Health Financia	al Syst	ems	FAYETTE REGIONAL HEAI	_TH SYSTEM	In Lie	u of Form CMS-2552-10
This report is	requir	ed by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can re	sult in all interim	FORM APPROVED
payments made	since t	he beginning of the co	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H	IOSPI TAL	. HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 15006		Worksheet S
AND SETTLEMENT	SUMMAR	Υ			From 10/01/2013	
					To 09/30/2014	Date/Time Prepared:
						2/25/2015 10:47 am
PART I - COST	REPORT	STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 2/25/20	15 Time: 10:47 am
use only	2. [] Manually submitted co	st report			
			report enter the number of		resubmitted this c	ost report
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.		
Contractor	5. [1	1Cost Report Status	6. Date Received:	1	O. NPR Date:	
use only		As Submitted			1. Contractor's Vendo	
, , ,	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CCN 1	2. [0]If line 5, co	olumn 1 is 4: Enter
		Settled with Audit	9. [N] Final Report for the	nis Provider CCN		nes 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 10/01/2013 and ending 09/30/2014 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 Provider(s)
				` '
				
Title				
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	261, 030	-80, 104	-23, 035	-481, 665	1. 00
2.00	Subprovider - IPF	0	3	0		-231, 168	2. 00
3.00	Subprovider - IRF	0	-11, 726	0		-22, 487	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	1	-11		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	249, 308		-,	,	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.

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150064 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/25/2015 10:37 am 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 CCN CBSA Provi der Date Payment System (P, Certi fi ed Number Number T, 0, or N) 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 N 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 Hospital -Based Health Clinic - FQHC 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: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2013 09/30/2014 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 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) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" for no Out-of Medi cai d 0ther In-State In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d Medicai d Medi cai d paid days el i gi bl e days unpai d paid days el i gi bl e days unpai d 4. 00 3.00 6.00 1.00 2 00 5.00 24.00 If this provider is an IPPS hospital, enter the 288 242 0 548 0 24.00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 33 0 0 0 13 25.00 Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.

0. od

o. od

61.06

primary care and/or general surgery FTE counts (line

used for cap relief and/or FTEs that are nonprimary

61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being

care or general surgery. (see instructions)

Health Financial Systems	EVALLE DE	EGIONAL HEAI	TH SVSTEM		In lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE CON				CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S- Part I	2 epared:
		Prograi	n Name	Program Cod	e Unweighted IME FTE Count		
		1. (00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, spe specialty, if any, and the num for each new program. (see ins column 1 the program name, ent program code, enter in column unweighted count and enter in FTE unweighted count.	per of FTE residents tructions) Enter in er in column 2 the 3 the IME FTE				0.00	0. 0	00 61.10
61.20 Of the FTEs in line 61.05, spe program specialty, if any, and residents for each expanded pr instructions) Enter in column enter in column 2 the program 3 the IME FTE unweighted count direct GME FTE unweighted coun	the number of FTE ogram. (see I the program name, code, enter in column and enter in column 4				0.00	O. C	00 61.20
						1.00	_
ACA Provisions Affecting the H	ealth Resources and Ser	rvices Admii	ni strati on	(HRSA)		1.00	
62.00 Enter the number of FTE reside			this cost	reporting pe	riod for which	0.0	00 62.00
your hospital received HRSA PC 62.01 Enter the number of FTE reside during in this cost reporting Teaching Hospitals that Claim	nts that rotated from a period of HRSA THC prog	a Teaching H gram. (see i	nstructi o		o your hospital	0.0	62. 01
63.00 Has your facility trained resi "Y" for yes or "N" for no in c	dents in non-provider s	settings dur	ing this			N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1 (col. 1 + col 2))	
C 11 5504 C 11 404 B 14	ETE D ' L L ' N			1.00	2.00	3.00	
Section 5504 of the ACA Base Y period that begins on or after				inis base yea	ar is your cost	reporting	
64.00 Enter in column 1, if line 63 in the base year period, the n resident FTEs attributable to settings. Enter in column 2 t resident FTEs that trained in of (column 1 divided by (column 2 trained in the column 3 trained	s yes, or your facilit umber of unweighted nor rotations occurring in ne number of unweighted your hospital. Enter in	ty trained n n-primary ca all non-pro d non-priman n column 3 1	residents are ovider ry care the ratio	0.	00 0.00	0. 00000	64.00
	Program Name	Progra	n Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3 (col. 3 + col 4))	
	1.00	2. (00	3. 00	4. 00	5. 00	
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				0.	00 0.00	0. 00000	00 65.00

unweighted primary care FTE

residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of

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)

