	
60.00	06000 LABORATORY	0	16, 501, 546			167, 635	
60. 01	06001 BLOOD LABORATORY	0	0	0.00000		0	
65. 00	06500 RESPI RATORY THERAPY	0	3, 058, 794			2, 932	1
66. 00	06600 PHYSI CAL THERAPY	0	1, 919, 127			28, 151	
69. 01	06901 CARDI AC REHAB	0	326, 753			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 823, 117			2, 301	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				424, 967	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0.00000	0. 000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		T	1			
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	89. 00
91.00	09100 EMERGENCY	0	, ,			63, 465	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	783, 543			0	
93. 00	04040 CLI NI C	0	4, 607, 196			16	
93. 01	04954 BI C	0	2, 116, 481			4	93. 01
93. 02	04953 UCI C	0	0	0. 00000		0	
93. 03	04955 CI C	0	0	0.00000		0	
93. 04	04956 RI C	0	0	0.00000		0	93. 04
93. 05	04950 PODI ATRY	0	1, 030	0.00000	0. 000000	0	93. 05
0= 0-	OTHER REIMBURSABLE COST CENTERS		1				
95.00	09500 AMBULANCE SERVICES		05 000 00.			74/ 500	95. 00
200.00	Total (lines 50-199)	0	85, 332, 324	1		746, 599	J200. 00

Health Financial Systems	FAYETTE REGIONAL HEAL	LTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet D Part IV
Timodon dagra		Component CCN: 15S064	To 09/30/2015	Date/Time Prepared: 2/25/2016 2:25 pm
		Title XVIII	Subprovi der -	PPS

			11.0	C XVIII	I PF	113	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		l	
	·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9	7		
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS			.T	al		
	05000 OPERATI NG ROOM	0	(0		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	(0		52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	(0		54. 00
	05700 CT SCAN	0	(0		57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	(0		59. 00
	06000 LABORATORY	0	(0		60.00
	06001 BLOOD LABORATORY	0	(0		60. 01
	06500 RESPI RATORY THERAPY	0	(0		65. 00
	06600 PHYSI CAL THERAPY	0	()	0		66. 00
	06901 CARDI AC REHAB	0	(0		69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	()	0		73. 00
74. 00	07400 RENAL DI ALYSI S	0	()	0		74. 00
	OUTPATIENT SERVICE COST CENTERS			J	al		
	08800 RURAL HEALTH CLINIC	0	(0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0		89. 00
	09100 EMERGENCY	0	(0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0		92.00
	04040 CLI NI C	0	(0		93. 00
	04954 BI C	0	(0		93. 01
	04953 UCI C	0	(0		93. 02
	04955 C1 C		(ا ا			93. 03
	04956 RI C	0	(0		93. 04
	04950 PODIATRY	<u> </u>	(٧	U		93. 05
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES						95. 00
200.00			,		o		200.00
200.00	10tal (11162 30-144)	0	()	이		J∠UU. UU

	AYETTE REGIONAL				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150064	Peri od: From 10/01/2014	Worksheet D Part II	
		Component	CCN: 15T064	To 09/30/2015	Date/Time Pre 2/25/2016 2:2	pared: 5 pm
	e XVIII	Subprovi der - I RF	PPS			
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILARY OFFICE OF SOUTHER	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	007.700	0 470 050	0.0045	10		F0 00
50. 00 05000 OPERATING ROOM	207, 798				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	·	0.0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	195, 945				6	54.00
57. 00 05700 CT SCAN	0	_	0.00000		0	57. 00 58. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	0	0. 00000 0. 00000		0	59.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	70, 350	16, 501, 546			34	60.00
60. 00 06000 LABORATORY	70, 330		0.00420		0	60.00
65. 00 06500 RESPI RATORY THERAPY	30, 752		l .		4	65. 00
66. 00 06600 PHYSI CAL THERAPY	63, 432				2, 820	
69. 01 06901 CARDI AC REHAB	24, 887				2,020	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 637		l .		_	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	213				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	35, 239				72	73.00
74. 00 07400 RENAL DI ALYSI S	0		0.00000		0	
OUTPATIENT SERVICE COST CENTERS	1					
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	00	0	89. 00
91. 00 09100 EMERGENCY	77, 614	12, 437, 582	0. 00624	10 414	3	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	783, 543	0.00000	00	0	92.00
93. 00 04040 CLI NI C	240, 623	4, 607, 196	0. 05222	28 0	0	93. 00
93. 01 04954 BI C	74, 099	2, 116, 481			0	93. 01
93. 02 04953 UCI C	0	0	0.00000		0	93. 02
93. 03 04955 CI C	0	0	0.00000		0	93. 03
93. 04 04956 RI C	0	0	0. 00000		0	93. 04
93. 05 04950 PODI ATRY	288	1, 030	0. 2796	12 0	0	93. 05
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 046, 877	85, 332, 324		118, 507	2, 955	200. 00

Heal th	Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 150064	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15T064	From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre 2/25/2016 2:2	pared: 5 pm
	Title XVIII Subprovider - PPS IRF						
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	·	Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
57. 00	05700 CT SCAN	0	0		0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	
	06901 CARDI AC REHAB	0	0		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00	07400 RENAL DI ALYSI S	0	0		0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
91.00	09100 EMERGENCY	0	0		0 0	0	
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
	04954 BIC	0	0		0	0	
	04953 UCI C	0	0		0 0	0	93.01
	04955 CI C	0	0		0	0	
	04956 RI C	0	0		0 0	0	
	04950 PODI ATRY	0	0		0 0	0	
73.03	OTHER REIMBURSABLE COST CENTERS	U	0		0 0	0	73.03
95 00	09500 AMBULANCE SERVICES						95. 00
200.00		0	0		0 0	n	200. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1		1	-1	,	

Heal th	Financial Systems F.	AYETTE REGIONAL	_ HEALTH SYSTEM	l	In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre 2/25/2016 2:2	
-			Ti tl	e XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS		1				
50. 00	05000 OPERATING ROOM	0				18	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0.00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 316, 420			658	
57. 00	05700 CT SCAN	0	0	0.00000		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	
60. 00	06000 LABORATORY	0	16, 501, 546			7, 930	
60. 01	06001 BLOOD LABORATORY	0	0	0.00000		0	
65. 00	06500 RESPI RATORY THERAPY	0	3, 058, 794			416	
66. 00	06600 PHYSI CAL THERAPY	0	1, 919, 127			85, 321	
69. 01	06901 CARDI AC REHAB	0	326, 753			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 823, 117			1, 766	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	10, 821, 858			21, 984	
74. 00	07400 RENAL DI ALYSI S	0	0	0.00000	0. 000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS	_					
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	89. 00
91. 00	09100 EMERGENCY	0	, ,			414	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	783, 543			0	
93. 00	04040 CLI NI C	0	4, 607, 196			0	
93. 01	04954 BI C	0	2, 116, 481			0	
93. 02	04953 UCI C	0	0	0.00000		0	
93. 03	04955 CI C	0	0	0.00000		0	
93. 04	04956 RI C	0	0	0.00000		0	93. 04
93. 05	04950 PODI ATRY	0	1, 030	0.00000	0. 000000	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	85, 332, 324	·I		118, 507	J200. 00

Health Financial Systems	FAYETTE REGIONAL HEAI	LTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150064 Component CCN: 15T064	Peri od: From 10/01/2014 To 09/30/2015	
		Title XVIII	Subprovi der -	PPS

		1111	e xviii	I RF	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9)		
	x col . 10)	10.00	x col. 12)	_		
ANCILLARY SERVICE COST CENTERS	11. 00	12. 00	13. 00			_
50. 00 05000 OPERATING ROOM		(1		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM				2		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		()		54. 00
57. 00 05700 CT SCAN))		57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)))		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON) 1		59.00
60. 00 06000 LABORATORY				n n		60.00
60. 01 06001 BLOOD LABORATORY				n n		60. 01
65. 00 06500 RESPI RATORY THERAPY		Č		0		65. 00
66. 00 06600 PHYSI CAL THERAPY		Č		0		66.00
69. 01 06901 CARDI AC REHAB	l ol	C		0		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C		o o		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	C		O		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	C		0		73. 00
74.00 07400 RENAL DIALYSIS	0	C		O		74.00
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	0	C) (O		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C)	O		89. 00
91. 00 09100 EMERGENCY	0	C		O		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		O		92. 00
93. 00 04040 CLI NI C	0	C		O		93. 00
93. 01 04954 BI C	0	(0		93. 01
93. 02 04953 UCI C	0	(0		93. 02
93. 03 04955 CI C	0	(0		93. 03
93. 04 04956 RI C	0	()		93. 04
93. 05 04950 PODI ATRY	0) (J		93. 05
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	_	,			200.00
200.00 Total (TITIES 30-199)	ı V	C	ሳ '	기		∠00. 00

Health Financial Systems	FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Peri od: From 10/01/2014	Worksheet D-1	
			To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

	Cook Cookin Description	L PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 108	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 027 0	2. 00 3. 00
3.00	do not complete this line.	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 370	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	52	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	52	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	29	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 208	9. 00
7. 00	newborn days)	., 200	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions)	F2	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	52	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT	222. 37	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	222. 31	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	222. 37	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	2, 619, 024	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1 ine 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	11, 563	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	11, 563	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2, 607, 461	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0 407 441	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2, 607, 461	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	861. 40	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 040, 571	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 040, 571	41.00

	(x iine 20)		in .
26.00	Total swing-bed cost (see instructions)	11, 563	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 607, 461	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		ı
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 607, 461	37. 00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		ı
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		ı
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	861. 40	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 040, 571	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 040, 571	41.00

	Financial Systems F TATION OF INPATIENT OPERATING COST	AYETTE REGIONAL		CCN: 150064	Peri od:	worksheet D-1	
COMPU	ATTON OF THEATTENT OFERATING COST		Frovider	CCN. 150004	From 10/01/2014		
					To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
		T		e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total nnatient Davs	Average Per		Program Cost (col. 3 x col.	
		impatront oostii		col . 2)		4)	
42.00	MUDCEDY (+i+le V e VIV enly)	1.00	2.00	3.00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	1, 707, 478	745	2, 291.	92 442	1, 013, 029	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	cst D-3 col 3	line 200)			1. 00 1, 658, 153	48. 00
	Total Program inpatient costs (sum of lines			ns)		3, 711, 753	
FO 00	PASS THROUGH COST ADJUSTMENTS			WI+ D	£ Dt-	104 4/1	
50. 00	Pass through costs applicable to Program in [III]	batient routine s	ervices (from	WKST. D, SUN	i or Parts i and	104, 461	50.00
51.00	Pass through costs applicable to Program in	oatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	51, 544	51.00
52. 00	and IV)	EO and E1)				154 005	52. 00
53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	156, 005 3, 555, 748	
	medical education costs (line 49 minus line					., ,	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge						55.00
56. 00	,					l e	56. 00
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ting cost and tar	get amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ndi ng 1996, u	pdated and co	ompounded by the		59.00
	market basket		•		, ,		
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less that						01.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)					(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payr	ment (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	r 31 of the c	ost reporting	period (See	11, 563	65. 00
	instructions)(title XVIII only)					44 - 40	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	11, 563	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 o	f the cost re	eporting period	0	67. 00
40 00	(line 12 x line 19)	no costo often Do	combon 21 of	the cost rone	erting ported		49.00
00.00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ie costs arter be	celliber 31 01	the cost repo	of tring period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil					Γ	70.00
71.00	Adjusted general inpatient routine service	9		` ,			71.00
72. 00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost application of the service o						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75.00
7/ 05	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	,						78.00
79.00	Aggregate charges to beneficiaries for excess				wo list 70)		79.00
80.00	Total Program routine service costs for complingation routine service cost per diem limi		st limitation	(line /8 mir	ius iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (82. 00
83.00	Reasonable inpatient routine service costs	•)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
86. 00							86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					,==	07.00
87. 00	Total observation bed days (see instructions	s)				657	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			861. 40	88. 00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015		
	_	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	140, 464	2, 607, 461	0. 053870	565, 940	30, 487	90.00
91.00 Nursing School cost	0	2, 607, 461	0. 00000	565, 940	0	91.00
92.00 Allied health cost	0	2, 607, 461	0.00000	565, 940	0	92.00
93.00 All other Medical Education	0	2, 607, 461	0. 00000	565, 940	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1500	Period: From 10/01/2014	Worksheet D-1
	Component CCN: 15S	64 To 09/30/2015	Date/Ti me Prepared: 2/25/2016 2:25 pm
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I PF	FF3	
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 173	
2.00	Inpatient days (including private room days, excluding swing-be			2, 173	
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 173	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5.00
	reporting period	daya) after Dagambar 1	01 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 529	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	Join days) ares	· ·	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar yea			O	13.00
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed of	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of t	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period	g			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 245, 064	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ne 21 minus line 26)		2, 245, 064	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and abasement on had abs	15000)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu:	s line 33)(see instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		11 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	2, 245, 064	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructions)		1, 033. 16	
39. 00	Program general inpatient routine service cost (line 9 x line 3)			1, 579, 702	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 1, 579, 702	40. 00 41. 00
	1	,	ı	., 3, .02	

COMPUTA	ATION OF INPATIENT OPERATING COST			00N 4F00(4	D 1 1		2552-10
					Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prep	
				e XVIII	Subprovi der -	2/25/2016 2: 2: PPS	5 pm
	Cost Contar Decement on	Total	Total		I PF Program Days		
	Cost Center Description	Total Inpatient Cost		Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 0 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	- 1				U	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.0	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description	ll					47.00
48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. line 200)		_	1. 00 234, 124	48. 00
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ns)		1, 813, 826	
	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	51, 573	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	4, 002	51.00
52. 00	Total Program excludable cost (sum of lines 5					55, 575	1
	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	sician anesth	etist, and	1, 758, 251	53. 00
54. 00	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	pdated and co	mpounded by the	0 0. 00	58. 00 59. 00
- 1	market basket Lesser of lines 53/54 or 55 from prior year o	cost report, up	dated by the m	arket basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61.00
	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	porting period	0	67. 00
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
Ī	Total title V or XIX swing-bed NF inpatient r PART III – SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLÝ		0	69. 00
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70. 00 71. 00
- 1	Program routine service cost (line 9 x line 7		THE 70 : TIME	2)			72.00
- 1	Medically necessary private room cost application Total Program general inpatient routine servi		•	ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient r 26, line 45)	•		orksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin						76.00
1	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
1	Aggregate charges to beneficiaries for excess				1: 70)		79.00
1	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ust iimm tätion	(IIIIe /8 MIN	us IIIIe /9)		80. 00 81. 00
1	Inpatient routine service cost limitation (li		•				82. 00 83. 00
1	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		<i>3)</i>				84. 00
1	Utilization review - physician compensation (85. 00 86. 00
H	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)				00.00
87. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0 00	87. 00 88. 00
88. 00		J (11110 Z1 T	· · · · · · · · · · /			0.00	1 22.00

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15S064	From 10/01/2014 To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	73, 291	2, 245, 064	0. 03264	5 0	0	90.00
91.00 Nursing School cost	0	2, 245, 064	0. 00000	o o	0	91.00
92.00 Allied health cost	0	2, 245, 064	0. 00000	o o	0	92.00
93.00 All other Medical Education	0	2, 245, 064	0.00000	0 0	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet D-1
	Component CCN: 15TO	4 To 09/30/2015	Date/Time Prepared: 2/25/2016 2:25 pm
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I RF	FF3	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			163	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		voto room dovo	163 0	2. 00 3. 00
3.00	do not complete this line.	i. IT you have only pri	vate room days,	Ü	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		163	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber e	or the cost	Ü	0.00
7. 00	Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Mays) after December 21	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) arter becember 3	or the cost	O	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	100	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (including privata re	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, enti-		, room dovo)	0	12 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year	-	, i		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	iays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost respont:	ng poriod (line	516, 399 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	period (line 6	0	23. 00
24.00	X line 18)	01 of the cost managetin	na nominal (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	si oi the cost reportir	ig period (Title	U	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)			0	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I)	ne 21 minus line 26)		0 516, 399	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			3.13, 3.77	27.00
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus Average per diem private room cost differential (line 34 x line		(ions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	516, 399	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			3, 168. 09	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			316, 809	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 316, 809	40. 00 41. 00
- 1. 00	Trotal Trogram general impatrent routine service cost (IIIIe 37 +	11110 40)	ı	310, 009	+1.00

	Financial Systems FA	YETTE REGIONAL			CCN: 150064	In Li Peri od:	eu of Form CMS-: Worksheet D-1	
COMPUT	ATTON OF INFATTENT OFERATING COST				CCN: 15T064	From 10/01/2014 To 09/30/2015	1	
			Comp		e XVIII	Subprovi der -	2/25/2016 2: 2 PPS	
		T	T	11 (1		I RF		
	Cost Center Description	Total Inpatient Cost	Total Inpati ent	Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+; +l o V e VIV only)	1.00	2.00	0	3.00	4. 00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.	00	0	42. 00
43.00	INTENSIVE CARE UNIT	0		0	0.	00	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47. 00
	<u> </u>						1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4				ns)		64, 556 381, 365	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst. D, su	m of Parts I and	47, 297	50. 00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y service	s (fr	om Wkst. D,	sum of Parts II	2, 955	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)					50, 252	52. 00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		elated, no	n-phy	sician anest	netist, and	331, 113	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						Ιο	54.00
55.00	Target amount per discharge						0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	arget amou	at (I	ine 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	ng cost and te	ii get alliou	10 (1	THE 30 III Hus	111le 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	endi ng 19	96, u	pdated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year o						0.00	60.00
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than						0	61.00
	amount (line 56), otherwise enter zero (see i		.5 (111105	J- X	00), 01 1% 0	the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)				0 0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST			6 11				
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	ember 31 o	r the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	s after Decemb	per 31 of	the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus l	ne 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	n December	31 o	f the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	December 3	1 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (I						71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)	•	n (line 14	x li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi	ce costs (line	72 + lin	e 73)				74. 00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	costs (f	rom W	orksheet B, I	Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ lir							76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus							77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p				70\		79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		COST LIMIT	ation	(IIne /8 mi	nus iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	* .					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		ns)					83. 00 84. 00
85. 00	Utilization review - physician compensation (ons)					85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						0	87. 00
	Adjusted general inpatient routine cost per o	diem (line 27 ÷					l .	88.00
89. UU	Observation bed cost (line 87 x line 88) (see	: INSTRUCTIONS)	1				1 0	89.00

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014		
		Component	CCN: 15T064	To 09/30/2015	Date/Time Prep 2/25/2016 2:29	
-		Ti tl	e XVIII	Subprovi der -	PPS	o piii
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO						
90.00 Capital -related cost	77, 094	516, 399	0. 14929	2 0	0	90.00
91.00 Nursing School cost	0	516, 399	0.00000	0	0	91.00
92.00 Allied health cost	0	516, 399	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	516, 399	0. 00000	0	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEAI	LTH SYSTEM	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet D-1	
			To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					

		Title XIX Hospital	Cost	
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)	3, 108	1. 00
2.00	Inpatient days (including private room days, excluding swing-be		3, 027	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days	, 0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)	2, 370	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room			5. 00
	reporting period	3 / 3		
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 31 of the cost	52	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor 21 of the cost	0	7. 00
7.00	reporting period	days) through becember 31 of the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31 of the cost	29	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding swing-bed and	105	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructi			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		0	12. 00
12.00	through December 31 of the cost reporting period	only (Therduring private room days)		12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea			
14.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed days)	0	
15. 00 16. 00	Nursery days (title V or XIX only)		450	16.00
	SWING BED ADJUSTMENT			10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the cost	222. 37	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of the cost	222. 37	18. 00
10.00	reporting period	arter beceinber 31 of the cost	222.37	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of the cost	0.00	19. 00
20.00	reporting period	often December 21 of the cost	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter beceiiber 31 of the cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)		2, 619, 024	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporting period (lin	e 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting period (line	6 11, 563	23 00
20.00	x line 18)	To the east reporting perrou (The	11,000	20.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19)	of the cost reporting period (line O	0	25. 00
23.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period (Title o		25.00
26.00	Total swing-bed cost (see instructions)		11, 563	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)	2, 607, 461	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	and observation bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	- 1! 22) (!+	0.00	
34.00	Average per diem private room charge differential (line 32 minu		0.00	
35.00	Average per diem private room cost differential (line 34 x line	31)	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d private room cost differential (lin	2 607 461	36. 00 37. 00
37.00	27 minus line 36)	a private room cost differential (IIII	e 2, 607, 461	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			
38. 00	Adjusted general inpatient routine service cost per diem (see i		861.40	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	•	90, 447	39. 00 40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	· ·	90, 447	
	7 . 3		1 -1 -1 -1	