	Financial Systems		EGIONAL HEALT				n Lie	u of Form		2552-10
HOSPI TAL	L AND HOSPITAL HEALTH CARE COMPI	LEX IDENIIFICATION DA	IA F	rovi der		Period: From 10/01/ To 09/30/		Workshe Part I Date/Ti		oared:
					Unwei ghted	Unwei gh	ted	2/25/20 Ratio (c		37 am
					FTEs Nonprovi der	FTEs i	n	(col . 1 2))	+ col.	
					Si te 1.00	2.00				
	ection 5504 of the ACA Current		n Nonprovi der	setti ng		2.00 for cost re		ng perio		
	eginning on or after July 1, 20 nter in column 1 the number of		y care resid	ent	0.0	00	0. 00	0.	000000	66. 00
F.	TEs attributable to rotations o nter in column 2 the number of	ccurring in all non-p	rovider sett	ngs.						
F ⁻	TEs that trained in your hospit	al. Enter in column 3	the ratio o							
	column 1 divided by (column 1 +	column 2)). (see ins Program Name	Program	Code	Unwei ghted	Unwei gh	ted	Ratio (c	ol. 3/	
					FTEs Nonprovi der	FTEs i Hospita		(col. 3 4))		
					Si te					
67. 00 Eı	nter in column 1 the program	1. 00	2.00		3. 00	4.00	0. 00	5. 0 0.	000000	67. 00
n	ame associated with each of our primary care programs in									
wl	hich you trained residents.									
	nter in column 2 the program ode. Enter in column 3 the									
	umber of unweighted primary are FTE residents attributable									
to	o rotations occurring in all									
	on-provider settings. Enter in olumn 4 the number of									
	nweighted primary care esident FTEs that trained in									
y	our hospital. Enter in column									
	the ratio of (column 3 ivided by (column 3 + column									
4)). (see instructions)									
							1. 00	2.00	3. 00	
	<pre>npatient Psychiatric Facility P s this facility an Inpatient Ps</pre>		PF), or does	it conta	ain an IPF sub	provi der?	Υ			70. 00
	nter "Y" for yes or "N" for no f line 70 yes: Column 1: Did th		proved GMF t	eaching r	orogram in the	e most	N	N	0	71. 00
re	ecent cost report filed on or b	efore November 15, 20	004? Enter "	Y" for ye	es or "N" for	no.		"		, , , , ,
§.	olumn 2: Did this facility trai 412.424 (d)(1)(iii)(D)? Enter "	Y" for yes or "N" for	no. Column	š: If col	lumn 2 is Y, e	enter 1, 2				
	r 3 respectively in column 3. (eginning of the fourth year, en									
tl	he new teaching program in exis npatient Rehabilitation Facilit	tence, enter 5. (see			·					
75. 00 I :	s this facility an Inpatient Re	habilitation Facility	(IRF), or d	oes it co	ontain an IRF		Υ			75. 00
	ubprovider? Enter "Y" for yes f line 75 yes: Column 1: Did th		proved GME t	eachi ng p	program in the	e most	N	N	0	76. 00
	ecent cost reporting period end o. Column 2: Did this facility									
CI	FR §412.424 (d)(1)(iii)(D)? Ent	er "Y" for yes or "N"	for no. Col	umn 3: I1	f column 2 is	Y, enter				
b	, 2 or 3 respectively in column eginning of the fourth year, en	ter à in column 3, or	if the 5th	or subsec	9 1					
tl	he new teaching program in exis	tence, enter 5. (see	<u>instructions</u>)						
L	ong Term Care Hospital PPS							1. 0	0	
80. 00 I :	s this a long term care hospita	I (LTCH)? Enter "Y"	for yes and	'N" for m	no.			N		80.00
85. 00 I :	EFRA Providers s this a new hospital under 42						no.	N		85. 00
	id this facility establish a ne 413.40(f)(1)(ii)? Enter "Y" fo		excl uded uni	t) under	42 CFR Section	on				86. 00
13						V		XIX		
	itle V and XIX Services					1.00		2.0	U	
	oes this facility have title V es or "N" for no in the applica		hospital ser	vi ces? Ēr	nter "Y" for	N		Υ		90. 00
91. 00 Ĭ :	s this hospital reimbursed for	title V and/or XIX th				N		N		91. 00
92. 00 A	ull or in part? Enter "Y" for y re title XIX NF patients occupy	ing title XVIII SNF b	eds (dual ce	rti fi cati				N		92. 00
	nstructions) Enter "Y" for yes oes this facility operate an IC				XIX? Enter	N		N		93. 00
",	Y" for yes or "N" for no in the oes title V or XIX reduce capit	applicable column.	•			N		N N		94. 00
aı	pplicable column.					IN.	0.00		0.05	
95. 00 I	fline 94 is "Y", enter the red	uction percentage in	tne applicab	e column	n.	1	0. 00	l	U. 00	95. 00