Heal th	Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 150064 Period: From 10/01/2014	Worksheet D-1	
	To 09/30/2015	Date/Time Pre	
	Title XIX Hospital	2/25/2016 2: 25 Cost	5 pm
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	(col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42.00	NURSERY (title V & XIX only) 699, 087 450 1, 553. 53 24	37, 285	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 1,707,478 745 2,291.92 13	29, 795	43. 00
44. 00	CORONARY CARE UNIT		44. 00
45. 00			45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
	Cost Center Description		
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 25, 601	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	183, 128	
F0 00	PASS THROUGH COST ADJUSTMENTS		F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53. 00
	medical education costs (line 49 minus line 52)		
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55. 00			55. 00
56. 00	Target amount (line 54 x line 55)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60. 00
61. 00		0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
01.00	instructions)(title XVIII only)		01.00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	, , , , , , , , , , , , , , , , , , , ,	0	66. 00
/7.00	CAH (see instructions)		/7.00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	U	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	3	
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
71.00	Program routine service cost (line 9 x line 71)		71.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
70.00	26, line 45)		70.00
76.00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00
77. 00 78. 00	Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost per drem from tatron Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	/57	07.00
87. 00 88. 00	· · · · · · · · · · · · · · · · · · ·	657 861. 40	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)	565, 940	

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	140, 464	2, 607, 461	0. 05387	0 565, 940	30, 487	90.00
91.00 Nursing School cost	0	2, 607, 461	0.00000	0 565, 940	0	91.00
92.00 Allied health cost	0	2, 607, 461	0. 00000	0 565, 940	0	92.00
93 00 All other Medical Education	0	2 607 461	0 00000	565 940	0	93 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet D-1
	Component CCN: 15S064		
	Title XIX	Subprovi der -	

	IPF		
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 173	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 173	1
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 173	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
	reporting period		, ,,,,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	289	9. 00
7. 00	newborn days)	207	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instructions)		44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	24	1
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	2, 245, 064	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (x line 18)	0	23. 00
24. 00		0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 245, 064	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	•
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0 0	l
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	•
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routing service cost per diem (see instructions)	1 022 14	38. 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 033. 16 298, 583	1
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	298, 583	41. 00

	Financial Systems FA	AYETTE REGIONAL HI	Provider CC	N: 150064	Peri od:	worksheet D-1	
,UMPU I	ATION OF INPATIENT OPERATING COST		Component C		From 10/01/2014		pared:
			Title	XIX	Subprovider -	2/23/2010 2.2	э рііі
	Cost Center Description	Total	Total /	Average Per	I PF Program Days	Program Cost	
		Inpatient Cost In	patient DaysDi	em (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	Indipositive to the second sec	1.00	2.00	3.00	4. 00	5. 00	1.0.0
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42. C
3. 00	INTENSIVE CARE UNIT	0	0	0.0	00	0	
4. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 0 45. 0
6. 00	1						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
0.00	December 1 and 1 a	-+ 0 21 2	11: 200)			1.00	40.6
8. 00 9. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines)		0 298, 583	
0.00	PASS THROUGH COST ADJUSTMENTS	ationt moutine on	micas (Fram W	leat D aum	of Donto L and]
0. 00	Pass through costs applicable to Program inp	attent routine se	rvices (from w	KST. D, SUN	n or Parts I and	0	50.0
1. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (from	Wkst. D, s	sum of Parts II	0	51. 0
2. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-physi	ci an anesth	netist, and	298, 583	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>32)</i>					
4. 00 5. 00	Program discharges Target amount per discharge					•	54. (55. (
5. 00	Target amount (line 54 x line 55)				>	0	56.
7. 00 3. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (lin	e 56 minus	line 53)	0	
9. 00	Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, upd	ated and co	ompounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upda	ted by the mar	ket basket		0.00	60.
1. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 en	ter the Lesser	of 50% of		0	61. (
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(TITIES 54 X 60), OI 1% OI	the target		
2.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0	
3. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
4. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the c	ost reporti	ng period (See	0	64. 0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	t reporting	period (See	0	65.0
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)	(title XVII	I only). For	0	66. (
7 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin						67. (
7.00	(line 12 x line 19)	e costs through b	ecember 31 or	the cost re	sporting period	0	07.0
8. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of th	e cost repo	orting period	0	68. (
9. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70. 0
1. 00	Adjusted general inpatient routine service c	ost per diem (lin					71. 0
2. 00 3. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	line 14 x line	35)			72. (
4. 00	Total Program general inpatient routine serv	•		, 			74.
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Wor	ksheet B, F	art II, column		75. (
5. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. (
7. 00 3. 00	Inpatient routine service cost (line 74 minu						78.
9. 00 0. 00				lino 70 mir	ous lino 70)		79. 80.
1.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ı ıımıtati VII (/O IIII I	143 TTHE 19)		81.
2. 00 3. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·					82. 83.
4. 00	Program inpatient ancillary services (see in						84. (
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 0 86. 0
J. UU	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ugii UJ)				
37. 00 38. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		 ine 2)			0	87. 0 88. 0
	Observation bed cost (line 87 x line 88) (se	•	1110 2)			l e	89. 0

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM	<u> </u>	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014	5	
		Component	t CCN: 15S064	To 09/30/2015	Date/Time Pre 2/25/2016 2: 2	
		Ti t	le XIX	Subprovi der -	2/23/2010 2.2	J PIII
		11.0	I C XI X	IPF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0.00000	0	0	90.00
91.00 Nursing School cost	0	0	0.00000	0	0	91. 00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0	0	93.00

	FAYETTE REGIONAL HEALTH SYSTEM			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 10/01/2014 To 09/30/2015	Date/Time Pre	narod:
			10 07/30/2013	2/25/2016 2: 2	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 568, 365		30.00
31. 00 03100 NTENSI VE CARE UNI T			1, 020, 791		31.00
40. 00 04000 SUBPROVI DER - PF			4 024		40.00
41. 00 04100 SUBPROVI DER - RF			4, 936		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			0		42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 28298	453, 724	128, 398	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		120, 370	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21255		258, 308	
57. 00 05700 CT SCAN		0.00000		0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		l o	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60. 00 06000 LABORATORY		0. 17316		267, 327	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	•
65. 00 06500 RESPIRATORY THERAPY		0. 26165		184, 012	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 62909	86, 894	54, 665	66. 00
69. 01 06901 CARDI AC REHAB		1. 03744	4 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45218	412, 939	186, 726	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 55672	5, 493	3, 058	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 38122	1, 105, 104	421, 294	73. 00
74.00 07400 RENAL DIALYSIS		0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
91. 00 09100 EMERGENCY		0. 17962		152, 326	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 72228		0	
93. 00 04040 CLI NI C		1. 45404			
93. 01 04954 BIC		0. 82083			
93. 02 04953 UCI C		0.00000		0	
93. 03 04955 CI C		0.00000		0	
93 U4 IU4930[K](.					

93.04

93.05

95.00

201. 00 202. 00

0

1, 658, 153 200. 00

0

6, 375, 913

6, 375, 913

0.000000

86. 861165

93.04

93.05

200.00

201.00 202.00

04956 RI C

04950 PODI ATRY

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

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

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

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150064	Peri od: From 10/01/2014	Worksheet D-3	
	Component	CCN: 15S064	To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
	Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
11.00 03100 INTENSIVE CARE UNIT			0		31.
0. 00 04000 SUBPROVI DER - I PF			2, 454, 522		40.
1. 00 04100 SUBPROVI DER - RF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				İ	43.
0.00 05000 OPERATING ROOM		0. 28298	36 27	8	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		o 0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21255		12, 137	
7. 00 05700 CT SCAN		0. 00000			1
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		1	1
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000			
0. 00 06000 LABORATORY		0. 17316		29, 028	
0. 01 06001 BLOOD LABORATORY		0. 00000	00	0	60.
5. 00 06500 RESPI RATORY THERAPY		0. 26165	2, 932	767	65.
6. 00 06600 PHYSI CAL THERAPY		0. 62909	28, 151	17, 710	66.
9. 01 06901 CARDI AC REHAB		1. 03744	14 0	0	69
1.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45218		1, 040	
2.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 55672		0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 38122		162, 008	
4. 00 07400 RENAL DI ALYSI S		0.00000	00 0	0	74.
OUTPATIENT SERVICE COST CENTERS B. 00 08800 RURAL HEALTH CLINIC		0,00000	20	0	88
9. 00 08900 RURAL HEALTH CLINIC 9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000 0. 00000		0	
1. 00 09100 EMERGENCY		0. 17962		-	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 77228		0	
3. 00 04040 CLINIC		1. 45404		-	
3. 01 04954 BI C		0. 82083		3	1
3. 02 04953 UCI C		0. 00000			
3. 03 04955 CI C		0. 00000			
3. 04 04956 RI C		0.00000		0	93.
3. 05 04950 PODI ATRY		86. 86116	5 0	0	93.
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50-94 and 96-98)			746, 599	234, 124	
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
02.00 Net Charges (line 200 minus line 201)			746, 599	1	202

Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS	ponent CCN: 15T064	To 00 /20 /2045	1	
INPATIENT ROUTINE SERVICE COST CENTERS		To 09/30/2015	Date/Time Prep 2/25/2016 2:2	
INPATIENT ROUTINE SERVICE COST CENTERS	Title XVIII	Subprovi der - I RF	PPS	
0. 00	Ratio of Cos	t Inpatient	Inpati ent	
0. 00	To Charges	Program	Program Costs (col. 1 x col.	
0. 00		Charges	2)	
0. 00	1.00	2. 00	3. 00	
1. 00	<u>'</u>			
0. 00		0		30.
1. 00		0		31.
2. 00		0		40.
3. 00		126, 813		41.
ANCILLARY SERVICE COST CENTERS 0. 00		0		42.
0.00				43.
2. 00	0. 2829	86 18	5	50.
4. 00	0. 00000			
7. 00 05700 CT SCAN 8. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 06000 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06000 060	0. 2125		-	
8. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY 0. 01 06001 BLOOD LABORATORY 5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	0. 00000			
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY 0. 01 06001 BLOOD LABORATORY 5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	0. 00000			1
0. 01 06001 BLOOD LABORATORY 5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	0.0000		0	59
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	0. 1731	63 7, 930	1, 373	60
6. 00 06600 PHYSI CAL THERAPY	0.0000	oc oc	0	60.
	0. 2616	58 416	109	65
	0. 6290		53, 675	
9. 01 06901 CARDI AC REHAB	1. 0374		0	
1.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 45218			
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 5567:		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 3812			
4. 00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0.0000	00 0	0	74.
8.00 08800 RURAL HEALTH CLINIC	0.0000	20	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000			
1. 00 09100 EMERGENCY	0. 1796		- 1	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 72228			
3. 00 04040 CLI NI C	1. 4540			
3. 01 04954 BI C	0. 8208		0	93
3. 02 04953 UCI C	0.0000		0	93
3. 03 04955 CI C	0. 00000	00 0	0	93
3. 04 04956 RI C	0. 00000	00 0	0	93.
3. 05 04950 PODI ATRY	86. 8611	65 0	0	93.
OTHER REIMBURSABLE COST CENTERS				4
5. 00 09500 AMBULANCE SERVICES				95.
00.00 Total (sum of lines 50-94 and 96-98)	(4)	118, 507		
01.00 Less PBP Clinic Laboratory Services-Program only charges (line 02.00 Net Charges (line 200 minus line 201)	9 61)	0 118, 507		201 202

Heal th	Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
		Component		From 10/01/2014		nanad.
		Component	CCN: 15U064	To 09/30/2015	Date/Time Pre 2/25/2016 2: 2	
		Ti tl	e XVIII S	Swing Beds - SNF		<u> </u>
	Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			13		31. 00
40.00	04000 SUBPROVI DER - I PF			0		40. 00
41.00	04100 SUBPROVI DER - I RF			2		41.00
42.00	04200 SUBPROVI DER			0		42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 28298	6 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 00000	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 21255	1, 603	341	54.00
57.00	05700 CT SCAN		0. 000000	0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000	0	0	58. 00

0.000000

0.173163

0.000000

0.261658

0.629096

1.037444

0.452188

0.556726

0.381226

0.000000

0.000000

0.000000

0.179628

0.722283

1.431816

0.817910

0.000000

0.000000

0.000000

86.861165

2, 353

181

28, 153

1, 822

12, 794

0

46, 909

46, 909

0 59.00

0 60.01

47

0 69.01

0

0

0 88.00

0 89.00

0 92.00

0 93.00

0 93.02

0 93.03

0 93.04

24, 208 200. 00

824

4,877

17, 711

60.00

65.00

66.00

71.00

72.00

73.00

74.00

91.00

93.01

93.05

95.00

201.00

202. 00

407

05900 CARDI AC CATHETERI ZATI ON

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 I MPL. DEV. CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

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)

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

06000 LABORATORY

06001 BLOOD LABORATORY

06600 PHYSI CAL THERAPY

06901 CARDI AC REHAB

07400 RENAL DIALYSIS

09100 EMERGENCY

04040 CLI NI C

04954 BI C

04955 CI C

04956 RI C

04950 PODI ATRY

95. 00 09500 AMBULANCE SERVICES

04953 UCI C

08800 RURAL HEALTH CLINIC

06500 RESPIRATORY THERAPY

59.00

60.00

60.01

65 00

66.00

69. 01

71.00

72.00

73.00

74.00

88.00

89.00

91.00

92 00

93.00

93. 01

93.02

93.03

93.04

93.05

200.00

201.00

202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150064	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Pre 2/25/2016 2:2	pared:
	Ti t	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			7/ 475		
30. 00 03000 ADULTS & PEDI ATRI CS			76, 175		30.0
31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF			15, 475 0		31. 0 40. 0
41. 00 04100 SUBPROVI DER - 1 PF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY			44, 322		43. 0
ANCI LLARY SERVI CE COST CENTERS			11,022		10.0
50. 00 05000 OPERATING ROOM		0. 28298	7, 396	2, 093	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21255	8 14, 748	3, 135	54.0
57. 00 05700 CT SCAN		0.00000	0 0	0	57.0
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000	0 0	0	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59. 0
60. 00 06000 LABORATORY		0. 17316		4, 839	
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. C
65. 00 06500 RESPI RATORY THERAPY		0. 26165		1, 042	
66. 00 06600 PHYSI CAL THERAPY		0. 62909		105	
69. 01 06901 CARDI AC REHAB		1. 03744		0	69. 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45218		2, 898	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 55672		0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38122		9, 241	
74. 00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS		0.00000	0 0	0	74.0
88. 00 08800 RURAL HEALTH CLINIC		0. 00000	0	0	88. 0
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89.0
91. 00 09100 EMERGENCY		0. 17962		2, 248	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		0. 72228		2, 240	1
93. 00 04040 CLINIC		1. 43181		0	93. 0
93. 01 04954 BI C		0. 81791		0	93. 0
93. 02 04953 UCI C		0. 00000		0	93. 0
93. 03 04955 CI C		0. 00000		0	93. 0
93. 04 04956 RI C		0. 00000		0	93. 0
93 05 04950 PODLATRY		86 86116		0	1

25, 601 200. 00 201. 00 202. 00

93.05

95.00

86. 861165

97, 398

97, 398

93.05

200.00

201.00 202.00

04950 PODI ATRY

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

PATIENT ANCILLARY SERVICE COST APPORTIONN	ENT Provi der	- CCN: 150064	Peri od:	Worksheet D-3	
	Componer	nt CCN: 15S064	From 10/01/2014 To 09/30/2015	Date/Time Pre 2/25/2016 2:2	pare 5 pm
	Ti	tle XIX	Subprovi der – I PF		
Cost Center Description	·	Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTE	ς	1.00	2.00	3.00	
. 00 03000 ADULTS & PEDIATRICS	5	T	0		30.
. 00 03100 INTENSIVE CARE UNIT			0		31.
. 00 04000 SUBPROVIDER - IPF			74, 734		40
.00 04100 SUBPROVI DER - I RF			0		41
. 00 04200 SUBPROVI DER			0		42
. 00 04300 NURSERY			0		43
ANCILLARY SERVICE COST CENTERS		•	<u> </u>		
. OO O5000 OPERATING ROOM		0.0000	00 4, 065	0	50
.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52
00 05400 RADI OLOGY-DI AGNOSTI C		0.0000	00 8, 106	0	54
00 05700 CT SCAN		0.0000	00 0	0	57
00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
00 06000 LABORATORY		0.0000			
01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06500 RESPIRATORY THERAPY		0.0000	·		
. 00 06600 PHYSI CAL THERAPY		0.0000		0	
.01 06901 CARDIAC REHAB .00 07100 MEDICAL SUPPLIES CHARGED TO PAT	LENTS	0. 0000 0. 0000		0 0	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATENTS	I EN I 3	0.0000		0	1
.00 07200 TWIE. DEV. CHARGED TO PATIENTS		0.0000		_	1
00 07400 RENAL DIALYSIS		0.0000			
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0		1 '
. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	1 88
00 08900 FEDERALLY QUALIFIED HEALTH CENT	ER	0.0000	00 0	0	89
00 09100 EMERGENCY		0.0000	00 6, 877	0	91
00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)	0.0000	00 0	0	92
. 00 04040 CLI NI C		0.0000			
. 01 04954 BI C		0.0000		0	
02 04953 UCI C		0.0000		0	
03 04955 CI C		0.0000		_	
. 04 04956 RI C		0.0000			
. 05 04950 PODI ATRY		0.0000	00 0	0	93
OTHER REIMBURSABLE COST CENTERS					١.,
00 09500 AMBULANCE SERVICES	(00)		E2 E22	_	95
7.00 Total (sum of lines 50-94 and 9			53, 532	0	200
1.00 Less PBP Clinic Laboratory Serv 2.00 Net Charges (line 200 minus lir	ces-Program only charges (line 61)		53, 532		201

Heal th	n Financial Systems	FAYETTE REGIONAL HEALTH	SYSTEM		In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Pr	ovi der	CCN: 150064	Peri od:	Worksheet D-3	
		Co	mponent	CCN: 15U064	From 10/01/2014 To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
			Ti t	le XIX	Swing Beds - SNF		o piii
	Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
				1.00	2. 00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00					0		30. 00
	03100 I NTENSI VE CARE UNI T				0		31. 00
40. 00	1 1				0		40.00
41.00	04100 SUBPROVI DER - I RF				0		41. 00
42.00	04200 SUBPROVI DER				0		42. 00
43.00					0		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00				0. 2829		-	50. 00
52. 00				0.0000		1	52. 00
54. 00				0. 2125		1	54.00
57. 00				0.0000		1	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)			0.0000		1	58. 00
59.00				0.0000		1	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY			0. 1731		0	60.00
65. 00				0. 0000 0. 2616		1	60. 01 65. 00
66. 00				0. 2010			66.00
	06901 CARDI AC REHAB			1. 0374		1	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 4521			71. 00
72. 00				0. 5567			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			0. 3812		1	73.00
74. 00	1 1			0.0000		1	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC			0.0000	00 00	0	88. 00
89. 00				0.0000	00	0	89. 00
91.00	09100 EMERGENCY			0. 1796	28 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 7222	33 0	0	92. 00
93.00	04040 CLI NI C			1. 4318	16 0	0	93. 00
93. 01	04954 BI C			0. 8179	10 0	0	93. 01
	04953 UCI C			0.0000	00	0	93. 02
93. 03				0.0000		0	93. 03
93. 04				0.0000		1	93. 04
93. 05	04950 PODI ATRY			86. 8611	65 0	0	93. 05