Health Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM		In	Lieu of Fo	rm CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150064	Peri od:	Worksh	eet S-2	
			From 10/01/2 To 09/30/2	014 Date/T	ime Pre	
			V		015 10:	37 am
			1.00		00	1
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	s or "N" for no	o in the	N		N	96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the approximately Rural Providers	olicable column	n.		0. 00	0. 00	97. 00
105.00 Does this hospital qualify as a Critical Access Hospital (CA			N			105. 00
106.00 If this facility qualifies as a CAH, has it elected the all	inclusive meth	hod of paymen	t N			106. 00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligible.	ole for cost re	eimbursement	N			107. 00
for I &R training programs? Enter "Y" for yes or "N" for no						
instructions) If yes, the GME elimination would not be on Wo 25 and the program would be cost reimbursed. If yes complete						
Column 2: If this facility is a CAH, do I&Rs in an approve	d medical educa	ation program				
train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions)	' for yes or "I	N" for no in				
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee schee	dul e? See 42	N			108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	Speech	Posni	ratory	
	1.00	2.00	3.00		00	1
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N	N	N		N	109. 00
for yes or "N" for no for each therapy.						
				1.00 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on	"N" for no i	n column 1 li	F VAS	N I	0	115. 00
enter the method used (A, B, or E only) in column 2. If column				IN		113.00
either "93" percent for short term hospital or "98" percent	9	•				
psychiatric, rehabilitation and long term hospital provider: 15-1, §2208.1.	s) based on the	e definition	II CMS			
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			"N" for	N Y		116. 00 117. 00
no. 118.00 Is the mal practice insurance a claims-made or occurrence pol	icy? Enter 1 i	if the policy	is	1		118. 00
claim-made. Enter 2 if the policy is occurrence.				I		
		Premi ums	Losses	Insu	rance	
		Premi ums	Losses	Insu	rance	
		Premi ums	Losses	Insu	rance	
		1.00	2.00		00	
118.01 List amounts of malpractice premiums and paid losses:			2.00		00	0118. 01
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.	00)118. 01
118.02 Are mal practice premiums and paid losses reported in a cost		1.00 386,09	2.00	3.	00	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee		1.00 386,09	2.00	3.	00	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 DO NOT USE THIS LINE	dule listing co	1.00 386,09 than the ost centers	2.00 59 1.00 N	3.	00 0	118. 02
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	dule listing co d Harmless pro	1.00 386,09 than the ost centers	2.00	3.	00	118. 02
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 DO NOT USE THIS LINE	dule listing co d Harmless prov n column 1 "Y"	1.00 386,09 than the ost centers vision in ACA for yes or	2.00 59 1.00 N	3.	00 0	118. 02
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questions had applicable amendments?	dule listing co d Harmless prov n column 1 "Y" ualifies for tl	1.00 386,09 than the ost centers vision in ACA for yes or the Outpatient	2.00 59 1.00 N	3.	00 0	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the contained by the containe	dule listing conditions during the desired that the desir	than the ost centers vision in ACA for yes or he Outpatient ructions)	2.00 59 1.00 N	3.	00 0	118. 02
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implementations.	dule listing conditions during the desired that the desir	than the ost centers vision in ACA for yes or he Outpatient ructions)	2.00 59 1.00 N	3.	00 0	118. 02 119. 00 120. 00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implementations. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	d Harmless promoted Harmless promoted to the column 1 "Y" ualifies for the column tas? (see instructions)	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to	2.00 59 1.00 N	3.	00 0	118. 02 119. 00 120. 00
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	dule listing condition of the dumination of the	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to	2.00 59 1.00 N	3.	00 0	118. 02 119. 00 120. 00 121. 00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implementations. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	d Harmless proving column 1 "Y" ualifies for thats? (see instrantable devices or yes and "N" or yes and "N"	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to	2.00 59 1.00 N	3.	00 0	118. 02 119. 00 120. 00
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1.	d Harmless promote column 1 "Y" ualifies for the tartable devices or yes and "N" there the certification to the certification of the ce	1.00 386,09 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If	2.00 59 1.00 N	3.	00 0	118. 02 119. 00 120. 00 121. 00
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118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments. (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendments. Enter in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 and 2 and 2 and 2 and 2 and 2 and 2	d Harmless proving column 1 "Y" ualifies for thats? (see instrantable devices or yes and "N" anter the certification that the certificati	1.00 386,09 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date	2.00 59 1.00 N N	3.	00 0	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00
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OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	TDENTIFICATION DATA	Provi der	CCN: 150064		0/01/2013 9/30/2014	Worksheet S- Part I Date/Time Pi 2/25/2015 10	repared
					1. 00	2.00	
All Providers 40.00 Are there any related organization					N		140. (
chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the	home office chain numb			ts	3. 00		
If this facility is part of a chain home office and enter the home off	n organization, enter o	on lines 141 thro		name and		of the	
41.00 Name: 42.00 Street:	Contractor's Name: PO Box:			ctor's Nu	mber:		141. (142. (
43. 00 Ci ty:	State:		Zip Coo	de:			143. (
44.00 Are provider based physicians' cos	ts included in Workshee	s+ Δ?				1. 00 Y	144. (
45.00 If costs for renal services are classervices only? Enter "Y" for yes on	aimed on Worksheet A, I		costs for i	npati ent		Ý	145. (
					1. 00	2.00	
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in enter the approval date (mm/dd/yyy	column 1. (See CMS Pub				N		146. (
17.00 Was there a change in the statistic	cal basis? Enter "Y" fo				N		147.
$18.00\mathrm{Was}$ there a change in the order of $19.00\mathrm{Was}$ there a change to the simplific				or	N N		148. 149.
no.		Part A	Part B	Т	itle V 3.00	Title XIX	
Does this facility contain a provi					the lowe		
55.00 Hospi tal		N	N		N	N	155.
66.00 Subprovi der - IPF 67.00 Subprovi der - IRF		N N	N N		N N	N N	156. 157.
8. 00 SUBPROVI DER		N			N		158.
9.00 SNF 0.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 160.
1. 00 CMHC			N		N	N	161.
1. 10 CORF			N		N	N	161.
Multicampus						1. 00	
5.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.	npus hospital that has	one or more campu	ıses in difi	ferent CB	SAs?	N	165.
	Name 0	County 1.00	2. 00	Zip Code 3.00	4. 00	FTE/Campus 5.00	
6.00 If line 165 is yes, for each		1. 00	2.00	0.00	1.00		00 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5							
Used the Joseph T. J. J. C. T.) ! !	-i D	d D-1 :	^ .		1. 00	
Health Information Technology (HIT 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10) reasonable cost incurred for the H	under Section §1886(n) 5 is "Y") and is a mear	? Enter "Y" for ningful user (line	yes or "N"	for no.	the	Y	167. 0168.
9.00 If this provider is a meaningful us transition factor. (see instruction	ser (line 167 is "Y") a	and is not a CAH (line 105 is				50169.
		ng date for the re			gi nni ng 1. 00	Endi ng 2. 00 09/30/2014	
					′01/2013		170.

	FINANCIAL Systems FA		LTH SYSTEM Provi der		Peri od:	wof Form CMS- Worksheet S-2	
					From 10/01/2013 To 09/30/2014		
					Y/N 1.00	Date	
	General Instruction: Enter Y for all YES responded/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	sponses. Ente	1.00 rall dates in 1	2.00 the	
00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bed	ai nni na of	the cost	N		1.
	reporting period? If yes, enter the date of	the change in colum	n 2. (see	instructions)			
				1.00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary.			N			2.
00	Is the provider involved in business transaction 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 the relationships? (see instructions)	., chain home officed to the provider of the provider of the control of the contr	ces, drug or its ne board	N			3.
				1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports					5.00	
00	Column 1: Were the financial statements pred Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 2: (see instructions) If no conjugations are conjugations.	Audited, "C" for Center date availab	Compiled,	Y	A		4.
00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total those on the filed financial statements. If no control is the cost reports are the cost reports and total the cost reports are the cost reports.	revenues different		N			5.
	those on the filed financial statements? If y	yes, subilli t recorici	11 ati 011.		Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N		6
00	the legal operator of the program? Are costs claimed for Allied Health Programs'				N		7
00	Were nursing school and/or allied health process reporting period? If yes, see instructions are processed and the second	ons.		· ·	N		8
00	Are costs claimed for Intern-Resident program yes, see instructions.			·	N		9
. 00	Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the	e current c	cost reporting	N		10
. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		R in an App	proved	N		11
						Y/N 1. 00	
00	Bad Debts Is the provider seeking reimbursement for bad	d dobte2 lf vos so	o instruct	Lone		Y	12
. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy.	ot collection polic	cy change d	luring this co		N	13
00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? If	yes, see ins	tructions.	N	14
00	Did total beds available change from the price	or cost reporting p	eriod? If			N	15
		Descripti	on	Y/N	rt A Date	Part B Y/N	
	Jacob B 4	0		1.00	2. 00	3. 00	
	PS&R Data Was the cost report prepared using the PS&R			Y	02/13/2015	N	16
00	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R						
00	Report used in columns 2 and 4 (see			1		, ,	
				N		N	17
00	Report used in columns 2 and 4 (see 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 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments			N		N	17
00	Report used in columns 2 and 4 (see 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 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						
00 00 00	Report used in columns 2 and 4 (see 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 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						