95.00

0 200. 00 201. 00 202. 00

0

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

200.00

201.00 202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 10/01/2014 To 09/30/2015		
		Ti +I	e XVIII	Hospi tal	2/25/2016 2: 2 PPS	5 pm
		11 (1	before 1/1	on/after 1/1	113	
		0	1.00	1. 01	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			ol		1.00
1. 00	DRG amounts other than outlier payments for discharges			0		1.00
	occurring prior to October 1 (see instructions)					
1. 02	DRG amounts other than outlier payments for discharges		2, 961, 71	7		1. 02
1. 03	occurring on or after October 1 (see instructions) DRG for federal specific operating payment for Model 4			o		1. 03
	BPCI for discharges occurring prior to October 1 (see					
1 04	instructions)					1.04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see			O .		1. 04
	instructions)					
2.00	Outlier payments for discharges. (see instructions)		9, 74			2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see			0		2. 01 2. 02
2.02	instructions)					2.02
3.00	Managed Care Simulated Payments			0		3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)		46. 9	8		4. 00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the		0.0	0		5. 00
	most recent cost reporting period ending on or before					
6. 00	12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which		0.0	0		6. 00
	meet the criteria for an add-on to the cap for new					
7.00	programs in accordance with 42 CFR 413.79(e)					7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0	U		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	О		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for		0.0	0		8. 00
0.00	allopathic and osteopathic programs for affiliated		0.0			0.00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap		0.0	0		8. 01
	slots under section 5503 of the ACA. If the cost report					
8. 02	straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap		0.0	0		8. 02
0.02	slots from a closed teaching hospital under section 5506		0.0			0.02
	of ACA. (see instructions)					
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.0	0		9. 00
10.00			0.0	0		10.00
	current year from your records					
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		0. 0 0. 0			11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.		0. 0			13. 00
14. 00	Total allowable FTE count for the penultimate year if that		0.0			14. 00
	year ended on or after September 30, 1997, otherwise enter					
15. 00	zero. Sum of lines 12 through 14 divided by 3.		0.0	0		15. 00
16. 00	Adjustment for residents in initial years of the program		0.0			16. 00
17. 00	Adjustment for residents displaced by program or hospital		0.0	0		17. 00
18. 00	closure Adjusted rolling average FTE count		0.0	0		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 00000			19. 00
	line 4).					
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0. 00000 0. 00000			20.00
22. 00	IME payment adjustment (see instructions)		i	Ö		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
22.00	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of t		ما		1 22 00
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.0	0		23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.0	0		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0	0		25. 00
26. 00	the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)		0. 00000	0		26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 00000			27. 00
	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see			0		28. 01
29. 00	instructions) Total IME payment (sum of lines 22 and 28)			0		29. 00
	1 113 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ı	Ü	•	

	by SCH and MDH, small rural hospitals						
	only. (see instructions)						
49. 00	Total payment for inpatient operating costs (see instructions)	3, 366, 7	72		49. 00		
50.00	Payment for inpatient program capital (from	232, 9	93		50. 00		
51 00	Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program		0		51. 00		
31.00	capital (Wkst. L, Pt. III, see instructions)				31.00		
52. 00	Direct graduate medical education payment		0		52. 00		
53 00	(from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care		0		53. 00		
33.00	payment				33.00		
54.00	Special add-on payments for new technologies		0		54.00		
55.00	Net organ acquisition cost (Wkst. D-4 Pt.		0		55. 00		
	III, col. 1, line 69)						
56. 00	Cost of physicians' services in a teaching		0		56. 00		
	hospital (see intructions)						
57. 00	Routine service other pass through costs		0		57. 00		
	(from Wkst. D, Pt. III, column 9, lines 30 through 35).						
58. 00	Ancillary service other pass through costs				58. 00		
36.00	from Wkst. D, Pt. IV, col. 11 line 200)		o o		36.00		
59. 00	Total (sum of amounts on lines 49 through	3, 599, 70	5		59. 00		
	58)						
60.00	Primary payer payments		0		60.00		
61.00		3, 599, 70	5		61. 00		
	beneficiaries (line 59 minus line 60)						
62. 00	Deductibles billed to program beneficiaries	493, 4	6		62. 00		
MCRI F32 - 8. 5. 158. 0							

near th Thancial Systems	TATETTE REGIONAL HEALTH STSTEM		III LI C	u 01 101111 01113-2332-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	150064	Peri od: From 10/01/2014	
			10 09/30/2015	Date/Time Prepared: 2/25/2016 2:25 pm

				10	0 09/30/2013	2/25/2016 2: 2	
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
				Prior to	·	On/After	
				October 1		October 1	
		0		1. 00	1. 01	2. 00	
63.00	Coinsurance billed to program beneficiaries			4, 018			63. 00
64. 00	Allowable bad debts (see instructions)			46, 589			64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)			30, 283			65. 00
66. 00	Allowable bad debts for dual eligible			9, 731			66. 00
00.00	beneficiaries (see instructions)			7, 731			00.00
67.00	Subtotal (line 61 plus line 65 minus lines			3, 132, 614			67. 00
	62 and 63)						
68. 00	Credits received from manufacturers for			0			68. 00
	replaced devices for applicable to MS-DRGs						
(0.00	(see instructions) Outlier payments reconciliation (sum of			0			(0.00
69. 00	lines 93, 95 and 96). (For SCH see			U			69. 00
	instructions)						
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70.00
	(SPECI FY)						
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 89	Pioneer ACO demonstration payment adjustment			0			70. 89
70.00	amount (see instructions)			0			70.00
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			U			70. 90
70. 91	HSP bonus payment HRR adjustment amount (see			0			70. 91
70.71	instructions)			Ü			' ' ' '
70. 92	Bundled Model 1 discount amount (see			0			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			-372			70. 93
70.04	instructions)			40.050			70.04
70. 94	HRR adjustment amount (see instructions)			-10, 958			70. 94 70. 95
70. 95 70. 96	Recovery of accelerated depreciation Low volume adjustment for federal fiscal		0	0			70. 95
70. 70	year (yyyy) (Enter in column 0 the		Ü	O			70.70
	corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal		2015	477, 613			70. 97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
70. 98	ending on or after 10/1) Low Volume Payment-3			0			70. 98
70. 70	HAC adjustment amount (see instructions)			0			70. 99
71. 00	Amount due provider (line 67 minus lines 68			3, 598, 897			71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			71, 978			71. 01
72. 00	Interim payments			3, 532, 233			72. 00
73. 00	Tentative settlement (for contractor use			0			73. 00
74. 00	only) Balance due provider (Program) (line 71			-5, 314			74. 00
74.00	minus lines 71.01, 72, and 73)			-5, 514			74.00
75. 00	Protested amounts (nonallowable cost report			548, 951			75. 00
	items) in accordance with CMS Pub. 15-2,						
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	igh 96)		_			
90. 00	Operating outlier amount from Wkst. E, Pt.			0			90. 00
91. 00	A, line 2 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2			0			91. 00
92. 00	Operating outlier reconciliation adjustment			0			92. 00
, 00	amount (see instructions)						1 00
93.00	Capital outlier reconciliation adjustment			0			93. 00
	amount (see instructions)						
94. 00	The rate used to calculate the time value of			0. 00			94. 00
05.00	money (see instructions)						05.00
95. 00	Time value of money for operating expenses (see instructions)			0			95. 00
96. 00	Time value of money for capital related			0			96. 00
, 0. 00	expenses (see instructions)						
					'		-

Health Financial Systems FAY	ETTE REGIONAL HEALTH	SYSTEM		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovi der (Period: From 10/01/2014 To 09/30/2015		
		Ti tl ∈	e XVIII	Hospi tal	PPS	
			Prior to 10/	1	On/After 10/1	
			1. 00	1. 01	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)					0	100.00
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions)					0	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)				0	102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)					0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (s	see instructions)	İ			0	104. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150064

M/S E, Part A Amounts (from Pro/Post Pro/Post Pro/100 Pro/100 Total (Go) 2 1 10 E Part A) Pro/Post Pro/100 Pro/Post Pro/100 Pro/Post Pro/Pos					Ti †l	e XVIII	Hospi tal	2/25/2016 2: 2 PPS	5 pm
1.00 BRG amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0			W/S E, Part A	Amounts (from			Peri od	Total (Col 2	
1.00 DRC amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
payments	1 00	DRG amounts other than outlier			2.00	3.00	4.00	5.00	1, 00
payments for discharges		payments				_		_	
1.02 December 1 December 2 December 3 December	1. 01		1. 01	0	0	0	0	0	1. 01
Description Description									
1.03 DRC for Federal specific	1. 02		1. 02	2, 961, 717	0	0	2, 961, 717	2, 961, 717	1. 02
1									
Operating payment for Model 4 BPCI occurring prior to October 1 1.04		1							
BPCI occurring prior to October 1	1. 03		1. 03	0	0	0	0	0	1. 03
October 1 1.04 0 0 0 0 0 0 0 0 0									
Operating payment for Model 4 BPCI occurring on or after October 1 Oct		October 1							
BRCI	1. 04		1. 04	0	0	0	0	0	1. 04
2.00									
discharges (see instructions) 2.02	2.00	4	2.00	0.747	0	0	0.747	0.747	2 00
2.01 Outlier payments for discharges for Model 4 BPCl Outlier payments Outlier	2.00		2.00	9, 747	U	0	9, 747	9,747	2. 00
3.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
Pecconcilitation Anomaged care simulated 3.00 0 0 0 0 0 0 0 0 0	3 00		2 01	0	0	0	0	0	3.00
payments	3.00	reconciliation	2.01		J	0	0		
Indirect Medical Education Adjustment	4. 00		3. 00	0	0	0	0	0	4. 00
5.00 Amount from Worksheet E, Part 21.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1 7	L ustment						
6.00 IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions) Imigration IME payment adjustment for the Add-on for Section 422 of the MMA IME payment adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see instructions) IME payment adjustment (see 28.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	5.00	Amount from Worksheet E, Part		0. 000000	0. 000000	0. 000000	0. 000000		5. 00
Instructions Compared adjustment for Compared adjustment for Compared adjustment for Compared adjustment for Compared adjustment for Compared adjustment for Compared adjustment for Compared adjustment factor Compared adjustment (See Compared adjustment (See Compared adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment adjustment (Sum of Compared adjustment adjustment (Sum of Compared adjustment Compared adjust	6 00		22.00	0	0	0	0	0	6. 00
managed care (see Instructions)	0.00		22.00	0	J	0	0	0	0.00
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6. 01		22. 01	0	0	0	0	0	6. 01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
(see instructions) IME adjustment (see 28.00 0 0 0 0 0 0 0 0 0		Indirect Medical Education Adju							
8.00 IME adjustment (see	7. 00		27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.01 IME payment adjustment add on for managed care (see instructions) 9.00 Total IME payment (sum of I see instructions) 9.01 Total IME payment for managed care (sum of I ines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 All owable disproportionate share instructions) 11.00 Disproportionate share adjustment 10.00 All owable disproportionate share adjustment 11.00 Disproportionate share adjustment 12.00 Disproportionate share adjustment add on 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00		28. 00	0	0	0	0	0	8. 00
For managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0									
Instructions	8. 01		28. 01	0	0	0	0	0	8. 01
1									
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 All lowable disproportionate share as 33.00 0.1200 0.1200 0.1200 0.1200 0.1200 share percentage (see instructions) 11.00 Disproportionate share as 34.00 88,852 0 0 88,852 88,85 adjustment (see instructions) 11.01 Uncompensated care payments 36.00 306,456 0 0 0 306,456 306,45 additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 47.00 3,366,772 0 0 0 3,366,772 3,366,77 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 3,366,772 0 0 3,366,772 3,366,77 (operating costs (see instructions) 70.00 232,993 0 0 232,993 232,99	9. 00		29. 00	0	0	0	0	0	9. 00
8.01 Disproportionate Share Adjustment	9. 01		29. 01	0	0	0	0	0	9. 01
Disproportionate Share Adjustment									
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments 36.00 306, 456 0 0 306, 456 306, 456 12.00 Total ESRD additional payment for high percentage of ESRD beneficiary discharges 12.00 Subtotal (see instructions) 13.00 Subtotal (see instructions) 47.00 3, 366, 772 0 0 0 3, 366, 772 3, 366, 772 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 3, 366, 772 0 0 3, 366, 772 3, 366, 772 (see instructions) 15.00 Total payment for inpatient 49.00 3, 366, 772 0 0 3, 366, 772 3, 366, 772 (see instructions)			ent						
11.00 Disproportionate share 34.00 88,852 0 0 88,852 88,853 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855 88,855	10.00			0. 1200	0. 1200	0. 1200	0. 1200		10.00
11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient deciral discharges 15.00 Payment for inpatient program 50.00 232,993 16.00 Payment for inpatient program 50.00 232,993 36.00 306,456 0 0 0 306,456 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3,366,772 0 0 3,366,772 3,366,772 0 0 232,993 0 0 232,993 0 0 232,993									
adjustment (see instructions) Uncompensated care payments 36.00 306,456 0 0 306,456 306,45	11. 00		34.00	88, 852	0	0	88, 852	88, 852	11. 00
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment		adjustment (see instructions)			_	_			
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 46.00 0 0 0 0 0 0 3, 366, 772 3, 366, 772 0 0 0 3, 366, 772 3, 366, 772 0 0 0 3, 366, 772 0 0 0 3, 366, 772 0 0 0 3, 366, 772 0 0 0 3, 366, 772 0 0 0 3, 366, 772 0 0 0 3, 366, 772 0 0 0 232, 993 232, 993	11. 01					0	306, 456	306, 456	11.01
13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 47.00 3, 366, 772 0 0 0 3, 366, 772 48.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00			0		0	0	0	12. 00
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,99	12 00		47.00	2 244 772	0	0	2 244 772	2 244 772	12 00
(completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,993				3, 300, 772	-	0	3, 300, 772	3, 300, 772	1
(see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,993									
15.00 Total payment for inpatient 49.00 3,366,772 0 0 3,366,772 3,366,772 operating costs (see instructions) 16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,993									
instructions) 16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,99	15. 00		49. 00	3, 366, 772	0	0	3, 366, 772	3, 366, 772	15. 00
16.00 Payment for inpatient program 50.00 232,993 0 0 232,993 232,99									
	16. 00		50.00	232, 993	0	0	232, 993	232, 993	16. 00
		capi tal							
17.00 Special add-on payments for 54.00 0 0 0 0 0 0 new technologies	17. 00		54.00	0	0	0	0	0	17. 00
17. 01 Net organ aquisition cost 55.00 0 0 0	17. 01		55. 00	0	0	0	0	0	17. 01
17.02 Credits received from 68.00 0 0 0		Credits received from	68. 00	0	0	0	0	0	17. 02
manufacturers for replaced devices for applicable MS-DRGs									
18.00 Capital outlier reconciliation 93.00 0 0 0	18. 00	Capital outlier reconciliation		О	0	0	О	0	18. 00
adjustment amount (see		,							
instructions)		THISTI UCTI OHS)	I	l l			l l	I	l

Health Financial Systems	FAYETTE REGIONAL HEALTH SYS	FAYETTE REGIONAL HEALTH SYSTEM		
LOW VOLUME CALCULATION EXHIBIT 4	Provi d	er CCN: 150064		Worksheet E Part A Exhibit 4

09/30/2015 Date/Time Prepared: To 2/25/2016 2:25 pm Title XVIII Hospi tal PPS W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Ε, Entitlement through 4) 4 00 0 1.00 2 00 3.00 5 00 19.00 SUBTOTAL 3, 599, 765 3, 599, 765 19. 00 W/S L, line (Amounts from L) 2.00 3. 00 4.00 5.00 0 1.00 20.00 Capital DRG other than outlier 232, 993 232, 993 232, 993 20.00 1 00 0 0 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 0 0 ol 21. 01 2.01 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 6.00 23.00 23.00 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 0.0000 24.00 10.00 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 232, 993 0 232, 993 232, 993 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0.000000 0. 132679 27. 00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 477, 613 477, 613 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Provider CCN: 150064

Peri od:

O

3 599 765

3, 599, 765 19. 00

Worksheet E

From 10/01/2014 Part A Exhibit 5 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 4. 00 2.00 3. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 961, 717 2, 961, 717 2, 961, 717 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 9,747 0 9,747 9,747 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 0 2.01 0 Operating outlier reconciliation 3 00 2 01 O 0 Ω 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) 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 29.01 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.1200 0.1200 0.1200 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 88.852 0 88.852 88.852 11.00 instructions) 11.01 Uncompensated care payments 36.00 306, 456 0 306, 456 306, 456 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see n 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 3, 366, 772 0 3, 366, 772 3, 366, 772 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 0 15.00 49.00 3, 366, 772 3, 366, 772 3, 366, 772 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 232, 993 232, 993 232, 993 16.00 Special add-on payments for new technologies 17.00 54.00 0 17.00 Net organ aquisition cost 55.00 0 17.01 17.01 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 0 18.00 amount (see instructions)

SUBTOTAL

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet E Part A Exhibi Date/Time Pre 2/25/2016 2:2	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	232, 993	3	0 232, 993	232, 993	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	(0	0	20. 01
21.00 Capital DRG outlier payments	2.00	(0 0	0	21. 00

		11 (1	CVALLE	nospi tai	113	
	Wkst. L, line					
		Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	232, 993	0	232, 993	232, 993	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00 Capital DRG outlier payments	2.00	0	0	0	0	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0. 0000	0. 0000		24. 00
25.00 Di sproporti onate share adjustment (see	11. 00	0	0	0	0	25. 00
instructions) 26.00 Total prospective capital payments (see instructions)	12. 00	232, 993	0	232, 993	232, 993	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	477, 613		477, 613	477, 613	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	-372	0	-372	-372	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-10, 958	0	-10, 958	-10, 958	31. 00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	Ö	0	0	31. 01
That detrois)					(Amt. to Wkst.	
		1.00	0.00	0.00	E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	00.07
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	FAYETTE REGIONAL HEALT	TH SYSTEM	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/25/2016 2:25 pm
		T1 11 \0.0111		BBC

			10 09/30/2015	2/25/2016 2:2	
		Title XVIII	Hospi tal	PPS	э рш
			1100pt tui		
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9, 945	1
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		6, 898, 162	
3. 00	PPS payments			4, 933, 106	1
4.00	Outlier payment (see instructions)			18, 601	1
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	1
6. 00	Line 2 times line 5			0	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	
10.00	Organ acquisitions			0 045	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 945	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				+
12 00	Reasonable charges			24 007	12 00
12. 00 13. 00	Ancillary service charges	0. 40)		26, 087 0	
14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	le 09)		26, 087	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			20, 007	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for				
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		ii a chargebasis	١	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18. 00	Total customary charges (see instructions)			26, 087	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	16, 142	•
. ,	instructions)	The second of th	, (555	.5,2	.,
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	ol	20.00
	instructions)		, ,		
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		9, 945	21.0
22. 00	Interns and residents (see instructions)			0	22. 0
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 0
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			4, 951, 707	24.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			1, 117, 227	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	3, 844, 425	27. 0
	instructions)			_	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			3, 844, 425	
31. 00	Primary payer payments			524	
32. 00	Subtotal (line 30 minus line 31)	C)		3, 843, 901	32.0
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)			22.0
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			232, 552	
35. 00	Adjusted reimbursable bad debts (see instructions)	ations)		151, 159	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	Ctrons)		137, 307	•
37. 00				3, 995, 060	
	MSP-LCC reconciliation amount from PS&R			1	38.0
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	a devices (see instruc	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			3, 995, 164	
40. 01	Sequestration adjustment (see instructions)			79, 903	
41. 00	Interim payments			3, 871, 735	1
42.00	,			0	1
43. 00	, , , ,			43, 526	1
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44.0
44. 00				1	
44. 00	§115. 2				
	§115. 2 TO BE COMPLETED BY CONTRACTOR			_	00 -
90. 00	\$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	1
90. 00 91. 00	\$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.0
90. 00 91. 00 92. 00	\$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 0 92. 0
90. 00 91. 00 92. 00 93. 00	\$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0 0.00 0	91. 0 92. 0

Health Financial Systems FAYETT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150064

					2/25/2016 2: 25	5 pm
			tle XVIII	Hospi tal	PPS	
		Inpati	ent Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 368, 3	26	3, 765, 149	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					0.00
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	l				
3. 01	ADJUSTMENTS TO PROVIDER	09/30/2015	112, 9	07 09/30/2015	106, 586	3. 01
3. 02		04/09/2015	51, 0		0	3. 02
3.03				0	o	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54	Cultural (1/2 0	0	10/ 50/	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		163, 9	07	106, 586	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 532, 2	33	3, 871, 735	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		0,002,2		0,071,700	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		•	<u> </u>		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	Т				
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02 5. 03				0		5. 02
5.03	Provider to Program			U		5.03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				o	l ől	5. 51
5. 52				Ö	Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	O	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					_
6. 01	SETTLEMENT TO PROVIDER			0	43, 526	6. 01
6.02	SETTLEMENT TO PROGRAM		5, 3		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 526, 9		3, 915, 261	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor		-	00	2.00	8. 00
00	1	1		1		

Inpatient Part A			11111	e XVIII	Subprovider - IPF	PPS	
1.00			Innatien	t Part A		 rt B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mpatron		Tui		
1.00							
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or neter a zero.			1. 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						_	
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero.	2.00			0		0	2.00
write "NONE" or enter a zero .0 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider .0 0 0 3.02 .03 .03 0 0 0 3.03 .04 0 0 0 3.03 .05 0 0 0 3.05 Provider to Program							
3.00 State separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		1 91					
amount based on subsequent revision of the interin 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 3.02 3.03 3.04 3.05 Provider to Program 3.51 3.52 ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO ADJUSTMENTS TO	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02					T	T	
3.03 0		ADJUSTMENTS TO PROVIDER					
3. 04 0 0 0 3. 04 3. 05							
ADJUSTMENTS TO PROGRAM							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
ADJUSTMENTS TO PROGRAM	3.03	Provider to Program				0	3.03
3.52 3.53 3.54 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50	3.50			0		0	3. 50
3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.54 3.54 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 0 0 0 3.59 0 0 0 0 3.59 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.51			0		0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.90 Total interim payments (sum of lines 1, 2, and 3.99) 1,381,310 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor New New New New New New New New New New	3.53			0			3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)							
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) 1,381,310 0 4.00	3. 99	· ·		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			1 201 210			4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1, 381, 310		0	4.00
TO BE COMPLETED BY CONTRACTOR Solution							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					II.	L	
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
Solution Solution					1		
Solution Solution		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.03	Provider to Program				0	3.03
5.51 0	5.50			0		0	5.50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 14, 072 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 395, 382 0 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				0		0	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 14,072 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 1,395,382 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 14, 072 0 6. 01 0 6. 02 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 14, 072 0 6. 01 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 395, 382 0 7. 00 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6. 00	,					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			14 070			6.01
7.00 Total Medicare program liability (see instructions) 1,395,382 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							1
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				·		_	
Number (Mo/Day/Yr) 0 1.00 2.00		(((((((((((((((((((., 0,0,302			1.00
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8.00