	<u> </u>	YETTE REGIONAL HEA				u of Form CMS	
HOSPI T	'AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S- Part II Date/Time Pr 2/25/2015 10	- repared:
				P	art A	Part B	7. 07 (4
		Descriptio	n	Y/N	Date	Y/N	
		0		1. 00	2. 00	3. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EYCEDT C	HII DDENS H	IOSDI TAI S)		1.00	
	Capital Related Cost	ALS ONLY (EXCELL O	III EDILENS TI	iosi i ials)			
	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			als made duri	ng the cost		22. 00 23. 00
24. 00	Were new leases and/or amendments to existing lf yes, see instructions	leases entered in	to during	this cost rep	porting period?		24. 00
25. 00	Have there been new capitalized leases entere instructions.	ed into during the	cost repor	ting period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	ired during the co	st reporti	ng period? It	f yes, see		26. 00
27. 00	Has the provider's capitalization policy charcopy.	nged during the cos	t reportin	ng period? If	yes, submit		27. 00
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letter	s of credit entere	d into dur	ing the cost	reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation a treated as a funded depreciation account? If			ebt Service Re	eserve Fund)		29. 00
30. 00	Has existing debt been replaced prior to its instructions.			debt? If yes,	see		30. 00
31. 00	Has debt been recalled before scheduled matur instructions.	ity without issuan	ce of new	debt? If yes,	see		31. 00
	Purchased Services						
32. 00	Have changes or new agreements occurred in pa arrangements with suppliers of services? If y			ed through cor	ntractual		32. 00
33. 00	If line 32 is yes, were the requirements of S no, see instructions.			ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facili If yes, see instructions.	ty under an arrang	ement with	n provi der-bas	sed physi ci ans?		34.00
35. 00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			nts with the բ			35. 00
					Y/N	Date	
					1. 00	2. 00	

			1.00	2.00					
	Home Office Costs								
36.00	Were home office costs claimed on the cost report?				36. 00				
37. 00	If line 36 is yes, has a home office cost statement been pu	repared by the home office?			37. 00				
	If yes, see instructions.								
38. 00	If line 36 is yes , was the fiscal year end of the home of			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			39. 00					
	see instructions.								
40. 00	If line 36 is yes, did the provider render services to the	home office? If yes, see			40. 00				
	instructions.								
		1.00	2.	00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position	KYLE	SMI TH		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 report	BLUE AND CO			42.00				
	preparer.								
43.00	Enter the telephone number and email address of the cost	317. 713. 7957	KCSMI TH@BLUEAN	DCO. COM	43. 00				
	report preparer in columns 1 and 2, respectively.								

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150064 Peri od: Worksheet S-2 From 10/01/2013 To 09/30/2014 Part II Date/Time Prepared: 2/25/2015 10:37 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 02/13/2015 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 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 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared: Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider C Provider CCN: 150064

					T	o 09/30/2014	Date/Time Pre 2/25/2015 10:	
							I/P Days / 0/P	J / alli
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		45	16, 425	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			45	16, 425	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		12	4, 380	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	
14. 00	Total (see instructions)			57	20, 805	0.00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		12			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	1	16	1)	0	17. 00
18. 00	SUBPROVI DER	42. 00		0) C)	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	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		0) C)		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	99. 10					0	
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			85				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0) c			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

		_			•	2/25/2015 10:	37 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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, 336	127	2, 603			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	185	768				2.00
3.00	HMO I PF Subprovi der	100	700				3.00
4.00	HMO IRF Subprovider	0	33				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	234	0	258	1		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	C			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 570	127	2, 861			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	552	125	908			8. 00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		34	421			13. 00
14. 00	Total (see instructions)	2, 122	286	4, 190		461. 22	1
15.00	CAH visits	O	O	C	1		15. 00
16. 00	SUBPROVI DER - I PF	961	243	1, 319			1
17. 00	SUBPROVI DER - I RF	567	33	851		l	1
18.00	SUBPROVI DER	0	O	C	0.00	0.00	
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	4, 284	405	11, 533	0.00	16. 25	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	., 20 .	.00	, 555	0.00	10.20	23. 00
24. 00	HOSPI CE	0	О	C	0.00	1. 38	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C)		24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	C			1
26. 00 26. 25	RURAL HEALTH CLINIC	0	0	0			1
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	٥	U	U	0.00	l	
28. 00	Observation Bed Days		0	630		302.33	28.00
29. 00	Ambul ance Tri ps	836	Š.	000			29. 00
30. 00	•			C)		30. 00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	0	24	28	1		32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0			[33.00

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: Provider CCN: 150064

					То	09/30/2014	Date/Time Prep 2/25/2015 10:	
		Full Time Equivalents	<u> </u>		Di scha	arges		
	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	569	254	1, 164	1. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider				55	194		2. 00 3. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF							4. 00 5. 00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF			İ				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8. 00 9. 00	INTENSIVE CARE UNIT							8. 00 9. 00
10. 00	BURN INTENSIVE CARE UNIT			1				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT			ı				11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14.00	Total (see instructions)	0. 00		0	569	254	1, 164	14.00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	0. 00		0	94	48	142	15. 00 16. 00
17. 00	SUBPROVIDER - IPF	0.00		0	46	40	68	17. 00
18. 00	SUBPROVI DER	0.00		0	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0.00		Ĭ		J	o .	19. 00
20.00	NURSING FACILITY			İ				20. 00
21. 00	OTHER LONG TERM CARE			- 1				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	0.00						25. 00
25. 10	CMHC - CORF	0. 00 0. 00		-				25. 10 26. 00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00		- 1				26. 00 26. 25
27. 00	Total (sum of lines 14-26)	0.00		- 1				20. 23
28. 00	Observation Bed Days	0.00		1				28. 00
29. 00	Ambul ance Trips			ı				29. 00
30. 00	Employee discount days (see instruction)			ı				30. 00
31. 00	Employee discount days - IRF			ı				31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 10/21/2015 | 1

					To	09/30/2014	Date/Time Pre 2/25/2015 10:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	001. 0)	
	DADT III WAGE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	24, 765, 284	0	24, 765, 284	1, 143, 630. 00	21. 65	1.00
2 00	instructions)		10 041	0	10 041	01 00	110 24	2 00
2. 00	Non-physician anesthetist Part A		10, 041	0	10, 041	91. 00	110. 34	2. 00
3.00	Non-physician anesthetist Part		433, 440	0	433, 440	3, 933. 00	110. 21	3. 00
4. 00	B Physician-Part A -		197, 827	0	197, 827	1, 521. 00	130. 06	4.00
	Admi ni strati ve		,	_	,			
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0 4, 359, 394	0		0. 00 30, 416. 00		
6. 00	Non-physician-Part B		928, 038		928, 038	18, 136. 00	1	1
7.00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0.00	7. 01
7.01	residents (in an approved		O		J	0.00	0.00	7.01
8. 00	programs) Home office personnel		0	_	0	0. 00	0.00	8. 00
9. 00	SNF	44. 00	0	o o	0	0.00		
10. 00	Excluded area salaries (see		4, 492, 927	87, 905	4, 580, 832	242, 764. 00	18. 87	10.00
	instructions) OTHER WAGES & RELATED COSTS							1
11. 00	Contract Labor: Direct Patient		379, 400	0	379, 400	4, 478. 00	84. 73	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0. 00	0.00	12. 00
12.00	management and other		0			0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	0	0. 00	0.00	13. 00
	A - Administrative		_	_				
14. 00	Home office salaries & wage-related costs		0	0	0	0. 00	0. 00	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0.00	16. 00
10.00	Physicians Part A - Teaching				, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	0.00	0.00] 10.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		3, 802, 782	0	3, 802, 782		I	17. 00
17.00	instructions)		3, 602, 762	0	3, 602, 762			17.00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		1, 107, 141	0	1, 107, 141			19. 00
20. 00	Non-physician anesthetist Part		1, 141	Ō	1, 141			20. 00
21. 00	A Non-physician anesthetist Part		49, 251	0	49, 251			21. 00
21.00	B		47, 231		47, 231			21.00
22. 00	Physician Part A - Administrative		21, 652	0	21, 652			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		602, 529	0	602, 529			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program)			_				
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	190, 996	92, 300	283, 296	8, 944. 00	31. 67	26. 00
27. 00	Administrative & General	5. 00	2, 102, 593			97, 388. 00		1
28. 00	Administrative & General under		678, 590	0	678, 590	3, 803. 00	178. 44	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
30.00	Operation of Plant	7. 00	399, 358			30, 685. 00	13. 46	30.00
31.00	Laundry & Linen Service	8. 00	22, 674			1, 932. 00		
32. 00 33. 00	Housekeeping under contract	9. 00	561, 309 0	14, 449 0	575, 758 0	61, 833. 00 0. 00		1
	(see instructions)							
34. 00 35. 00	Di etary Di etary under contract (see	10. 00	507, 916 0	-299, 751 0	208, 165 0	14, 637. 00 0. 00		1
	instructions)		O					
36.00	Cafeteria	11. 00 12. 00	0	312, 150	312, 150	24, 118. 00 0. 00		
37. 00 38. 00	Maintenance of Personnel Nursing Administration	13. 00	345, 457	8, 911	354, 368	0.00 17, 113.00		
39. 00	Central Services and Supply	14. 00	83, 192	2, 214	85, 406	5, 918. 00	14. 43	39. 00
40. 00	Pharmacy	15. 00	444, 008	7, 917	451, 925	23, 678. 00	19. 09	40. 00

Health Financial Systems	FA	YETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150064 F	Peri od:	Worksheet S-3	
					rom 10/01/2013		
				-	Γo 09/30/2014		
						2/25/2015 10:	37 am_
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	670, 251	28, 488	698, 739	28, 985. 00	24. 11	41. 00
Records Library							
42.00 Social Service	17. 00	0	0	(0.00	0. 00	42.00
43.00 Other General Service	18. 00	0	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 10/01/2013 To 09/30/2014 2/25/2015 10:37 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours 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, 712, 961 19, 712, 961 1, 094, 857. 00 18. 01 1.00 instructions) 2.00 Excluded area salaries (see 4, 492, 927 87, 905 4, 580, 832 242, 764. 00 18.87 2.00 instructions) 3.00 Subtotal salaries (line 1 15, 220, 034 -87, 905 15, 132, 129 852, 093. 00 17.76 3.00 minus line 2) 4.00 Subtotal other wages & related 379, 400 379, 400 4, 478. 00 84.73 4.00 costs (see inst.) Subtotal wage-related costs 5.00 3, 824, 434 C 3, 824, 434 0.00 25. 27 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 19, 423, 868 -87, 905 19, 335, 963 856, 571. 00 22 57