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		157, 188		0	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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		C		0	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3.04			C		0	3. 04
3. 05	Describes to Describe		C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 50	ADJUSTIMENTS TO FROGRAM		0			3. 51
3. 52			O			3. 52
3. 53			Ö		l o	3. 53
3. 54			Ö		l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		157, 188		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5.03			C		0	5. 03
	Provi der to Program			1		
5.50	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 51 5. 52			0			5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
5. 77	5. 50-5. 98)				o o	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		6, 891		0	6. 02
7.00	Total Medicare program liability (see instructions)		150, 297		0	7. 00
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	()	1.00	2.00	8. 00
5. 50	Thams of contradiction			I .	1	0.00

Health Financial Systems FAYETT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					2/25/2016 2: 2	5 pm
				wing Beds - SNF		
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		19, 515		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3.01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	
3.05			0		0	3. 05
	Provider to Program		_	ı	1	
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3.51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0 0	
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 99	3. 50-3. 98)		0			3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		19, 515		0	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		17,010			1.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			T	T	
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		T 0	5. 50
5. 51	TENTATIVE TO PROGRAW					
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	
0. ,,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		1		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		19, 516		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	None of Contractors	()	1. 00	2. 00	0.00
	Name of Contractor			1	1	8.00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of F						
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150064 Period: From 10/01/2014 To 09/30/2015 Period: From 10/01/2015 Period: From 10/01/2014 Period:					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1, 067	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		1, 650	2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			150	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		3, 115	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			97, 552, 128	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			2, 256, 869	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			295, 750	8. 00	
9.00						
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 289,83					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	00 Palance due provider (line 0 (or line 10) minus line 30 and line 31) (occ instructions)					

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

0 30.00 0 31.00 289,835 32.00

Health Financial Systems	FAYETTE REGIONAL HEAI	LTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 150064		Worksheet E-2
		Component CCN: 15U064	From 10/01/2014 To 09/30/2015	
		·		2/25/2016 2:25 pm
		Ti +1 o V/// / /	Swing Rode SNE	DDC

		Component Con. 150064	10 04/30/2013	2/25/2016 2: 2	5 pm
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		19, 914	0	1
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A				3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr				
4.00	Per diem cost for interns and residents not in approved teaching	g program (see		0. 00	4. 00
	instructions)				
5.00	Program days		52	0	5. 00
6.00	Interns and residents not in approved teaching program (see inst			0	0.00
7.00	Utilization review - physician compensation - SNF optional metho	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		19, 914	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		19, 914	0	
11. 00	Deductibles billed to program patients (exclude amounts application professional services)	ole to physician	0	0	11. 00
12 00	Subtotal (line 10 minus line 11)		19, 914	0	12. 00
	Coinsurance billed to program patients (from provider records) (avaluda sai neuranca	19, 914	0	
13.00	for physician professional services)	excrude corrisurance	٩	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		19, 914	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		17, 711	0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	
	410A RURAL DEMONSTRATION PROJECT		0	ŭ	16. 55
			o o	0	
	Adjusted reimbursable bad debts (see instructions)		o	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	o	0	
19. 00	Total (see instructions)	,	19, 914	0	•
19. 01	Sequestration adjustment (see instructions)		398	0	
20. 00	Interim payments		19, 515	0	20.00
21. 00	Tentative settlement (for contractor use only)		o	0	
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	1 21)	1	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance		o	0	23. 00
	chapter 1, §115.2	•			

Health Financial Systems	FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 150064	Peri od: From 10/01/2014	Worksheet E-2
		Component CCN: 15U064		
		Title XIX	Swing Beds - SNF	PPS

				2/25/2016 2::	25 pm
		Title XIX	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		0		3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching p	orogram (see	0.00		4.00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instru		0		6.00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9.00	Primary payer payments (see instructions)		0		9. 00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0		11.00
	professional services)				
	Subtotal (line 10 minus line 11)		0		12. 00
13. 00	Coinsurance billed to program patients (from provider records) (ex for physician professional services)	cl ude coi nsurance	0		13. 00
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0		16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
17.00	Allowable bad debts (see instructions)		0		17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0		17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0		18. 00
19. 00	Total (see instructions)		0		19. 00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
20. 00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		0		22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance v	vith CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2				

Health Financial Systems	FAYETTE REGIONAL HEAL	_TH SYSTEM	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/25/2016 2:25 pm
		T: +1 - V/// 1 1	11	DDC

				2/25/2016 2: 25	5 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PA	DT A SEDVICES COST	DELMDLIDSEMENT	1. 00	
1. 00	Inpatient services	INT A SERVICES - COST	KLIWDUKSLWLNI	0	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions	.)		0	
3.00	Organ acquisition	5)		0	
4. 00	Subtotal (sum of lines 1 through 3)			0	
5. 00	Primary payer payments			0	
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			0	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			U	0.00
	Reasonable charges				İ
7.00	Routine service charges			0	7.0
8.00	Ancillary service charges			o	8.0
9.00	Organ acquisition charges, net of revenue			o	9.00
10.00	Total reasonable charges			o	10.0
	Customary charges				1
11.00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	11.0
12.00	Amounts that would have been realized from patients liable for p			o	12.0
	had such payment been made in accordance with 42 CFR 413.13(e)		_		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.0
14.00	Total customary charges (see instructions)			0	14.0
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15.0
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds line	e 14) (see	0	16. 0
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	17.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			0	
	Deductibles (exclude professional component)			0	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			0	
	Coinsurance			0	
	Subtotal (line 22 minus line 23)			0	
	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		0	
	Subtotal (sum of lines 24 and 25, or line 26)			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
	Recovery of Accelerated Depreciation			0	
30.00	Subtotal (see instructions)			0	
	Sequestration adjustment (see instructions)			0	
30. 01					31.0
30. 01 31. 00	Interim payments			0	
30. 01 31. 00 32. 00	Interim payments Tentative settlement (for contractor use only)			Ō	32. 0
30. 01 31. 00	Interim payments			-	32. 00 33. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet E-3
	Component CCN: 15S064		
	Title XVIII	Subprovi der -	PPS
		I PF	

	IPF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 433, 61	2 1.0
2. 00	Net IPF PPS Outlier Payments	89, 34	
3. 00	Net IPF PPS ECT Payments		0 3.0
1. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Novemb 15, 2004. (see instructions)	oer 0.0	0 4.0
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced program or hospital closure, that would not be counted without a temporary cap adjustment under 4 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0 4.0
5. 00	New Teaching program adjustment. (see instructions)	0.0	0 5.0
5. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "teaching program" (see instuctions)	new 0.0	0 6.0
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "teaching program" (see instuctions)	new 0.0	0 7.0
3. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.0	0 8.0
9. 00	Average Daily Census (see instructions)	5. 95342	5 9.0
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.00000	0 10.0
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0 11.0
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 522, 95	8 12.0
3.00	Nursing and Allied Health Managed Care payment (see instruction)		0 13.0
4.00	Organ acquisition (DO NOT USE THIS LINE)		14. 0
5. 00	Cost of physicians' services in a teaching hospital (see instructions)		0 15.0
6.00	Subtotal (see instructions)	1, 522, 95	8 16.0
7. 00	Pri mary payer payments		0 17. 0
8.00	Subtotal (line 16 less line 17).	1, 522, 95	8 18. 0
9.00	Deducti bl es	97, 48	8 19. 0
0.00	Subtotal (line 18 minus line 19)	1, 425, 47	0 20.0
1.00	Coi nsurance	15, 96	6 21.0
2.00	Subtotal (line 20 minus line 21)	1, 409, 50	4 22.0
3.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22, 08	5 23.0
4. 00	Adjusted reimbursable bad debts (see instructions)	14, 35	5 24.0
5. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18, 39	3 25.0
6. 00	Subtotal (sum of lines 22 and 24)	1, 423, 85	9 26.0
7. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0 27.0
8. 00	Other pass through costs (see instructions)		0 28.0
9.00	Outlier payments reconciliation		0 29.0
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 30.0
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0 30. 5
0. 99	Recovery of Accelerated Depreciation		0 30. 9
1.00	Total amount payable to the provider (see instructions)	1, 423, 85	9 31.0
1. 01	Sequestration adjustment (see instructions)	28, 47	7 31.0
2.00	Interim payments	1, 381, 31	0 32.0
3.00	Tentative settlement (for contractor use only)		0 33.0
4. 00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	14, 07	2 34.0
5. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0 35.0
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Worksheet E-3, Part II, line 2	89, 34	6 50.0
51. 00	Outlier reconciliation adjustment amount (see instructions)		0 51.0
52. 00	The rate used to calculate the Time Value of Money	0.0	0 52.0
53. 00	Time Value of Money (see instructions)		0 53.0

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet E-3
	Component CCN: 15T064		
	Title XVIII	Subprovi der -	PPS
		IRF	

	i RF		
	DADT LLL MEDICADE DADT A CEDIUCEC LDE DDC	1.00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	155, 746	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0.0000	1
4.00	Outlier Payments	1, 266	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or price		
3.00	to November 15, 2004 (see instructions)	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
0.0.	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	0.0.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	v 0.00	7.00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	v 0.00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	0. 446575	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0	
13.00	Total PPS Payment (see instructions)	157, 012	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	157, 012	
18.00	Primary payer payments	157 013	
19. 00 20. 00	Subtotal (line 17 less line 18). Deductibles	157, 012 3, 648	
21. 00	Subtotal (line 19 minus line 20)	153, 364	
22. 00	Coi nsurance	155, 304	1
23. 00	Subtotal (line 21 minus line 22)	153, 364	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	133, 304	
25. 00	Adjusted reimbursable bad debts (see instructions)	0	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
27. 00	Subtotal (sum of lines 23 and 25)	153, 364	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	•
29. 00	Other pass through costs (see instructions)	0	
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	153, 364	32.00
32. 01	Sequestration adjustment (see instructions)	3, 067	32. 01
33.00	Interim payments	157, 188	
34. 00	Tentative settlement (for contractor use only)	0	
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-6, 891	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.00
	§115. 2		
EO 00	TO BE COMPLETED BY CONTRACTOR	1.077	F0 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	1, 266	
51.00	Outlier reconciliation adjustment amount (see instructions)	0.00	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	
55.00	Time value of money (see first dections)	1	1 33.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E-3 From 10/01/2014 Part VII To 09/30/2015 Date/Time Prepared:

			lo 09/30/2015	Date/lime Pre 2/25/2016 2:2	
		Title XIX	Hospi tal	Cost	о рііі
		THE ALX	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI)	SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		183, 128		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		183, 128	0	1
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpati ent pri mary payer payments			0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		183, 128	0	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		135, 973		8.00
9.00	Ancillary service charges		97, 398	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		233, 371	0	12. 00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		233, 371	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	50, 243	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete only	If line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)		0	0	10.00
19. 00	Interns and Residents (see instructions)	-+:>	0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instru		102 120	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		183, 128	0	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be continuous than outlier payments	ompreted for PPS provide	0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0	Ü	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		183, 128	0	1
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		100, 120		27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	, ,		183, 128	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
	Utilization review		0		35. 00
36. 00		33)	183, 128	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	0	0	37. 00
	Subtotal (line 36 ± line 37)		183, 128	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		183, 128	0	40.00
41.00	Interim payments		424, 377	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-241, 249	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				
			·		

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150064	Peri od: From 10/01/2014	Worksheet E-3
	Component CCN: 15SO6-		Date/Time Prepared: 2/25/2016 2:25 pm
	Title XIX	Subprovi der -	

		Title XIX	I PF		
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XIX	1	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	0 1 010 11 1220 1 010 711 71	02		
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4.00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		ol	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		·		
	Reasonable Charges				1
8.00	Routine service charges		74, 734		8.00
9.00	Ancillary service charges		53, 532	0	9. 00
10.00	Organ acquisition charges, net of revenue		o		10.00
11.00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		128, 266	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services.	vices on a charge	0	0	13. 00
	basis	9			
14.00	Amounts that would have been realized from patients liable for pays	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFI	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		128, 266	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	128, 266	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	Leted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00 28. 00	Subtotal (sum of lines 22 through 26)		-		
	Customary charges (title V or XIX PPS covered services only)		0	0	•
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		O	0	20.00
30.00	Excess of reasonable cost (from line 18)		-	-	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32. 00	Deductibles		0		
33. 00	Coinsurance		0	0	33. 00 34. 00
35. 00	Allowable bad debts (see instructions) Utilization review		0	U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	•
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)			0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	O	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments		268, 767	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-268, 767	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub 15-2	-200, 707	0	43. 00
10.00	chapter 1, §115.2			O	10.00
	1				'

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

| Period: | Worksheet G | From 10/01/2014 | To 09/30/2015 | Date/Time Prepared: 2/25/2016 2:25 pm

					2/25/2016 2: 2	5 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	2.22	4 00	
	AUDDENT AGGETG	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 214 015	·I /			1 00
1.00	Cash on hand in banks	1, 214, 815			0	1
2.00	Temporary investments	0		-		
3.00	Notes recei vabl e Accounts recei vabl e	0 111 000	ή `	0	0	
4.00		8, 111, 892	1	0	0	1
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	422, 817		0	0	
7. 00	Inventory	862, 921	1		0	
8. 00	Prepai d expenses	315, 659			0	
9. 00	Other current assets	310,009			0	1
10. 00	Due from other funds				0	
11. 00	Total current assets (sum of lines 1-10)	10, 928, 104	1	-	1	1
11.00	FIXED ASSETS	10, 920, 104	1	<u> </u>	0	11.00
12. 00	Land	1, 244, 594	(0	0	12. 00
13. 00	Land improvements	606, 043			1	
14. 00	Accumulated depreciation	000,043		-		
15. 00	Bui I di ngs	55, 308, 231		-	Ö	1
16. 00	Accumulated depreciation	-57, 022, 436	1	-	0	
17. 00	Leasehold improvements	138, 533	1	-	Ö	1
18. 00	Accumulated depreciation	130, 333			Ö	
19. 00	Fi xed equipment				0	
20. 00	Accumulated depreciation				0	1
21. 00	Automobiles and trucks				0	1
22. 00	Accumulated depreciation			-	0	
23. 00	Major movable equipment	25, 052, 118	1	-	0	
24. 00	Accumulated depreciation	25, 052, 110			Ö	1
25. 00	Mi nor equipment depreciable				0	
26. 00	Accumulated depreciation				0	
27. 00	HIT designated Assets				Ö	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e			1	Ö	1
30. 00	Total fixed assets (sum of lines 12-29)	25, 327, 083				
30.00	OTHER ASSETS	23, 327, 003	<u>' </u>	0	0	30.00
31. 00	Investments	17, 288, 638	3 (0	0	31.00
32. 00	Deposits on Leases	17,200,000		-	· -	1
33. 00	Due from owners/officers			1	Ö	
34. 00	Other assets	1, 220, 714	1	,	Ö	1
35. 00	Total other assets (sum of lines 31-34)	18, 509, 352	1	1	Ö	
36. 00	Total assets (sum of lines 11, 30, and 35)	54, 764, 539	1	·	l	1
00.00	CURRENT LI ABILITIES	01,701,007	1	<u>, </u>		00.00
37. 00	Accounts payable	6, 588, 131		0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 365, 028	1	-	Ö	1
39. 00	Payrol I taxes payable	1,000,020		-	Ö	
40. 00	Notes and Loans payable (short term)	738, 984	1		Ö	1
41. 00	Deferred income	700,701			Ö	
42. 00	Accel erated payments	0		1	Ĭ	42. 00
43. 00	Due to other funds	0		0	0	1
44. 00	Other current liabilities	8, 927, 649			Ö	1
45. 00	Total current liabilities (sum of lines 37 thru 44)	17, 619, 792	1	o o		
10.00	LONG TERM LIABILITIES	11/01////2	-1	<u>, </u>		10.00
46. 00	Mortgage payable	1 0		0	0	46. 00
47. 00	Notes payable	0		o o		
48. 00	Unsecured Loans	0		-	l	1
49. 00	Other long term liabilities	23, 620, 863		-	Ō	1
50. 00	Total long term liabilities (sum of lines 46 thru 49	23, 620, 863		o o	l	1
51. 00	Total liabilites (sum of lines 45 and 50)	41, 240, 655		0	l	
	CAPITAL ACCOUNTS	,,				1
52.00	General fund balance	13, 523, 884	ı			52. 00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				Ö	
20.00	replacement, and expansion					- 5. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	13, 523, 884	. (o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	54, 764, 539	1	ol o	Ō	
	59)					

Provider CCN: 150064

Period: Worksheet G-1 From 10/01/2014 To 09/30/2015 Date/Time Prepared:

					To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
		General	Fund	Special P	urpose Fund	Endowment Fund	5 piii
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	25, 285, 677	3.00	4.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-11, 673, 536				2.00
3.00	Total (sum of line 1 and line 2)		13, 612, 141		0		3.00
4.00	(o	,,		0	0	4.00
5. 00		0			o	Ō	5. 00
6. 00		0			o	Ō	6.00
7. 00		0			0	0	7. 00
8.00		0			0	0	8.00
9. 00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		0		0	_	10.00
11. 00	Subtotal (line 3 plus line 10)		13, 612, 141		0		11.00
12. 00	TEMPORARILY RESTRICTED NET ASSEST OF	88, 257	10,012,111		0	0	12.00
13. 00	TEMPORALE RESTRICTED NET ASSEST OF	0			0	Ö	13.00
14. 00		0			0	l ő	14.00
15. 00		0			0	Ö	15. 00
16. 00					0	l ő	16.00
17. 00					0	0	17.00
18. 00	Total deductions (sum of lines 12-17)		88, 257		0	Ĭ	18.00
19. 00	Fund balance at end of period per balance		13, 523, 884		0		19.00
17.00	sheet (line 11 minus line 18)		13, 323, 004				17.00
	, , , , , , , , , , , , , , , , , , , ,	Endowment Fund	PI ant	Fund		'	
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0.00	7.00		0		1, 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Total (Sail of Title 1 and Title 2)		0				4.00
5. 00			0				5.00
6. 00			0				6.00
7. 00			0				7.00
8.00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0	, and the second		0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12. 00	TEMPORARILY RESTRICTED NET ASSEST OF		0				12.00
13. 00			n N				13.00
14. 00			0				14.00
15. 00			o o				15. 00
16. 00			ol O				16.00
17. 00			ol O				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	٩		o		18.00
19. 00	Fund balance at end of period per balance				0		19.00
. 7. 00	sheet (line 11 minus line 18)				<u> </u>		' /. 50
	12	1	ı		1		'

Health Financial Systems FAY STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150064

			0 09/30/2015	2/25/2016 2:2	
	Cost Center Description	Inpatient	Outpati ent	Total	
	· · · · · · · · · · · · · · · · · · ·	1.00	2. 00	3.00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	4, 953, 054		4, 953, 054	1. 00
2.00	SUBPROVI DER - I PF	3, 832, 226		3, 832, 226	2.00
3.00	SUBPROVI DER - I RF	210, 152		210, 152	3. 00
4.00	SUBPROVI DER		j	0	4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 995, 432	2	8, 995, 432	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	2, 177, 337	'	2, 177, 337	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 177, 337	'	2, 177, 337	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	11, 172, 769		11, 172, 769	17. 00
18. 00	Ancillary services	11, 630, 983		66, 687, 883	18. 00
19. 00	Outpati ent servi ces		20, 12., 022	26, 421, 622	19. 00
20. 00	RURAL HEALTH CLINIC		_	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		′I "I	0	21. 00
22. 00	HOME HEALTH AGENCY		836, 725	836, 725	22. 00
23. 00	AMBULANCE SERVICES		1, 036, 445	1, 036, 445	
24. 00	CMHC				24. 00
24. 10	CORF		이	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	_			25. 00
26. 00	HOSPICE	(,	228, 513	26. 00
27. 00	NRCC	00.000.75	5, 741, 153	5, 741, 153	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	. 22, 803, 752	89, 321, 358	112, 125, 110	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		54, 343, 990		29. 00
30.00	ADD (SPECIFY)				
30.00	ADD (SPECIFY)				30. 00 31. 00
32. 00					32.00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		<u></u>		36. 00
37. 00	DEDUCT (SPECIFY)		J		37. 00
38. 00	DEDUCT (SECTED)		´		38. 00
39. 00					39. 00
40. 00			<u> </u>		40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)				42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	fer	54, 343, 990		43. 00
	to Wkst. G-3, line 4)		2 ., 2 . 2, 7, 0		
		•	. '		•