-398, 051

5, 608, 293

319, 034. 00

17. 58

7.00

6,006,344

7.00

Total overhead cost (see

instructions)

FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
Provi der CCN: 150064	Peri od: Worksheet S-3
	From 10/01/2013 Part IV To 09/30/2014 Date/Time Prepared:
	Tringing to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr

PART IV - WAGE RELATED COSTS		To 09/30/2014	Date/Time Prep 2/25/2015 10:3	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Empl oyer Contributions 424, 158 1.00 401K Empl oyer Contributions 424, 158 1.00 2.00 3.00 401K Empl oyer Contributions 424, 158 1.00 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.3.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00 Tax Shel tered Annuity (TSA) Employer Contribution 0 2. 00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0.		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	1.00	401K Employer Contributions	424, 158	1.00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
5.00	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)		
The color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 3,625,811 8.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.	7.00	Employee Managed Care Program Administration Fees	0	7. 00
Prescription Drug Plan		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan	8.00	Health Insurance (Purchased or Self Funded)	3, 625, 811	8. 00
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	-124, 857	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) -172, 354 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 173, 038 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumul ative portion) 16.00 TAXES	11.00	Life Insurance (If employee is owner or beneficiary)	-116, 375	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 173,038 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 173,038 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES	13.00	Disability Insurance (If employee is owner or beneficiary)	-172, 354	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only 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)) Day Care Cost and Allowances 21.00 Day Care Cost and Allowances Tuition Reimbursement 10.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00			14. 00
Non cumulative portion TAXES	15.00	'Workers' Compensation Insurance	173, 038	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		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 40,444 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 62,730 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 5,584,496 24.00 Part B - Other than Core Related Cost 0 24.00		TAXES		
19.00 Unemployment Insurance 40,444 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)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 62,730 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,584,496 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 25.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24	17. 00	FICA-Employers Portion Only	1, 671, 901	17.00
20.00 State or Federal Unemployment Taxes 0 0 0THER 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 62,730 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,584,496 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 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost	19.00	Unempl oyment Insurance	40, 444	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 Cost Reported on Lines 1 through 4 above. (see instructions) 22.00 Tuition Reimbursement Cost Reported on Lines 1 through 4 above. (see instructions) Cost Cost Cost Cost Cost Cost Cost Cost	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 Contact		OTHER		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 62, 730 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 5, 584, 496 Part B - Other than Core Related Cost 24. 00	21.00		0	21.00
23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 62, 730 5, 584, 496 24. 00				
24.00 Total Wage Related cost (Sum of lines 1 -23) 5,584,496 Part B - Other than Core Related Cost	22. 00		0	
Part B - Other than Core Related Cost	23.00	Tuition Reimbursement		
	24. 00		5, 584, 496	24.00
25. 00 OTHER 413, 474 25. 00				
	25. 00	OTHER	413, 474	25.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part V Date/Time Prepared: 2/25/2015 10:37 am

		11	0 09/30/2014	2/25/2015 10:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		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	Subprovider - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	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
13. 00	Hospi tal -Based Hospi ce		0	0	
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	17. 00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-	2552-10
	BEALTH AGENCY STATISTICAL DATA			CCN: 150064	Period: From 10/01/2013	Worksheet S-4	
			Component	CCN: 157097	To 09/30/2014		
					Home Health	PPS	37 alli
					Agency I		
0.00	Country					00	0.00
0.00	County	Title V	Title XVIII	Title XIX	FAYETTE Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3. 00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	0		0 0		1. 00
2.00	Unduplicated Census Count (see instructions)	0. 00	235. 00		0.00 0.00 0.00 0.00 0.00		2. 00
					,py (q	
		Enter the number		Staff	Contract	Total	
		your norman	work week				
	HOME HEALTH ACENOV NUMBER OF ENDLOYEES	C)	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0. (0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		l .	
5. 00 6. 00	Direct Nursing Service			0. (0. (l .	
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. (0. (
9. 00	Physi cal Therapy Supervisor			0.0		l .	1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. (1
12. 00	Speech Pathology Service			0.0	0.00	0.00	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (1
15. 00	Medical Social Service Supervisor			0.0	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. (1
18. 00	Other (specify)			0. (1
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19. 00
	you provided services during the cost reporting period.						
20. 00	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	ountains the materials.	5.11.5		99915			20. 01
		Full Ep Without	With Outliers	LUPA Episode	es PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3. 00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 468 256, 452	100 11, 270		10 42 21 4, 025		1
23. 00	Physical Therapy Visits	325	0		14 3	342	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	40, 500 306	0		50 375 5 1	42, 625 312	1
26. 00	Occupational Therapy Visit Charges	38, 250	0		25 125	39, 000	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	5 675	0		0 0	l .	27. 00 28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	23 4, 140	0		0 0		1
31. 00	Home Heal th Aide Visits	737	26		0 19		1
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	49, 473 3, 864	1, 725 126		0 1, 242 29 65		1
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 389, 490	0 12, 995		0 96 5, 767	0 427, 648	
	30, 32, and 34)		.2, 770				
36. 00	Total Number of Episodes (standard/non outlier)	259		'	62 7	328	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	23, 281	3 1, 736	1, 0 ⁻	0 13 634	3 26, 664	37. 00 38. 00
30.00	Trotal Mon-Routine Medical Supply Charges	23, 201	1, 730	1, 0	15 034	1 20,004	1 30.00