Heal th	Financial Systems FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150064	Peri od:	Worksheet G-3	
			From 10/01/2014		
			To 09/30/2015		
	<u> </u>			2/25/2016 2: 2	5 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		112, 125, 110	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	,		70, 851, 434	2. 00
3.00	Net patient revenues (line 1 minus line 2)			41, 273, 676	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		54, 343, 990	
5. 00	Net income from service to patients (line 3 minus line 4)	,		-13, 070, 314	5. 00
0.00	OTHER I NCOME			10,070,011	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11. 00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and quests			0	14. 00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23. 00
	OTHER REVENUE			2, 061, 622	
	Total other income (sum of lines 6-24)			2, 061, 622	
	Total (line 5 plus line 25)			-11, 008, 692	
	CALM ON DICE ACCETS			4 772	

4, 772

253, 256 27. 01

406, 816 27. 02 664, 844 28. 00 -11, 673, 536 29. 00

27.00

27. 00 GAIN ON DISP ASSETS

27. 01 UNREALIZED LOSS ON DERIVATIVES

27.02 NET UNREALIZED LOSS ON INVESTMENTS
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

7.00	Physical Therapy	l O	81,695	l O	81, 695	7.00
8.00	Occupational Therapy	0	56, 797	0	56, 797	8. 00
9.00	Speech Pathology	0	0	0	0	9. 00
10.00	Medical Social Services	0	35, 589	0	35, 589	10. 00
11. 00	Home Health Aide	0	104, 502	0	104, 502	11. 00
12.00	Supplies (see instructions)	0	0	0	0	12. 00
13.00	Drugs	0	0	0	0	13. 00
14.00	DME	0	0	0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES					
15. 00	Home Dialysis Aide Services	0	0	0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	18. 00
	Health Promotion Activities	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0	0	21. 00
22. 00	Homemaker Service	0	0	0	0	22. 00
23. 00	All Others (specify)	0	0	0	0	23. 00
24. 00	Total (sum of lines 1-23)	9, 105	848, 129	0	848, 129	24. 00

18, 615

54, 661

0

0

0

0

0

0

0

0

0

0

0

54, 204

0

0

0

0

0

0

0

0

0

O

848, 129

159, 163

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23 00

24.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23 00

Medical Social Services

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Home Heal th Aide

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

Drugs

Clinic

DMF

Health Financial Systems	FAYETTE REGIONA	L HEALTH SYSTEM		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - HHA STATISTICAL BAS	SIS	Provi der CCN: 1			Worksheet H-1	
				From 10/01/2014		
		HHA CCN:	157097	To 09/30/2015	Date/Time Prep	
					2/25/2016 2: 25	pm .
				Home Health	PPS	
				Agency I		
	Capital Related Costs					

						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		Bl dgs &	Movabl e	Pl ant		nReconciliation		
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		1.00	2.00	(SQUARE FEET)	4.00	FA 00	Г 00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00		0			1	1		1. 00
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable		Ō			0		2. 00
2.00	Equipment		U			0		2.00
3.00	Plant Operation & Maintenance	0	0	0	J	0		3. 00
4. 00	Transportation (see	0	0	0				4. 00
4.00	instructions)	U	U	0				4.00
5.00	Administrative and General	0	0	0		-291, 272	556, 857	5. 00
0.00	HHA REIMBURSABLE SERVICES		J		1	271,272	000,007	0.00
6.00	Skilled Nursing Care	0	0	0		0 0	278, 274	6. 00
7. 00	Physical Therapy	0	0	0		0	81, 695	
8. 00	Occupational Therapy	0	0	0		0	56, 797	
9. 00	Speech Pathology	0	0	0		0	0	9. 00
10. 00	Medical Social Services	0	0	0		0	35, 589	
11. 00	Home Heal th Aide	0	0	0		0	104, 502	
12. 00	Supplies (see instructions)	0	0	0		0	0	12. 00
13. 00	Drugs	0	0	0	,	0	0	13. 00
14. 00	DME	0	0	0		0	0	14. 00
	HHA NONREIMBURSABLE SERVICES		-	_	'			
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0	o	16.00
17.00	Private Duty Nursing	0	0	0	1	0	0	17.00
18.00	Clinic	0	0	0	1	0	0	18.00
19.00	Health Promotion Activities	0	0	0	1	0	0	19.00
20.00	Day Care Program	0	0	0	1	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	1	0	0	21.00
22.00	Homemaker Service	0	0	0	1	0	0	22.00
23.00	All Others (specify)	0	0	0		0	o	23.00
24.00	Total (sum of lines 1-23)	0	0	0		-291, 272	556, 857	24.00
25.00	Cost To Be Allocated (per	0	0	0		O	291, 272	25.00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	O	0. 523064	26. 00

Provi der CCN: 150064 HHA CCN: 157097

						Home Health Agency I	PPS	
			CAPI TAL			Agency i		
			RELATED COSTS					
	Cost Center Description	HHA Trial	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	
	·	Bal ance (1)	FLXT	BENEFITS		& GENERAL	PLANT	
				DEPARTMENT				
		0	1. 00	4. 00	4A	5. 00	7. 00	
1. 00	Administrative and General	0	1	145, 067	145, 067	31, 196	0	1. 00
2.00	Skilled Nursing Care	423, 830	1	0	423, 830		0	2. 00
3.00	Physical Therapy	124, 427	1	0	124, 427		0	3. 00
4.00	Occupational Therapy	86, 505		0	86, 505	18, 602	0	4. 00
5.00	Speech Pathology Medical Social Services	0	1	0	E4 204	11 (5)	0	5. 00
6. 00 7. 00	Home Health Aide	54, 204 159, 163		0	54, 204 159, 163		0	6. 00 7. 00
8. 00	Supplies (see instructions)	139, 103	0	0	139, 103	34, 227	0	8. 00
9. 00	Drugs		1	0	0	0	0	9. 00
10. 00	DME		0	0	0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	o	0	Ö	0	ő	11. 00
12. 00	Respiratory Therapy	0	0	0	C	0	o	12. 00
13.00	Private Duty Nursing	0	0	0	C	0	0	13.00
14.00	Clinic	0	0	0	C	0	0	14.00
15.00	Health Promotion Activities	0	0	0	C	0	0	15.00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17.00
18. 00	Homemaker Service	0	0	0	C	0	0	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19. 00
20.00	Total (sum of lines 1-19) (2)	848, 129	0	145, 067	993, 196		0	20.00
21. 00	Unit Cost Multiplier: column				0.000000			21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	Cost Center Description	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY		NURSI NG ADMI NI STRATI ON	
		PLANT 7. 01	LINEN SERVICE 8.00	9.00	10. 00	11.00	ADMI NI STRATI ON 13. 00	
1.00	Administrative and General	PLANT	8.00 4,880	9.00		11.00	ADMI NI STRATI ON 13. 00 73, 665	1. 00
2.00	Administrative and General Skilled Nursing Care	PLANT 7. 01	8.00 4,880 0	9.00	10. 00	11.00	ADMI NI STRATI ON 13. 00 73, 665 0	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	PLANT 7. 01	8.00 4,880 0 0	9.00 0 0	10. 00	11.00	ADMI NI STRATI ON 13. 00 73, 665 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	PLANT 7. 01	8.00 4,880 0 0 0	9.00 0 0 0	10. 00 C C	11.00	ADMI NI STRATI ON 13. 00 73, 665 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	PLANT 7. 01	8.00 4,880 0 0 0 0	9.00 0 0 0 0	10. 00 C C C	11. 00 30, 033 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	PLANT 7. 01	LINEN SERVICE 8.00 4,880 0 0 0 0 0	9.00 0 0 0 0	10. 00 C C C C	11. 00 30, 033 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	PLANT 7. 01	8. 00 4, 880 0 0 0 0 0 0 0	9.00 0 0 0 0 0	10.00 C C C C C	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	PLANT 7. 01	LINEN SERVICE 8.00 4,880 0 0 0 0 0	9.00 0 0 0 0	10. 00 C C C C	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	PLANT 7. 01	8. 00 4, 880 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0	10.00 C C C C C	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0	10.00 C C C C C	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0	10.00 C C C C C	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	PLANT 7. 01	LINEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	PLANT 7. 01	8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	UNEN SERVICE 8.00 4,880 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0	10. 00	11. 00 30, 033 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 73, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems FAYETT ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS 150064 | Peri od: | Worksheet H-2 | From 10/01/2014 | Part I | Date/Time Prepared: | 2/25/2016 2: 25 pm Provider CCN: 150064 HHA CCN:

							2/25/2016 2: 2	5 pm
						Home Health Agency I	PPS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	
	·	SERVICES &		RECORDS &		Residents Cost		
		SUPPLY		LI BRARY		& Post		
						Stepdown		
		11.00	45.00	1/ 00	0.4.00	Adjustments	24.22	
1. 00	Administrative and General	14. 00	15. 00 0	16. 00 14, 919	24. 00 299, 760	25.00	26. 00 299, 760	1. 00
2.00	Skilled Nursing Care		0	14, 717	514, 973		514, 973	
3. 00	Physical Therapy		o	0	151, 184	1	151, 184	3. 00
4. 00	Occupational Therapy		o	o	105, 107		105, 107	4. 00
5. 00	Speech Pathology	O	o	Ö	(1	0	5. 00
6.00	Medical Social Services	0	0	o	65, 860	0	65, 860	6. 00
7.00	Home Health Aide	0	0	0	193, 390	0	193, 390	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	
9. 00	Drugs	0	0	0	C	0	0	9. 00
10.00	DME	0	0	0	(0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	(0	0	11. 00 12. 00
13. 00	Private Duty Nursing		0	0		0	0	13. 00
14. 00	Clinic		Ö	Ö	(Ö	0	14. 00
15. 00	Health Promotion Activities	O	o	o	C	o	0	15. 00
16.00	Day Care Program	0	0	О	C	o	0	16. 00
17. 00	Home Delivered Meals Program	0	0	O	C	o	0	17. 00
18. 00	Homemaker Service	0	0	0	C	0	0	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19. 00
20.00	Total (sum of lines 1-19) (2)	0	0	14, 919	1, 330, 274	. 0	1, 330, 274	
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
		27. 00	28. 00					
1. 00	Administrative and General		20.00					1. 00
2.00	Skilled Nursing Care	149, 797	664, 770					2. 00
3.00	Physi cal Therapy	43, 977	195, 161					3. 00
4.00	Occupational Therapy	30, 574	135, 681					4. 00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	19, 158	85, 018					6.00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	56, 254	249, 644					7. 00 8. 00
9. 00	Drugs		0					9. 00
10. 00	DME		o					10.00
11. 00	Home Dialysis Aide Services	O	0					11. 00
12.00	Respiratory Therapy	0	0					12. 00
13.00	Private Duty Nursing	0	0					13. 00
14. 00		0	0					14. 00
	Health Promotion Activities	0	0					15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0					16. 00 17. 00
18. 00	Homemaker Service		0					18.00
19. 00	All Others (specify)		0					19. 00
20. 00		299, 760	1, 330, 274					20.00
21. 00	Unit Cost Multiplier: column	0. 290884						21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	1 1						I

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	FAYETTE REGIONAL HEAL	LTH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE	TS TO HHA COST CENTERS STATISTICAL	Provider CCN: 150064	Peri od:	Worksheet H-2
BASIS			From 10/01/2014	
		HHA CCN: 157097	10 09/30/2015	Date/Time Prepared:

Home Health PPS Agency I CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF OPERATION OF Cost Center Description NEW BLDG & FIXT **BENEFITS** & GENERAL **PLANT PLANT** (SQUARE DEPARTMENT (ACCUM. (SQUARE (SQUARE FEET) (GROSS COST) FEET) FEET) SALARI ES) 1.00 5A 5.00 7. 00 7. 01 4.00 0 730, 403 1.00 Administrative and General C 145, 067 1.00 0 0 0 0 0 0 0 0 0 0 0 2.00 Skilled Nursing Care 423, 830 2.00 3.00 Physical Therapy 0 124, 427 3.00 0 0 0 000000000000000 Occupational Therapy 4.00 0 4.00 86, 505 0 0 5.00 Speech Pathology 5.00 6.00 Medical Social Services 54, 204 6.00 7.00 Home Health Aide 0 0 0 159, 163 7.00 8.00 0 Supplies (see instructions) 0 0 8.00 9.00 Drugs C 0 9.00 10.00 DMF 10.00 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 13.00 0 14.00 Clinic 0 0 0 0 0 0 0 0 0 14.00 0 Health Promotion Activities 15.00 0 15.00 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 17.00 0 Homemaker Service 0 18.00 18.00 OI All Others (specify) 0 n 19.00 19.00 20.00 Total (sum of lines 1-19) 0 730, 403 993, 196 20.00 145, 067 21.00 Total cost to be allocated 213, 581 21.00 22.00 Unit cost multiplier 0.000000 0. 198612 0.215044 0.000000 0. 000000 22.00 CAFETERI A LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG CENTRAL Cost Center Description LINEN SERVICE ADMINISTRATION (SQUARE (MEALS (MAN SERVICES & (POUNDS OF FEET) SERVED) HOURS) **SUPPLY** (FTE'S) LAUNDRY) (100%)9.00 10.00 11.00 13. 00 14.00 8.00 1.00 1, 924 Administrative and General 33, 748 1,622 1.00 0000000000000000000 2.00 Skilled Nursing Care C 2.00 3.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 0 3.00 Occupational Therapy 0 0 0 4.00 4.00 0 0 5.00 Speech Pathology 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Health Aide 0 0 0 7.00 0 8 00 0 ol 8.00 Supplies (see instructions) 0 9.00 Drugs 0 9.00 10.00 DME 10.00 0 0 11.00 Home Dialysis Aide Services 11.00 0 0 Respiratory Therapy 12 00 12 00 Private Duty Nursing 13.00 13.00 0 14.00 Clinic 0 0 14.00 15 00 Health Promotion Activities Ω 0 15 00 0 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 ol Homemaker Service 0 0 0 18.00 18.00 19 00 All Others (specify) O Ω O 0 19 00 20.00 Total (sum of lines 1-19) 1,924 0 C 33, 748 1,622 20.00 30, 033 Total cost to be allocated 4,880 21.00 73, 665 2. 536383 0.000000 0.000000 0.889919 45. 416153 0.000000 22.00 22.00 Unit cost multiplier

ALLOCA BASIS	ATION OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS STATISTICAL	Provi der 0		Peri od: From 10/01/2014	Worksheet H-2 Part II	
				HHA CCN:	157097	To 09/30/2015	Date/Time Pre 2/25/2016 2:2	
						Home Health Agency I	PPS	
	Cost Center Description	PHARMACY	MEDI CAL			Agency	1	
		(100%)	RECORDS &					
			LI BRARY					
			(GROSS					
			CHARGES)					
	1	15. 00	16. 00					
1.00	Administrative and General	0	836, 725					1.00
2.00	Skilled Nursing Care	0	0					2. 00
3. 00	Physi cal Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4. 00
5.00	Speech Pathology	0	0					5. 00
6. 00	Medical Social Services	0	0					6. 00
7. 00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11. 00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respiratory Therapy	0	0					12. 00
13.00	Private Duty Nursing	0	0					13. 00
14. 00	Clinic	0	0					14. 00
15. 00	Health Promotion Activities	0	0					15. 00
16. 00	Day Care Program	0	0					16. 00
	3	0	0					17. 00
18. 00	Homemaker Servi ce	0	0					18. 00
	1 3/	0	0					19. 00
20. 00	Total (sum of lines 1-19)	0	836, 725					20. 00
21. 00	Total cost to be allocated	0	14, 919					21. 00
22 00	Unit cost multiplier	0 000000	0. 017830					22 00

0. 017830

22. 00

0.000000

22.00 Unit cost multiplier

	Financial Systems		TETTE REGIONAL	HEALTH SYSTEM			u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	-S		Provi der HHA CCN:	CCN: 150064 157097	Period: From 10/01/2014 To 09/30/2015		pared:
				Ti tl	e XVIII	Home Health	2/25/2016 2: 2! PPS	5 pm
		I =				Agency I		
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line		Costs (from	+ 2)	'	(col. 3 ÷ col.	
		_		Part II)			4)	
	PART I - COMPUTATION OF LESSER	OF ACCRECATE D	1.00	2.00	3.00	4.00	5. 00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE T	ROOKAW COST, A	OUNEOATE OF T	IL TROOKAW ET	WITATION COST, OF	`	
	Cost Per Visit Computation	1 000			T		115.01	
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00	•	(664, 7		145. 24 252. 80	1. 00 2. 00
3. 00	Occupational Therapy	4. 00		(232. 33	
4.00	Speech Pathology	5. 00		(0 0	0. 00	
5. 00	Medical Social Services	6. 00			85, 0		1, 574. 41	5. 00
6.00	Home Heal th Ai de	7. 00		_	249, 6		67. 47	6.00
7. 00	Total (sum of lines 1-6)		1, 330, 274	(1,330,2° Program Visi			7. 00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deductibles			
		0	1. 00	2.00	Coi nsurance	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care	•	17140	(31		8.00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care	•	50031 50035	(76 30		8. 01 8. 02
8. 03	Skilled Nursing Care	•	50042	(35		8. 03
8. 04	Skilled Nursing Care	•	99915	(57		8. 04
9. 00	Physi cal Therapy	•	17140	(1	0		9.00
9. 01	Physi cal Therapy		50031	(1	28		9. 01
9. 02 9. 03	Physical Therapy Physical Therapy		50035 50042	(1	17 13		9. 02 9. 03
9. 03 9. 04	Physical Therapy	1	99915	(1	30		9.03
10.00	Occupational Therapy		17140	Ć	1	0		10.00
10. 01	Occupational Therapy		50031	(19	95		10. 01
10. 02	Occupational Therapy		50035	(17		10. 02
10. 03	Occupational Therapy		50042 99915	(9		10.03
10. 04 11. 00	Occupational Therapy Speech Pathology		17140	(39 0		10. 04 11. 00
11. 01	Speech Pathology		50031	(0		11. 01
11. 02			50035	(0		11. 02
11. 03	Speech Pathology	1	50042	(1	0		11. 03
11. 04	111111111111111111111111111111111111111		99915	(0		11. 04
12. 00 12. 01	Medical Social Services Medical Social Services		17140 50031	(•	0	-	12. 00 12. 01
	Medical Social Services		50035	(ól –	1		12. 01
12. 03	Medical Social Services		50042	Ć		Ö		12. 03
12. 04	Medical Social Services		99915	(6		12. 04
13.00	Home Health Aide		17140	(3		13.00
13. 01	Home Health Aide Home Health Aide	1	50031	(•	39		13.01
13. 02 13. 03	Home Health Aide		50035 50042	(á	13 5		13. 02 13. 03
13. 04	Home Health Aide		99915	(10	67		13. 04
	Total (sum of lines 8-13)			(3, 1	19		14. 00
	Cost Center Description	From Wkst. H-2			Total HHA	Total Charges	Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Record)	÷ col. 4)	
		20, 11110	2, Tart 1)	Part II)		itecor u)		
		0	1. 00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput. Cost of Medical Supplies		ما		\	0 0	0.00000	45.00
15 NN	ILOST OF MEDICAL SUBDILLES	8.00	O	(0. 000000	15.00

Heal th	Financial Systems	F/	AYETTE REGIONAL	HEALTH SYSTEM	Л	In Li∈	eu of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COSTS	S		Provider	CCN: 150064 157097	Peri od: From 10/01/2014 To 09/30/2015		pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	- P
			Program Visits		Cost of	Agency		
			Par	t B	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6.00 OF AGGREGATE F	7.00 PROGRAM COST, A	8.00 GGREGATE OF TH	9.00 HE PROGRAM LI	10.00 MITATION COST, OF	11. 00 R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1.00	Skilled Nursing Care	0				0 280, 168		1.00
2.00	Physical Therapy Occupational Therapy	0				0 98, 086 0 83, 639		2. 00 3. 00
4.00	Speech Pathology	0	O			0 0		4. 00
5. 00 6. 00	Medical Social Services Home Health Aide	0	1			0 23, 616 0 28, 810		5. 00 6. 00
7. 00	Total (sum of lines 1-6)	0	1			0 514, 319		7. 00
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
8. 00	Limitation Cost Computation Skilled Nursing Care							8. 00
8. 01	Skilled Nursing Care							8. 01
8. 02 8. 03	Skilled Nursing Care Skilled Nursing Care							8. 02 8. 03
8.04	Skilled Nursing Care							8. 04
9. 00 9. 01	Physical Therapy Physical Therapy							9. 00 9. 01
9. 02	Physi cal Therapy							9. 02
9. 03 9. 04	Physical Therapy Physical Therapy							9. 03 9. 04
10.00	Occupational Therapy							10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy							10. 01 10. 02
10.03	Occupational Therapy							10.03
10. 04 11. 00	Occupational Therapy Speech Pathology							10. 04 11. 00
11. 01 11. 02	Speech Pathology Speech Pathology							11. 01 11. 02
11. 02	1 .							11. 02
11. 04 12. 00	Speech Pathology Medical Social Services							11. 04 12. 00
12. 00	Medical Social Services							12. 00
12. 02 12. 03	Medical Social Services Medical Social Services							12. 02 12. 03
12. 04	Medical Social Services							12. 04
13. 00 13. 01	Home Health Aide Home Health Aide							13. 00 13. 01
13. 02	Home Health Aide							13. 02
13. 03 13. 04	Home Health Aide Home Health Aide							13. 03 13. 04
14. 00								14. 00
		Prog	ram Covered Cha	rges	Cost of Services			
			Dam	+ D		Dart D		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Part B Not Subject to	,	
			Deductibles & Coinsurance	Deductibles & Coinsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Supplies and Drugs Cost Computa Cost of Medical Supplies	itions 0	O	(0 0	0	15. 00
	Cost of Drugs		o			0		16. 00

PPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der CCN	N: 150064	Peri od:	Worksheet H-	3
				HHA CCN:	157097	From 10/01/2014 To 09/30/2015	Part I Date/Time Pr 2/25/2016 2:	
				Title X	VIII	Home Health Agency I	PPS	25 piii
	Cost Center Description	Total Program				Agency		
	·	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COSI, AGGRE	GATE OF THE P	PROGRAM LI	MITATION COST, OR		
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
. 00	Skilled Nursing Care	280, 168						1.0
2. 00	Physical Therapy	98, 086						2.0
3. 00	Occupational Therapy	83, 639						3.0
. 00	Speech Pathology	0						4. 0
. 00	Medical Social Services	23, 616						5. 0
. 00	Home Health Aide	28, 810						6.0
. 00	Total (sum of lines 1-6)	514, 319						7. C
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
. 00	Skilled Nursing Care							8. (
. 01	Skilled Nursing Care							8. (
. 02	Skilled Nursing Care							8. (
. 03	Skilled Nursing Care Skilled Nursing Care							8. (
. 00	Physical Therapy							9. (
). 01	Physical Therapy							9. (
0.02	Physical Therapy							9. (
. 02	Physical Therapy							9. (
. 04	Physical Therapy							9. (
0.00	Occupational Therapy							10. (
0. 01	Occupational Therapy							10.0
0. 02	Occupational Therapy							10. (
0. 03	Occupational Therapy							10. (
0. 04	Occupational Therapy							10. (
1. 00	Speech Pathology							11. (
1. 01	Speech Pathology							11. (
1. 02	Speech Pathology							11. (
1. 03	Speech Pathology							11.0
1.04	Speech Pathology							11.
2.00	Medical Social Services Medical Social Services							12. (
2. 01 2. 02	Medical Social Services Medical Social Services							12.0
2. 02	Medical Social Services							12.
2. 03	Medical Social Services							12.
3. 00	Home Heal th Aide							13.
3. 00	Home Health Aide							13.
3. 02	Home Heal th Aide							13.
3. 03	Home Health Aide							13.
3. 04	Home Health Aide							13. (
	Total (sum of lines 8-13)							14.

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10								2552-10		
APPORT	IONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 150064	Perio		Worksheet H-3	
					LILLA CON	157007		10/01/2014	Part II	
					HHA CCN:	157097	То	09/30/2015	Date/Time Prep 2/25/2016 2:2	
					Ti tl	e XVIII	Ho	me Health	PPS	о ріп
Agency I										
	Cost Center Description	From Wkst. C,	Cost to Charge	Tot	tal HHA	HHA Shared	Tr	ransfer to		
		Part I, col.	Ratio	Char	ge (from	Ancillary	F	Part I as		
		9, line		pr	ovi der	Costs (col.	1 I	ndi cated		
				re	cords)	x col. 2)				
		0	1. 00		2.00	3.00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHA	RED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physical Therapy	66. 00	0. 629096		0		0 col	. 2, line 2.	00	1. 00
2.00	Occupational Therapy									2. 00
3.00	Speech Pathology									3. 00
4.00	Cost of Medical Supplies	71. 00	0. 452188		0		0 col	. 2, line 15	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 381226		0		0 col	. 2, line 16	5. 00	5. 00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	L HEALTH SYSTEM Provider	CCN: 150064	Peri od:	u of Form CMS-2 Worksheet H-4	
	HHA CCN:	157097	From 10/01/2014 To 09/30/2015	Part I-II	epar
	Ti tl	e XVIII	Home Health Agency I	PPS	
				t B	4
		Part A		Deductibles &	
		1.00	Coi nsurance 2. 00	Coi nsurance 3.00	+
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CL	USTOMARY CHARGE		2.00	0.00	т
Reasonable Cost of Part A & Part B Services					1
Reasonable cost of services (see instructions)			0 0		
Total charges			0 0	0)
Customary Charges		T			4
Amount actually collected from patients liable for payment	for services		0	0) :
on a charge basis (from your records) Amount that would have been realized from patients liable	for navment		0 0	0) .
for services on a charge basis had such payment been made with 42 CFR §413.13(b)				0	
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
Total customary charges (see instructions)			0 0	0	
Excess of total customary charges over total reasonable co- only if line 6 exceeds line 1)	st (complete		0 0	0	
Excess of reasonable cost over customary charges (complete 1 exceeds line 6)	only if line		0 0	0	
Primary payer amounts			0 0	0	
			Part A	Part B	
			Servi ces 1.00	Servi ces 2. 00	+
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				_, _,	Г
Total reasonable cost (see instructions)			0	0	
Total PPS Reimbursement - Full Episodes without Outliers			0	465, 965	
700 Total PPS Reimbursement - Full Episodes with Outliers			0	14, 756	
70 Total PPS Reimbursement - LUPA Episodes			0	19, 227	
Total PPS Reimbursement - PEP Episodes	0.00		0	7, 873	
00 Total PPS Outlier Reimbursement - Full Episodes with Outli 00 Total PPS Outlier Reimbursement - PEP Episodes	ers		0	3, 676	
00 Total PPS Outlier Reimbursement - PEP Episodes 00 Total Other Payments			0	0	
OD DME Payments			0	Ö	
ON Oxygen Payments			0	Ö	
OO Prosthetic and Orthotic Payments			0	0	
Part B deductibles billed to Medicare patients (exclude co	i nsurance)			0) 2
OO Subtotal (sum of lines 10 thru 20 minus line 21)			0	511, 497	/ 2
OO Excess reasonable cost (from line 8)			0	0) 2
OO Subtotal (line 22 minus line 23)			0	511, 497	/ 2
OO Coinsurance billed to program patients (from your records)				0	
Net cost (line 24 minus line 25)			0	511, 497	
Reimbursable bad debts (from your records)	- !+				2
DO Reimbursable bad debts for dual eligible beneficiaries (se DO Total costs - current cost reporting period (line 26 plus			0	F11 407	, 2
	1111e 2/)		0	511, 497 0	
				0	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	i∩ns\			511, 497	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) FOO Proneer ACO demonstration payment adjustment (see instruct	i ons)		()		
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Fromeer ACO demonstration payment adjustment (see instruct Subtotal (see instructions)	ions)		0		
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruct Subtotal (see instructions) Sequestration adjustment (see instructions)	ions)			9, 917 501, 266	3 3
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Fromeer ACO demonstration payment adjustment (see instruct Subtotal (see instructions)	ions)		0	9, 917	3 3
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruct Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)			0	9, 917 501, 266	3:

PROGRAM BENEFICIARIES

....

Peri od: From 10/01/2014 To 09/30/2015 Worksheet H-5
Date/Time Prepared:

GRAM BENEFICIARIES

HHA CCN: 157097

0

1.00

2.00

8.00

2/25/2016 2:25 pm Home Health PPS

PPS Agency I Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 1.00 Total interim payments paid to provider 501, 266 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 0 0 3. 01 0 3.02 0 3.02 0 3 03 3.03 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 0 3.50 0 0 3.51 0 3.51 3.52 0 0 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 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 501, 266 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 0 5.01 0 0 5.02 5.02 5.03 5.03 0 0 Provider to Program 5.50 0 0 5.50 5.51 0 0 5.51 0 5 52 0 5 52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 314 6.01 SETTLEMENT TO PROGRAM 0 6.02 Λ 6.02 7.00 Total Medicare program liability (see instructions) 501, 580 7.00 NPR Date Contractor (Mo/Day/Yr) Number

8.00 Name of Contractor

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150064	Period: Worksheet K

Hospi ce CCN: 151548 To 09/30/2015 Date/Time Prepared: 2/25/2016 2:25 pm Hospi ce I Transportation Salaries (from Empl oyee Contracted 0ther Benefits (from Wkst. K-2) Wkst. K-1) Services (from Wkst. K-3) (see inst.) 1.00 2.00 3.00 4.00 5. 00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 2.00 Capital Related Costs-Movable Equip. 0 2.00 0 3.00 Plant Operation and Maintenance 0 0 0 3.00 4.00 Transportation - Staff 0 0 0 4.00 0 0 0 5.00 Volunteer Service Coordination 0 0 5.00 0 Administrative and General 0 0 48, 102 6.00 0 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 0 7.00 0 8.00 0 8.00 0 0 0 VISITING SERVICES 9.00 Physician Services 0 0 0 0 9.00 10.00 Nursing Care 28, 831 0 0 0 0 0 0 0 0 0 0 0 10.00 0 Nursing Care-Continuous Home Care 0 11.00 0 11.00 0 12.00 Physical Therapy 0 0 12.00 13.00 Occupational Therapy 0 13.00 Speech/ Language Pathology Medical Social Services 0 0 14.00 0 14.00 0 0 15.00 15.00 3,676 0 16.00 Spiritual Counseling 0 0 0 16.00 Dietary Counseling 0 0 0 17.00 17.00 0 0 0 0 Counseling - Other 18.00 18.00 01 0 19.00 Home Health Aide and Homemaker 6, 176 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 20.00 0 0 21.00 0ther 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 0 23.00 Anal gesi cs 0 0 23.00 0 0 0 0 0 0 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 0 0 24.00 0 25.00 Other - Specify 0 25.00 0 26.00 Durable Medical Equipment/Oxygen 0 0 26.00 0 0 27.00 27.00 Patient Transportation 0 28 00 Imaging Services 0 0 28.00 Labs and Diagnostics 0 29.00 0 29.00 0 30.00 Medical Supplies 0 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 32 00 Radiation Therapy 0 0 32.00 0 33.00 Chemotherapy 0 0 33.00 34.00 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 0 0 Bereavement Program Costs 0 0 0 0 0 35.00 0 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00

0

38, 683

0

0

38.00

0

48, 102 39. 00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

38.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150064	Peri od: Worksheet K
		From 10/01/2014

					om 10/01/2014		
			Hospi ce CCN:	151548 To	09/30/2015	Date/Time Pre	
						2/25/2016 2: 2	5 pm
		Total (cols. Rec	l assi fi cati Sub	+0+0 (00	Hospi ce I	Total (col. 8	
		1-5)		± col. 7)	Adjustments	± col. 9)	
		6.00	7.00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1. 00	Capital Related Costs-Bldg and Fixt.	0	٥	0	O	0	1. 00
2.00	Capital Related Costs-Movable Equip.		0	0	0	0	2. 00
3.00	Plant Operation and Maintenance		0	0	0	0	3. 00
4. 00	Transportation - Staff		0	0	0	0	4. 00
5. 00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6. 00	Administrative and General	48, 102	o	48, 102	0	48, 102	6. 00
0.00	I NPATI ENT CARE SERVI CE	10, 102	٩	10, 102	۷۱	10, 102	0.00
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	o	0	o	0	8. 00
0.00	VI SI TI NG SERVI CES	<u> </u>			٥,	5	0.00
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10. 00	Nursing Care	28, 831	o	28, 831	0	28, 831	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	20,001	0	0	11. 00
12. 00	Physical Therapy	0	o	0	0	0	12. 00
13. 00	Occupational Therapy	0	o	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	o	0	0	0	14. 00
	Medical Social Services	3, 676	o	3, 676	0	3, 676	15. 00
	Spiritual Counseling	0	o	0	0	0	16. 00
	Di etary Counsel i ng	o	o	Ö	o	0	17. 00
18. 00	Counseling - Other	o	o	Ö	o	0	18. 00
19. 00	Home Health Aide and Homemaker	6, 176	o	6, 176	o	6, 176	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	o	0	o	0	20. 00
21. 00	Other	0	o	0	O	0	21. 00
	OTHER HOSPICE SERVICE COSTS	*			'		
22. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22. 00
23.00	Anal gesi cs	0	0	0	o	0	23. 00
24.00	Sedatives / Hypnotics	0	0	0	o	0	24. 00
25.00	Other - Specify	0	0	0	o	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26. 00
27.00	Patient Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	0	0	0	0	28. 00
29.00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radi ati on Therapy	0	0	0	o	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	o	0	o	0	36.00
37.00	Fundrai si ng	0	o	0	o	0	37. 00
38.00	Other Program Costs	0	o	0	o	0	38. 00
39.00	Total (sum of lines 1 thru 38)	86, 785	o	86, 785	o	86, 785	39. 00
		·	·	·		,	

			Hospi ce C	CN: 151548 1	0 09/30/2015	2/25/2016 2:2	
					Hospi ce I	2/23/2010 2.2	o piii
		Admi ni strator	Director	Soci al	Supervi sors	Nurses	
		1.00	2.00	Servi ces	4.00	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2. 00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	o	0	3.00
4. 00	Transportation - Staff	0	0	0	_	0	4. 00
5.00	Volunteer Service Coordination		0	1	=	0	5.00
6.00	Administrative and General		0			0	6.00
0.00	I NPATI ENT CARE SERVI CE	J O		10	<u> </u>	0	0.00
7. 00	Inpatient - General Care	0	0	0	ol	0	7. 00
8.00	Inpatient - Respite Care		0			0	8.00
0.00	VI SI TI NG SERVI CES	<u> </u>			<u> </u>	0	0.00
9. 00	Physician Services	0	0	0	ol	0	9. 00
10. 00	Nursing Care		0		-	28, 831	10.00
11. 00	Nursing Care-Continuous Home Care		0	0		20, 031	11.00
12. 00	Physical Therapy		0	0	_	0	12. 00
13. 00	Occupational Therapy		0	0		0	13. 00
14. 00	Speech/ Language Pathology		0	0	_	0	14. 00
15. 00	Medical Social Services		0	3, 676	_	0	15. 00
16. 00	Spiritual Counseling		0	3,070	l .	0	16. 00
17. 00	Di etary Counseling		0	0	_	0	17. 00
18. 00	Counseling - Other		0	0	_	0	18. 00
19. 00	Home Health Aide and Homemaker		0	Ö	=	0	19. 00
20. 00	HH Ai de & Homemaker - Cont. Home Care		0		_	0	20.00
	Other		0		_	0	21. 00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>		<u> </u>	<u> </u>		21.00
22. 00	Drugs, Biological and Infusion Therapy	T		I			22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation	0	0	0	o	0	27. 00
28. 00	Imaging Services	0	0	0	_	0	28. 00
29. 00	Labs and Diagnostics	0	0	Ö	ol	0	29. 00
30. 00	Medical Supplies	0	0	0	ol	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	ol	0	31. 00
32. 00	Radi ati on Therapy	0	0	Ō	ol	0	32. 00
33. 00	Chemotherapy	0	0		_	0	33. 00
34. 00	Other	0	0		_	0	34. 00
5 50	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>			<u> </u>		
35. 00	Bereavement Program Costs	0	0	0	ol	0	35. 00
36. 00	Volunteer Program Costs		0		_	0	36. 00
37. 00	Fundrai si ng		0	Ō	o	0	37. 00
38. 00	Other Program Costs		0	Ō	o	0	38. 00
	Total (sum of lines 1 thru 38)		0	3, 676	Ö	28, 831	
		1			1	•	•

Health Financial Systems	FAYETTE REGIONAL HEAL	TH SYSTEM		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der 0	CCN: 150064	Peri od: From 10/01/2014	Worksheet K-1
		Hospi ce CC	CN: 151548	To 09/30/2015	Date/Time Prepared: 2/25/2016 2:25 pm

Total Aides All - Other Total (1)				nospi ce c	CN. 151546 1	0 09/30/2013	2/25/2016 2:25 pm
Therapists Service Cost Centers						Hospi ce I	
CENERAL SERVICE COST CENTERS				Ai des	All-Other	Total (1)	
1.00				7.00	8. 00	9. 00	
2.00		GENERAL SERVICE COST CENTERS					
Plant Operation and Maintenance	1.00	Capital Related Costs-Bldg and Fixt.					1.00
A.00	2.00						2. 00
Solid Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	Plant Operation and Maintenance		0	C	0	3.00
Administrative and General 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	Transportation - Staff		0	C	0	4. 00
INPATIENT CARE SERVICE Inpati ent - General Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00	Volunteer Service Coordination		0	C	0	5. 00
1,00	6.00	Administrative and General		0	C	0	6. 00
R.O. Inpatient - Respite Care 0 0 0 0 8.0		I NPATI ENT CARE SERVI CE					
VISITING SERVICES	7.00	Inpatient - General Care		0	C	0	7. 00
9.00 Physician Services 0 0 0 0 0 0 0 10 10	8.00			0	C	0	8. 00
10. 00 Nursing Care		VISITING SERVICES					
11.00	9.00	Physi ci an Servi ces		0	C		9. 00
12.00 Physical Therapy 0 0 0 0 0 12.0				0	C	28, 831	10.00
13.00				0	C	0	11. 00
14.00 Speech Language Pathology 0 0 0 0 0 14.00			0	0	C	0	12. 00
15.00 Medical Social Services 0 0 3,676 15.00 16.00 Spiritual Counseling 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling - Other 0 0 0 0 19.00 Home Health Aide and Homemaker 6,176 0 6,176 19.00 19.00 Hill Aide & Homemaker - Cont. Home Care 0 0 0 0 21.00 Other 0 0 0 0 22.00 Other 0 0 0 0 23.00 Anal gesics 24.00 24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 25.00 26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 29.00 Labs and Diagnostics 0 0 0 30.00 Medical Supplies 0 0 0 31.00 Outpatient Services (including E/R Dept.) 0 0 0 33.00 Other - Specify 0 0 0 33.00 Other - Specify 0 0 0 33.00 Other - Specify 0 0 0 33.00 Other - Specify 0 0 0 34.00 Other - Specify 0 0 0 35.00 Sedatives 0 0 0 36.00 Other - Specify 0 0 0 37.00 Other - Specify 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program	13.00	Occupational Therapy	0	0	C	0	13.00
16.00 Spiritual Counseling 0	14.00	Speech/ Language Pathology	0	0	C	0	14.00
17.00 Dietary Counseling	15.00	Medical Social Services		0	C	3, 676	15. 00
18.00 Counseling - Other 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 6,176 0 0 0 20.00 19.00 18.00 19.00	16.00	Spiritual Counseling		0	C	o	16. 00
19.00 Home Heal th Ai de and Homemaker 6,176 0 6,176 19.00	17.00	Di etary Counsel i ng		0	C	0	17. 00
20.00	18.00	Counseling - Other		0	C	0	18. 00
21.00 Other OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE OTHER HOSPICE SERVICE OTHER HOSPICE SERVICE COSTS OTHER HOSPICE SERVICE SERVICE OTHER HOSPICE STORY OTHER HOSPICE SERVICE OTHER HOSPICE STORY OTHER HOSPIC	19.00	Home Health Aide and Homemaker		6, 176	C	6, 176	19. 00
DTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesics 23.00 23.00 24.00 25.00 24.00 25.00 24.00 25.00 25.00 26.00 27.00 26.00 27.00 27.00 28.00	20.00	HH Aide & Homemaker - Cont. Home Care		0	C	0	20.00
22. 00 Drugs, Biological and Infusion Therapy 22. 02 23. 00 Anal gesics 23. 02 24. 00 Sedati ves / Hypnotics 24. 02 25. 00 Other - Specify 25. 02 26. 00 Durable Medical Equipment/Oxygen 26. 02 27. 00 Patient Transportation 0 0 0 27. 02 28. 00 Imaging Services 0 0 0 28. 02 29. 00 28. 02 0 0 0 29. 02 29. 00 28. 02 0 0 0 0 29. 02 29. 02 29. 02 0 0 0 0 29. 02 29. 02 29. 02 29. 02 0 0 0 29. 02 29. 02 29. 02 29. 02 0 0 0 29. 02 <td>21.00</td> <td>Other</td> <td></td> <td>0</td> <td>C</td> <td>0</td> <td>21. 00</td>	21.00	Other		0	C	0	21. 00
23.00 Anal gesics 24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 25.00 Other - Specify 26.00 Durable Medical Equipment/Oxygen 26.00 Patient Transportation 0 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 29.00 29							
24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 25.00 Other - Specify 26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 29.0	22.00	Drugs, Biological and Infusion Therapy					22. 00
25.00 Other - Specify 25.00 Durable Medical Equipment/Oxygen 26.00 Durable Medical Equipment/Oxygen 26.00 Durable Medical Equipment/Oxygen 26.00 Patient Transportation 0							23. 00
26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 31.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 34.00	24.00	Sedatives / Hypnotics					24. 00
27. 00 Patient Transportation 0 0 0 27. 0 28. 00 Imaging Services 0 0 0 28. 0 29. 00 Labs and Diagnostics 0 0 0 0 29. 0 30. 00 Medical Supplies 0 0 0 0 30. 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 0 32. 00 Radiation Therapy 0 0 0 0 0 33. 0 33. 00 Chemotherapy 0 0 0 0 33. 0 34. 00 Other 0 0 0 0 34. 0 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 0 35. 0 35. 00 Bereavement Program Costs 0 0 0 36. 0 36. 00 Volunteer Program Costs 0 0 0 37. 0 38. 00 Other Program Costs 0 0 0 0 38. 0	25.00	Other - Specify					25. 00
28.00 Imaging Services 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 33.00 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00	26.00	Durable Medical Equipment/Oxygen					26. 00
29.00 Labs and Diagnostics 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 0 35.00 35.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00				0	C	0	27. 00
30.00 Medical Supplies 0 0 0 0 330.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 Other HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 38.00 Other Program Costs 0 0 0 0 38.00 Other Program Costs 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 0 38.00 38.00 Other Program Costs	28. 00	I maging Services		0	C	0	28. 00
31.00 Outpati ent Services (including E/R Dept.) 0 0 0 31.00 32.00 Radi ati on Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other HOSPICE NONREIMBURSABLE SERVICE				0	C	0	29. 00
Radiation Therapy 0 0 0 0 32.0				0	C	0	30.00
33.00 Chemotherapy 0 0 0 33.00 34.00 Other HOSPICE NONREIMBURSABLE SERVICE	31.00	Outpatient Services (including E/R Dept.)		0	C	0	31.00
34.00 Other O O O O 34.00	32.00	Radi ati on Therapy		0	C	0	32.00
HOSPICE NONREIMBURSABLE SERVICE	33.00	Chemotherapy		0	C	0	33.00
35. 00 Bereavement Program Costs 0 0 0 35. 0 36. 00 Volunteer Program Costs 0 0 0 36. 0 37. 00 Fundraising 0 0 0 0 37. 0 38. 00 Other Program Costs 0 0 0 38. 0	34.00			0	C	0	34.00
36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 38.00 Other Program Costs 0 0 0 0							
37. 00 Fundraising 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0				0	0	0	35. 00
38.00 Other Program Costs 0 0 0 38.0	36.00	Volunteer Program Costs		0	C	0	36. 00
	37.00	Fundrai si ng		0	C	0	37. 00
39.00 Total (sum of lines 1 thru 38) 0 6,176 0 38,683 39.0	38. 00	Other Program Costs		0	C	0	38. 00
	39. 00	Total (sum of lines 1 thru 38)	0	6, 176	C	38, 683	39.00

Health Financial Systems

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

						2/25/2016 2:2	5 pm
					Hospi ce I		
	·		CAPI TAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1. 00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3.00	Plant Operation and Maintenance	0	0		0 0)	3. 00
4.00	Transportation - Staff	0	0		0 0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0 0	0	5. 00
6.00	Administrative and General	48, 102	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9. 00
10.00	Nursing Care	28, 831	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11. 00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13. 00
14.00	Speech/ Language Pathology	0	0		0 0	0	14. 00
15.00	Medical Social Services	3, 676	0		0 0	0	15. 00
16.00	Spiritual Counseling	0	0		0 0	0	16. 00
17.00	Di etary Counsel i ng	0	0		0 0	0	17. 00
18.00	Counseling - Other	0	0		0 0	0	18. 00
19.00	Home Health Aide and Homemaker	6, 176	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20. 00
21.00	Other	o	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	'					
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23.00	Anal gesi cs	0	0		0 0	0	23. 00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24. 00
25.00	Other - Specify	o	0		0 0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	o	0		0 0	0	26. 00
27.00	Patient Transportation	o	0		0 0	0	27. 00
28.00	Imaging Services	o	0		0 0	0	28. 00
29.00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	31.00
32. 00	Radi ati on Therapy	o	0		0 0	0	32.00
33. 00	Chemotherapy	0	0		0 0	Ō	33. 00
34. 00	Other	0	0		0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE	-1					
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0		0		36.00
37. 00	Fundrai si ng		0		0	ő	37. 00
38. 00	Other Program Costs		0				38.00
	Total (sum of lines 1 thru 38)	86, 785	0		0		1
07.00	1.112. (12 0. 1.1.00 1 1 4 00)	55,700	J	1	-1	1	37.00

| In Lieu of Form CMS-2552-10 | Provider CCN: 150064 | Period: From 10/01/2014 | Part I | Pospice CCN: 151548 | To 09/30/2015 | Date/Time Prepared: Provider COMP | Pospice CCN: 151548 | To 09/30/2015 | Date/Time Prepared: Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider COMP | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Provider CCN: 150064 | Prov

			Hospi ce (CCN: 151548 1	0 09/30/2015	2/25/2016 2:25 pm
					Hospi ce I	2, 20, 20 to 2, 20 pm
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE	TOTAL (col. 5A	
		SERVI CES	(cols. 0 - 5)	& GENERAL	± col . 6)	
		COORDI NATOR	, ,		·	
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	48, 102	48, 102		6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	l .		0	7. 00
8.00	Inpatient - Respite Care	0	C	0	0	8. 00
	VI SI TI NG SERVI CES					
9.00	Physi ci an Servi ces	0		-	0	9. 00
10. 00	Nursing Care	0	,	35, 851	64, 682	10.00
11. 00	Nursing Care-Continuous Home Care	0	C	0	0	11.00
12. 00	Physi cal Therapy	0	C	0	0	12. 00
13. 00	Occupational Therapy	0	C	0	0	13.00
14. 00	1 3 9 93	0	C	0	0	14.00
	Medical Social Services	0	3, 676	4, 571	8, 247	15. 00
	Spiritual Counseling	0	C	0	0	16. 00
	Di etary Counsel i ng	0		0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	18.00
19. 00	Home Health Aide and Homemaker	0	6, 176	7, 680	13, 856	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	20.00
21. 00	Other	0	<u> </u> C) 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	1			0	22.00
22. 00	Drugs, Biological and Infusion Therapy	0	C		0	22. 00
23. 00	Anal gesi cs			0	0	23. 00
	Sedatives / Hypnotics				0	24. 00
25. 00	Other - Specify				0	25. 00
26. 00 27. 00	Durable Medical Equipment/Oxygen Patient Transportation				0	26. 00 27. 00
	Imaging Services				0	28.00
	Labs and Diagnostics				0	29. 00
	Medical Supplies				0	30.00
31. 00	Outpatient Services (including E/R Dept.)				0	31. 00
32. 00	Radi ati on Therapy			ή	0	32.00
33. 00	Chemotherapy		_	-	0	33.00
34. 00	Other		_	-	0	34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		1	,	<u> </u>	34.00
35. 00	Bereavement Program Costs	1 0	C	0	0	35. 00
36. 00	Volunteer Program Costs		_	_	0	36. 00
37. 00	Fundrai si ng				0	37.00
38. 00	Other Program Costs				0	38.00
	Total (sum of lines 1 thru 38)		86, 785		86, 785	
57.50	1.2.2. (22 3	1	1 25,700	1	55, 700	1 07. 00

| In Lieu of Form CMS-2552-10 | Provider CCN: 150064 | From 10/01/2014 | Part II | Hospice CCN: 151548 | To 09/30/2015 | Date/Time Prepared: 2/25/2016 2: 25 pm

					10 077 007 2010	2/25/2016 2: 2	5 pm
					Hospi ce I		
		CAPITAL RE	LATED COST		'		
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATION	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.	(22,102)	COORDI NATOR	
		'''	VALUE	FT.)		(HOURS)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
		0	0				2.00
2.00	Capital Related Costs-Movable Equip.	0	0				
3.00	Plant Operation and Maintenance	0	0		0		3.00
4.00	Transportation - Staff	0	0		0	_	4. 00
5.00	Volunteer Service Coordination	0	0		0		5. 00
6.00	Administrative and General	0	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0		7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physician Services	0	0		0 0	0	9. 00
10.00	Nursi ng Care	o	0		0 0	0	10. 00
11.00	Nursing Care-Continuous Home Care	ol	0		0 0	0	11. 00
12. 00	Physical Therapy	0	0		0 0	0	12.00
13. 00	Occupational Therapy	0	0		0 0		13. 00
14. 00	Speech/ Language Pathology		0		0 0		14. 00
15. 00	Medical Social Services		0		0 0	-	15. 00
16. 00	Spiritual Counseling	0	0		0 0	0	16.00
17. 00		0	0		0 0		17. 00
	Di etary Counsel i ng	0	0		0 0		
18.00	Counseling - Other	0	0		-1	0	18.00
19. 00	Home Health Aide and Homemaker	0	0		0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0		20.00
21. 00	Other	[0	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS		_	T			
22. 00	Drugs, Biological and Infusion Therapy	0	0		0		22. 00
23. 00	Anal gesi cs	0	0		0	-	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	-	24. 00
25. 00	Other - Specify	0	0		0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27.00	Patient Transportation	0	0		0 0	0	27. 00
28.00	I maging Services	O	0		0 0	0	28. 00
29. 00	Labs and Diagnostics	o	0		0 0	0	29. 00
30. 00	Medical Supplies	0	0		0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0 0	Ö	31.00
32. 00	Radi ati on Therapy	0	0		0 0		32.00
33. 00	Chemotherapy	0	0		0 0	-	33.00
34. 00	Other	0	0		0 0		34.00
34.00		l U	0		0 0	0	34.00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE	0	0		0 0	0	25 00
35. 00	Bereavement Program Costs						35. 00
36. 00	Volunteer Program Costs	0	0		0		36.00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0		0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0		0	0	39. 00
40. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 000000	0. 000000	40.00

						2/25/2016 2::	25 pm
					Hospi ce I		
		RECONCI LI ATI ON	ADMI NI STRATI VE				
			& GENERAL				
			(ACC. COST)				
	I	6A	6. 00				
	GENERAL SERVICE COST CENTERS	_	ı	1			
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0					2. 00
3.00	Plant Operation and Maintenance	0					3. 00
4.00	Transportation - Staff	0					4. 00
5.00	Volunteer Service Coordination						5. 00
6.00	Administrative and General	-48, 102	38, 683				6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0					7. 00
8.00	Inpatient - Respite Care	0	0				8.00
	VISITING SERVICES						
9. 00	Physi ci an Servi ces	0	0				9. 00
10.00	Nursing Care	0	28, 831				10.00
	Nursing Care-Continuous Home Care	0	0				11. 00
	Physi cal Therapy	0	0				12. 00
13.00	Occupational Therapy	0	0				13. 00
14.00	Speech/ Language Pathology	0	0				14. 00
15.00	Medical Social Services	0	3, 676				15. 00
16.00	Spiritual Counseling	0	0				16. 00
17.00	Di etary Counsel i ng	0	0				17. 00
18.00	Counseling - Other	0	0				18. 00
19.00	Home Health Aide and Homemaker	0	6, 176				19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.00
21.00	Other	0	0				21. 00
	OTHER HOSPICE SERVICE COSTS						
	Drugs, Biological and Infusion Therapy	0	0				22. 00
	Anal gesi cs	0	0				23. 00
24.00	Sedatives / Hypnotics	0	0				24. 00
	Other - Specify	0	0				25. 00
	Durable Medical Equipment/Oxygen	0	0				26. 00
	Patient Transportation	0	0				27. 00
	I maging Services	0	0				28. 00
	Labs and Diagnostics	0	0				29. 00
30.00	Medical Supplies	0	0				30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	1			31. 00
32.00	Radiation Therapy	0	0				32. 00
33.00	Chemotherapy	0	0				33. 00
34.00	Other	0	0				34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0				35. 00
36.00	Volunteer Program Costs	0	0				36. 00
	Fundrai si ng	0	0				37. 00
38.00	Other Program Costs	0	0				38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		48, 102				39. 00
40.00	Unit Cost Multiplier		1. 243492				40. 00

Health Financial Systems FAYETTE REGALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Cost Center Description							2/25/2016 2: 2	5 pm
Cost Center Description						Hospi ce I		
Cost Center Description		·		CAPI TAL				
Selection Fixt Benefits B				RELATED COSTS				
1.00		Cost Center Description	Hospi ce Tri al	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
1.00			Bal ance (1)	FLXT	BENEFITS		& GENERAL	
1.00					DEPARTMENT			
2. 00 Inpatient - General Care 0			0	1. 00	4. 00	4A	5. 00	
3.00	1.00	Administrative and General		0	7, 68	7, 683	1, 652	1. 00
4.00 Physician Services 0 0 0 0 0 0 0 0 0	2.00	Inpatient - General Care	0	0		0	0	2. 00
5.00 Nursing Care 64,682 0 0 64,682 13,910 5.00 6.00 Nursing Care-Continuous Home Care 0 <td< td=""><td>3.00</td><td>Inpatient - Respite Care</td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>3. 00</td></td<>	3.00	Inpatient - Respite Care	0	0		0	0	3. 00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 7.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 7.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	Physi ci an Servi ces	0	0		0	0	4. 00
7. 00 Physical Therapy 0 11.00 0 0 0 11.00 0	5.00	Nursi ng Care	64, 682	0		0 64, 682	13, 910	5. 00
8. 00 Occupational Therapy 0 11.00 0 0 0 0 0 0 0 0 0 0 12.00 0 0 0 0 11.00 0 0 0 0 0 0 12.00 0 0 0 0 0 12.00 0 <td>6.00</td> <td>Nursing Care-Continuous Home Care</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>6. 00</td>	6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
9.00 Speech Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 8.247 0 0 0 8.247 11.00 Spiritual Counseling 0 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 0 13.00 Counseling 0 0 0 0 0 14.00 Home Health Aide and Homemaker 13.856 0 0 13.856 2.980 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 16.00 Other 0 0 0 0 0 0 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 18.00 Analgesics 0 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 0 20.00 Other - Specify 0 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22.00 Patient Transportation 0 0 0 0 0 23.00 Imaging Services 0 0 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 0 0 25.00 Other Seedical Secondary 0 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 27.00 Radiation Therapy 0 0 0 0 0 28.00 Other Services (including E/R Dept.) 0 0 0 0 29.00 Other Services (including E/R Dept.) 0 0 0 0 29.00 Other Services (including E/R Dept.) 0 0 0 0 29.00 Other Services (including E/R Dept.) 0 0 0 0 29.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 20.00 Other Services (including E/R Dept.) 0 0 0 0 21.00 0 0 0 0 0 22.00 Other Services (including E/R Dept.) 0 0 0 0 23.00 Other Services (including E/R Dept.) 0 0 0 0 24.00 Other Services (including E/R Dept.) 0 0 0 0 25.00 Other Services (including	7.00	Physical Therapy	0	0		0	0	7. 00
10.00 Medical Social Services 8,247 0 0 8,247 1,773 10.00 11.00 Spiritual Counseling 0 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 0 13.00 Counseling - Other 0 0 0 0 0 14.00 Home Health Aide and Homemaker 13,856 0 0 13,856 2,980 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 16.00 Other 0 0 0 0 0 0 0 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 18.00 Anal gesics 0 0 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 Other - Specify 0 0 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22.00 Patient Transportation 0 0 0 0 0 23.00 Imaging Services 0 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 0 25.00 Medical Supplies 0 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 27.00 Radiation Therapy 0 0 0 0 0 28.00 Chemotherapy 0 0 0 0 0 29.00 Other 0 0 0 0 0 29.00 Other 0 0 0 0 0 29.00 Other 0 0 0 0 29.00 Other 0 0 0 0 20.00 Other 0 0 0 0 21.00 Otherapy 0 0 0 0 22.00 Otherapy 0 0 0 0 23.00 Otherapy 0 0 0 0 24.00 Otherapy 0 0 0 0 25.00 Otherapy 0 0 0 0 26.00 Otherapy 0 0 0 0 27.00 Otherapy 0 0 0 0 28.00 Chemotherapy 0 0 0 0 29.00 Otherapy 0 0 0 0 29.00 Otherapy 0 0 0 0 29.00 Otherapy 0 0 0 0 20.00 Otherapy 0 0 0 0 21.00 Otherapy 0 0 0 0 22.00 Otherapy 0 0 0 0 23.00 Otherapy 0 0 0 0 24.00 Otherapy 0 0 0 0 25.00 Otherapy 0 0 0 0 26.00 Otherapy 0 0 0 0 27.00 Otherapy 0 0 0 0 28.00 Otherapy 0 0 0 0 29.00 Otherapy 0 0 0 0 30.00 Othe	8.00	Occupational Therapy	0	0		0	0	8. 00
11.00 Spiritual Counseling 0	9.00	Speech/ Language Pathology	0	0		0	0	9. 00
12. 00 Di etary Counsel ing 0 0 0 0 0 0 12. 00 13. 00 Counsel ing - Other 0 0 0 0 0 0 13. 00 14. 00 Mome Heal th Aide and Homemaker 13, 856 0 0 0 13, 856 2, 980 14. 00 15. 00	10.00	Medical Social Services	8, 247	0		0 8, 247	1, 773	10.00
13.00 Counseling - Other O O O O O O O O O	11. 00	Spiritual Counseling	0	0		0	0	11. 00
14. 00 Home Heal th Ai de and Homemaker 13,856 0 0 13,856 2,980 14.00 15. 00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16. 00 Other 0 0 0 0 0 0 15.00 17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18. 00 Anal gesics 0 0 0 0 0 0 17.00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 18.00 19. 00 Other - Specify 0 0 0 0 0 0 0 19.00 20. 00 Other - Specify 0	12.00	Di etary Counsel i ng	0	0		0	0	12.00
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 18.00 20.00 Other - Specify 0 0 0 0 0 0 19.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 22.00 0 23.00 Imaging Services 0 0 0 0 0 0 0 22.00 0 0 22.00 0 0 0 22.00 0 0 0 0 0 0 0	13.00	Counseling - Other	0	0		0	0	13.00
16.00 Other 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 18.00 20.00 Other - Specify 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00	Home Health Aide and Homemaker	13, 856	0		0 13, 856	2, 980	14. 00
17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 0 18. 00 19. 00 Sedati ves / Hypnotics 0 0 0 0 0 0 19. 00 20. 00 Other - Speci fy 0 <td>15.00</td> <td>HH Aide & Homemaker - Cont. Home Care</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>15. 00</td>	15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
18.00 Analgesics	16.00	Other	0	0		0 0	0	16. 00
18.00 Analgesics	17. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17. 00
20.00 Other - Specify 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 <t< td=""><td>18.00</td><td>Anal gesi cs</td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>18. 00</td></t<>	18.00	Anal gesi cs	0	0		0	0	18. 00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 24.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 <	19.00	Sedatives / Hypnotics	0	0		0	0	19. 00
22. 00 Patient Transportation 0 0 0 0 0 22. 00 23. 00 Imaging Services 0 0 0 0 0 0 23. 00 24. 00 Labs and Diagnostics 0 0 0 0 0 0 0 24. 00 25. 00 Medical Supplies 0 0 0 0 0 0 0 0 25. 00 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 25. 00 27. 00 Radiation Therapy 0 0 0 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 0 28. 00 29. 00 Other 0	20.00	Other - Specify	0	0		0	0	20. 00
23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 0 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
24. 00 Labs and Diagnostics 0 0 0 0 0 24. 00 25. 00 Medical Supplies 0 0 0 0 0 0 25. 00 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26. 00 27. 00 Radiation Therapy 0 0 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 0 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 0 0 0 0 0 0 31. 00 31. 00 Vol unteer Program Costs 0 0 0 0 0 0 0 0 32. 00 33. 00 Other Program Costs 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00	Patient Transportation	0	0		0	0	22. 00
25. 00 Medical Supplies 0 0 0 0 0 25. 00 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26. 00 27. 00 Radiation Therapy 0 0 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 0 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 0 0 0 0 0 0 31. 00 31. 00 Vol unteer Program Costs 0 0 0 0 0 0 0 0 0 0 32. 00 32. 00 Fundrai si ng 0	23.00	I maging Services	0	0		0	0	23. 00
26. 00 Outpati ent Services (including E/R Dept.) 0 0 0 0 0 26. 00 27. 00 Radi ati on Therapy 0 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 0 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 0 0 30. 00 31. 00 Vol unteer Program Costs 0 0 0 0 0 0 0 32. 00 32. 00 Fundrai si ng 0 0 0 0 0 0 0 32. 00 33. 00 Other Program Costs 0 0 0 0 0 0 0 0 0 0 0 33. 00 0 34. 00 Total (sum of lines 1 thru 33) (2) 86, 785 0 7, 683 94, 468 20, 315 34. 00	24.00	Labs and Diagnostics	0	0		0	0	24. 00
27. 00 Radiation Therapy 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 0 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 0 0 30. 00 31. 00 Vol unteer Program Costs 0 0 0 0 0 0 32. 00 32. 00 Fundraising 0 0 0 0 0 0 32. 00 33. 00 Other Program Costs 0 0 0 0 0 0 0 33. 00 34. 00 Total (sum of lines 1 thru 33) (2) 86, 785 0 7, 683 94, 468 20, 315 34. 00	25.00	Medical Supplies	0	0		0	0	25. 00
28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 0 31.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
29.00 Other 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	27.00	Radi ati on Therapy	0	0		0	0	27. 00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	28.00	Chemotherapy	0	0		0 0	0	28. 00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	29.00	Other	0	0		0	0	29. 00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	30.00	Bereavement Program Costs	0	0		0 0	0	30.00
32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00 7,683 94,468 20,315 34.00	31.00	Volunteer Program Costs	0	0		0 0	0	31. 00
33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	32.00		0	0		0 0	0	32.00
34.00 Total (sum of lines 1 thru 33) (2) 86,785 0 7,683 94,468 20,315 34.00	33.00	Other Program Costs	0	0		0 0	0	33. 00
	34.00	Total (sum of lines 1 thru 33) (2)	86, 785	0	7, 68	94, 468	20, 315	34.00
33.00 Julii 2031 multipiter (366 ilistructions) 0.000000 33.00	35.00	Unit Cost Multiplier (see instructions)				0. 000000		35. 00

Health Financial Systems FAYETTE RE ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150064 Hospi ce CCN:

Cost Center Description OPERATION OF PLANT PLANT LI NEN SERVI CE Hospi ce I HOUSEKEEPI NG DI ETARY PLANT PLANT LI NEN SERVI CE	
PLANT PLANT LI NEN SERVI CE	
7.00 7.01 8.00 9.00 10.00	
1.00 Administrative and General 0 0 0 0	1.00
2.00 Inpatient - General Care 0 0 0 0	2.00
3.00 Inpatient - Respite Care 0 0 0 0	3.00
4.00 Physician Services 0 0 0 0 0	4.00
5.00 Nursing Care 0 0 0 0 0	5.00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0	6.00
7.00 Physical Therapy 0 0 0 0 0	7.00
8.00 Occupational Therapy 0 0 0 0 0	8.00
9.00 Speech/ Language Pathology 0 0 0 0	9.00
10.00 Medical Social Services 0 0 0 0	10. 00
11.00 Spiritual Counseling 0 0 0 0 0	11. 00
12. 00 Di etary Counsel i ng	12. 00
13.00 Counseling - Other 0 0 0 0	13. 00
14.00 Home Heal th Aide and Homemaker 0 0 0 0	14. 00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0	15. 00
16.00 Other 0 0 0 0	16. 00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0	17. 00
	18. 00
	19. 00
	20. 00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0	21. 00
	22. 00
	23. 00
	24. 00
	25. 00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0	26. 00
	27. 00
	28. 00
	29. 00
30.00 Bereavement Program Costs 0 0 0 0	30. 00
	31. 00
	32. 00
	33. 00
	34. 00
	35. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider (

							2/25/2016 2: 2	5 pm
						Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NO	3	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRA	TI ON	SERVICES &		RECORDS &	
					SUPPLY		LI BRARY	
		11. 00	13.00		14. 00	15. 00	16. 00	
1.00	Administrative and General	(0	0	0	4, 074	1. 00
2.00	Inpatient - General Care	(0	0	0	0	2. 00
3.00	Inpatient - Respite Care	(0	0	0	0	3. 00
4.00	Physi ci an Servi ces	(0	0	0	0	4. 00
5.00	Nursi ng Care	C		0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	(0	0	0	0	6. 00
7.00	Physi cal Therapy	(0	0	0	0	7. 00
8.00	Occupational Therapy	(0	0	0	0	8. 00
9.00	Speech/ Language Pathology	(C		0	0	0	0	9. 00
10.00	Medical Social Services	(0	0	0	0	10.00
11. 00	Spiritual Counseling	(0	0	0	0	11. 00
12.00	Di etary Counsel i ng	(0	0	0	0	12. 00
13.00	Counseling - Other	(0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	(0	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	(0	0	0	0	15. 00
16.00	Other	(0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	(0	0	0	0	17. 00
18. 00	Anal gesi cs	(0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	(0	0	0	0	19. 00
20.00	Other - Specify	(0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	(0	0	0	0	21. 00
22. 00	Patient Transportation	(0	0	0	0	22. 00
23. 00	I maging Services	(0	0	0	0	23. 00
24. 00	Labs and Diagnostics	(0	0	0	0	24. 00
25. 00	Medical Supplies	(0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0		0	0	0	0	26. 00
27. 00	Radiation Therapy	(0	0	0	0	27. 00
28. 00	Chemotherapy	(0	0	0	0	28. 00
29. 00	Other	(0	0	0	0	29. 00
30.00	Bereavement Program Costs	(0	0	0	0	30. 00
31.00	Volunteer Program Costs	(0	0	0	0	31. 00
32. 00	Fundrai si ng	[C	P	0	0	0	0	32. 00
33. 00	Other Program Costs	[C	P	0	0	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	[C	P	0	0	0	4, 074	
35. 00	Unit Cost Multiplier (see instructions)		1					35. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider (

						2/25/2016 2: 2	5 pm
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24. 00	25. 00	26.00	27. 00	28. 00	
1.00	Administrative and General	13, 409					1. 00
2.00	Inpatient - General Care	C) 0	0	0	0	2. 00
3.00	Inpatient - Respite Care	C) 0	0	0	0	3. 00
4.00	Physician Services	C	0	0	0	0	4. 00
5.00	Nursing Care	78, 592	2 0	78, 592	9, 994	88, 586	5. 00
6.00	Nursing Care-Continuous Home Care	C	0	0	0	0	6. 00
7.00	Physi cal Therapy	C	0	0	0	0	7. 00
8.00	Occupational Therapy	C	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	C	0	0	0	0	9. 00
10.00	Medical Social Services	10, 020	0	10, 020	1, 274	11, 294	10.00
11. 00	Spiritual Counseling	C	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	C	0	0	0	0	12. 00
13.00	Counseling - Other	C	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	16, 836	0	16, 836	2, 141	18, 977	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	C	0	0	0	0	15. 00
16.00	Other	C	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	C	0	0	0	0	17. 00
18.00	Anal gesi cs	C	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	C	0	0	0	0	19. 00
20.00	Other - Specify		0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	C	0	0	0	0	21. 00
22. 00	Patient Transportation	C	0	0	0	0	22. 00
23. 00	I maging Services		0	0	0	0	23. 00
24.00	Labs and Diagnostics		o	0	0	0	24. 00
25. 00	Medical Supplies		o	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)		o	0	0	0	26. 00
27. 00	Radiation Therapy		ol o	l o	0	0	27. 00
28. 00	Chemotherapy		ol o	0	0	0	28. 00
29. 00	Other		ol o	0	0	0	29. 00
30. 00	Bereavement Program Costs			0	0	0	30.00
31. 00	Volunteer Program Costs			0	0	0	31. 00
32. 00	Fundrai si ng			0	0	0	32.00
33. 00	Other Program Costs			1 0	n	0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	118, 857		118, 857		118, 857	34.00
	Unit Cost Multiplier (see instructions)	1.0,007		1.0,007	0. 127162		35. 00
55. 50	James 3032 mar trpirer (300 riistraotrolis)	I	1	l .	0. 127 102	I	, 55. 55

STATISTICAL BASIS

						2/25/2016 2: 2	5 pm
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)		,	ŕ	
		1.00	4. 00	5A	5. 00	7. 00	
1.00	Administrative and General	0	38, 683	C	7, 683	0	1. 00
2.00	Inpatient - General Care	O	0) c	0	0	2. 00
3.00	Inpatient - Respite Care	o	0	ol c	0	0	3. 00
4.00	Physi ci an Servi ces	O	0) c	0	0	4. 00
5.00	Nursi ng Care	l ol	0		64, 682	0	5.00
6.00	Nursing Care-Continuous Home Care	o	0		0	0	6. 00
7. 00	Physi cal Therapy	0	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8. 00
9. 00	Speech/ Language Pathology	ا	0		0	0	9. 00
10. 00	Medical Social Services		0		8, 247	0	10.00
11. 00	Spiritual Counseling		0		0,2.7	0	11.00
12. 00	Di etary Counsel i ng		0		o o	0	12.00
13. 00	Counseling - Other		0		o o	0	13. 00
14. 00	Home Health Aide and Homemaker		0		13, 856	0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care		0		10,000	0	15. 00
16. 00	Other		0		o o	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy		0			0	17. 00
18. 00	Anal gesi cs		0			Ö	18. 00
19. 00	Sedatives / Hypnotics		0			0	19.00
20. 00	Other - Specify		0		o o	0	20.00
21. 00	Durable Medical Equipment/Oxygen		0		o o	0	21.00
22. 00	Patient Transportation		0		o o	0	22. 00
23. 00	Imaging Services		0		o o	0	23. 00
24. 00	Labs and Diagnostics		0		o o	0	24.00
25. 00	Medical Supplies		0		o o	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)		0		0	0	26. 00
27. 00	Radi ati on Therapy		0			0	27. 00
28. 00	Chemotherapy		0			0	28. 00
29. 00	Other		0			0	29. 00
30. 00	Bereavement Program Costs		0			0	30.00
31. 00	Volunteer Program Costs		0			0	31.00
32. 00	Fundrai si ng		0			0	32. 00
33. 00	Other Program Costs		0			0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		38, 683		94, 468	0	34.00
35. 00	Total cost to be allocated	0	7, 683		20, 315	0	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 198614		0. 215046	_	
30.00	Join Cost Multiplier (See Histructions)	0.000000	0. 190014	1	0. 213046	0.000000	30.00

STATISTICAL BASIS

							2/25/2016 2: 2	5 pm
						Hospi ce I		
	Cost Center Description	OPERATION OF	LAI	UNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LI NEI	N SERVICE	(SQUARE	(MEALS	(MAN	
		(SQUARE		OUNDS OF	FEET)	SERVED)	HOURS)	
		FEET)		(UNDRY)				
		7. 01		8. 00	9. 00	10.00	11. 00	
1.00	Administrative and General	C		0)	0	0	1. 00
2.00	Inpatient - General Care	C		0)	0	0	2. 00
3.00	Inpatient - Respite Care	C		0)	0	0	3. 00
4.00	Physi ci an Servi ces	C		0)	0	0	4. 00
5.00	Nursi ng Care	C		0)	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	C)	0)	0	0	6. 00
7.00	Physi cal Therapy	C		0)	0	0	7. 00
8.00	Occupational Therapy	C)	0)	0	0	8. 00
9.00	Speech/ Language Pathology			0)	0	0	9. 00
10.00	Medical Social Services	C		0)	0	0	10.00
11.00	Spiritual Counseling		ol	0)	0	0	11. 00
12.00	Di etary Counseling			0)	0	0	12.00
13.00	Counseling - Other		ol	0)	0	0	13.00
14. 00	Home Health Aide and Homemaker			0)	0	0	1
15. 00	HH Aide & Homemaker - Cont. Home Care			0)	0	0	15. 00
16. 00	Other			0)	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy			0)	0	0	1
18. 00	Anal gesi cs			0)	0	0	1
19. 00	Sedatives / Hypnotics		ol .	0	,	0	0	1
20.00	Other - Specify		ol .	0	,	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen		ol .	0	,	0	0	21. 00
22. 00	Pati ent Transportation			0	,	0	0	1
23. 00	Imaging Services			0		0	0	1
24. 00	Labs and Diagnostics			0		0	0	24. 00
25. 00	Medical Supplies			0		0	0	25. 00
	Outpatient Services (including E/R Dept.)			0		0	٥	26. 00
27. 00	Radi ati on Therapy		á	0		0	o o	27. 00
28. 00	Chemotherapy		S)	0		0	l o	28. 00
29. 00	Other		ál –	0		0	0	1
30. 00	Bereavement Program Costs		ál –	0) 0	0	30.00
31. 00	Volunteer Program Costs		()	0]		0	31.00
32. 00	Fundrai si ng		()	0]		0	32. 00
33. 00	Other Program Costs		()	0]		0	1
34. 00	Total (sum of lines 1 thru 33) (2)		()	0				34.00
35. 00	Total cost to be allocated		()	0]		0	1
	1	0. 000000	()	0. 000000	0. 00000	0. 000000	_	
30.00	Unit Cost Multiplier (see instructions)	0.000000	'l	0. 000000	J 0. 000001	J ₁ 0.000000	J 0. 000000	1 30.00

						2/25/2016 2:25 pm
					Hospi ce I	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	'	ADMI NI STRATI ON	SERVICES &	(100%)	RECORDS &	
			SUPPLY	, ,	LI BRARY	
		(FTE'S)	(100%)		(GROSS	
		` ′	` ′		CHARGES)	
		13.00	14.00	15. 00	16.00	
1.00	Administrative and General	0	0	(228, 513	1.00
2.00	Inpatient - General Care	o	0	· C	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	3.00
4.00	Physi ci an Servi ces	0	0		0	4. 00
5.00	Nursing Care	0	0		0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	·	0	6. 00
7.00	Physi cal Therapy	o	0		0	7.00
8.00	Occupational Therapy	o	0		0	8. 00
9.00	Speech/ Language Pathology	o	0		0	9.00
10.00	Medical Social Services	o	0		0	10.00
11. 00	Spiritual Counseling	0	0	d	0	11. 00
12. 00	Di etary Counsel i ng	0	0	d	0	12. 00
13. 00	Counseling - Other	0	0		0	13. 00
14. 00	Home Health Aide and Homemaker	0	0	d	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	15. 00
16. 00	Other	0	0		o o	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0		o o	17. 00
18. 00	Anal gesi cs	0	0		0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	19. 00
20. 00	Other - Specify	0	0		0	20. 00
21. 00	Durable Medical Equipment/Oxygen	o	0		0	21. 00
22. 00	Pati ent Transportation	o	0		0	22. 00
23. 00	I maging Services	o	0		o	23. 00
24. 00	Labs and Diagnostics	o	0		o	24. 00
25.00	Medical Supplies	0	0	1 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		o	26. 00
27. 00	Radi ati on Therapy	o	0		o	27. 00
28. 00	Chemotherapy	0	0	1 0	0	28. 00
29.00	Other	o	0	1 0	0	29. 00
30.00	Bereavement Program Costs	o	0		0	30.00
31.00	Volunteer Program Costs	0	0	1 0	0	31.00
32.00	Fundrai si ng	0	0	1 0	0	32. 00
33. 00	Other Program Costs	o	0		0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		228, 513	34.00
35. 00	Total cost to be allocated		0	l d	4, 074	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.000000		
					1	1

Heal th	Financial Systems	FAYETTE REGIONAL HEA	ALTH SYSTEM	1	In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150064	Peri od:	Worksheet K-5	
			Hospi co (CCN: 151548	From 10/01/2014 To 09/30/2015		narod:
			nospi ce (JON. 131340	10 09/30/2013	2/25/2016 2: 2	
					Hospi ce I		
	Cost Center Description				ge Total Hospice		
		Ι,	col . 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
	ANOLILIADY OFFICE OF SOUT OFFITTED		0	1.00	2. 00	3. 00	
4 00	ANCI LLARY SERVI CE COST CENTERS			0 (000	2/		4 00
1.00	PHYSI CAL THERAPY		66.00		96 0	0	
2.00	OCCUPATIONAL THERAPY		67.00				2.00
3.00	SPEECH PATHOLOGY		68.00	l .	2/		3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00		26 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	l .	(2)		5. 00
6.00	LABORATORY		60. 00 60. 01			0	6. 00
6. 01 7. 00	BLOOD LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00			0	
7. 00 8. 00	CLINIC		93.00			0	7. 00 8. 00
8. 00 8. 01	BIC		93.00			0	
8. 01	UCIC		93.01			0	8.01
8. 03	CIC		93. 02			0	8. 03
8. 04	RIC		93.03			0	
8. 05	PODLATRY		93. 04			0	8. 05
8. 06	UROLOGY		93.06		55	0	8.06
8. 07	PULMONOLGY		93. 00	1			8. 07
9. 00	RADI OLOGY-THERAPEUTI C		55. 00				9.00
10. 00	OTHER ANCILLARY SERVICE COST CENTERS		76.00	1			10.00
11. 00	Totals (sum of lines 1-10)		70.00	1		0	
11.00	Trotars (sam or rines i 10)	ı		1	į.	١	1

	Financial Systems FAYETTE REGIONAL	HEALTH SYSTE	М	In Lie	u of Form CMS-	<u> 2552-10</u>
CALCULATION OF HOSPICE PER DIEM COST		Provi der	CCN: 150064	Peri od:	Worksheet K-6	
		Hospi ce	CCN: 151548	From 10/01/2014 To 09/30/2015		
				Hospi ce I		
		Title XVIII	Title XIX	0ther	Total	
		1.00	2. 00	3. 00	4. 00	
1.00	Total cost (see instructions)				118, 857	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1, 197	2. 00
3.00	Average cost per diem (line 1 divided by line 2)				99. 30	3. 00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1, 19	7			4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	118, 86	2			5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)			0		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		o			8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		o			9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00	Aggregate NF cost (line 3 times line 10)			0		11. 00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12. 00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13. 00

Heal th	Financial Systems FAYETTE REGIONAL HEA	ALTH SYSTEM	In Lie	u of Form CMS-2	2552-10			
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150064	Peri od: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prep 2/25/2016 2:29	pared:			
		Title XVIII	Hospi tal	PPS				
	DART I FULLY PROOPERTING METHOD			1. 00				
	PART I - FULLY PROSPECTIVE METHOD							
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 232,99							
1. 00	Model 4 BPCI Capital DRG other than outlier				1. 00 1. 01			
2. 00	Capital DRG outlier payments				2. 00			
2. 01	Model 4 BPCI Capital DRG outlier payments		0	2. 01				
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)				3. 00			
4.00	Number of interns & residents (see instructions)				4. 00			
5.00	Indirect medical education percentage (see instructions)				5. 00			
6.00	Indirect medical education adjustment (multiply line 5 by the s	0	6. 00					
	1.01) (see instructions)							
7. 00	Percentage of SSI recipient patient days to Medicare Part A pat	tient days (Worksheet E	, part A line	0. 00	7. 00			
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instruct		0.00	8. 00				
9. 00	Sum of lines 7 and 8				9.00			
10. 00					10.00			
11. 00	Disproportionate share adjustment (see instructions)			0	11. 00			
12.00	, , , , , , , , , , , , , , , , , , , ,			232, 993	12.00			
	PART II - PAYMENT UNDER REASONABLE COST			1. 00				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00			
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00			
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00			
4.00	Capital cost payment factor (see instructions)			0	4. 00			
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00			
				1. 00				
	PART III - COMPUTATION OF EXCEPTION PAYMENTS							
1.00	Program inpatient capital costs (see instructions)			0	1. 00			
2.00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		0	2. 00			
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00			
4.00	Applicable exception percentage (see instructions)			0.00				
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst	tructions)		0 0. 00				
7. 00	Adjustment to capital minimum payment level for extraordinary of		· Lino 6)	0.00				
8. 00	Capital minimum payment level (line 5 plus line 7)	circuiistances (iiile 2 x	. Title 0)	0				
9. 00	Current year capital payments (from Part I, line 12, as applications)	ahl e)		o o				
10. 00	Current year comparison of capital minimum payment level to cap		Less Line 9)	0				
11. 00	Carryover of accumulated capital minimum payment level over cap			0				
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital paym	monto (lino 10 nluo lim	o 11)	0	12. 00			
13. 00	Current year exception payment (if line 12 is positive, enter 1			0				
14. 00	Carryover of accumulated capital minimum payment level over cap			0				
17.00	(if line 12 is negative, enter the amount on this line)	or tar payment for the f	or owing period	١	17.00			
15. 00	Current year allowable operating and capital payment (see instr	ructions)		0	15. 00			
16. 00		:		0	16. 00			
17. 00	Current year exception offset amount (see instructions)			0	17. 00			