Health Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM		In lie	eu of Form CMS-2	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CCN: 150064	Peri od:	Worksheet S-7	
	1		From 10/01/2013		
			To 09/30/2014	Date/Time Pre	pared:
		CNE D	C ' D I CNE	2/25/2015 10:	37 am
	Group	SNF Days	Swing Bed SNF		
	1.00	2.00	Days 3.00	col. 2 + 3) 4.00	
69.00	PE2	2.00	0 0		69. 00
70.00	PE2 PE1		0 8		
71. 00	PD2		0 0		
72.00	PD1		0 0	0	1
73. 00	PC2		0 0	0	
74.00	PC1		0 0	0	
75. 00	PB2		0 0	0	
76. 00	PB1		0	0	
77. 00	PA2		0 0	0	
78. 00	PA1		0 10		
199.00	AAA		0 0	0	
200. 00 TOTAL	AAA		0 234	_	200.00
200. 00 10 TAL			CBSA at	CBSA on/after	200.00
			Beginning of	October 1 of	
			Cost Reporting		
			Peri od	Reporting	
				Period (if	
				appl i cabl e)	
			1. 00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA			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 perio	od (if applicab	·			
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
		1.00	2.00	Expenses?	
	40.4	1.00	2. 00	3.00	
A notice published in the Federal Register Volume 68, No. 1					
payments beginning 10/01/2003. Congress expected this increexpenses. 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			is filereases assi	ici a teu	
202. 00 Staffing	gory. (See This	Tructions)	0 0.00		202. 00
203. 00 Recruitment			0 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 0.00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3))		0		207. 00
5)		1	- 1	1	,

Health Financial Systems	FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
HOSPITAL IDENTIFICATION DATA		Provi der CCN: 150064	From 10/01/2013	
		Component CCN: 151548	To 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
			Hospi ce I	
	Unduplicated			

						Hospice I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 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	2, 405	0	0	0	0	2, 405	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	2, 405	0	0	0	0	2, 405	5. 00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	39	2	0	0	2	43	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	61. 67	0.00	0.00	0.00	0.00	55. 93	8. 00
	5/line 6)							
9.00	Unduplicated Census Count	39	2	0	0	2	43	9. 00

Heal th	Financial Systems FAYETTE REGIONAL HEAL	TH SYSTEM		In lie	eu of Form CMS-2	2552-10		
	TAL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 150064	Peri od:	Worksheet S-10			
	THE GROOM ENGINES THIS THIS CELL STATE			From 10/01/2013				
				To 09/30/2014	Date/Time Prep 2/25/2015 10:			
					1. 00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 column	1 8)	0. 419957	1. 00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				5, 844, 385	2. 00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental		from Medicaio	1?	N	4. 00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medicaid			253, 203	5. 00		
6.00	Medicaid charges				19, 314, 798	6. 00		
7.00	Medicaid cost (line 1 times line 6)		6 !!.	0 1 5 . 5	8, 111, 385	7. 00		
8. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine / min	us sum of iii	ies 2 and 5; if	2, 013, 797	8. 00		
	State Children's Health Insurance Program (SCHIP) (see instructi	ons for a	ach line)					
9. 00	Net revenue from stand-alone SCHIP	0113 101 0	den inic)		0	9. 00		
10. 00	Stand-alone SCHIP charges					10. 00		
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				Ö			
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m	inus line 9:	if < zero then	Ö	12. 00		
	enter zero)				_			
	Other state or local government indigent care program (see instr	uctions f	or each line)					
13.00	Net revenue from state or local indigent care program (Not inclu	ıded on li	nes 2, 5 or 9	9)	0	13.00		
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	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 indi	gent care	program (III	ne 15 minus line	0	16. 00		
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to fur	ndi ng char	ity care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of ho				l o	18. 00		
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local			ns (sum of lines	2, 013, 797			
	8, 12 and 16)	3 .			,			
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
	I=		1. 00	2. 00	3. 00			
20. 00	Total initial obligation of patients approved for charity care (2, 313, 3	75 0	2, 313, 375	20. 00		
21. 00	charges excluding non-reimbursable cost centers) for the entire Cost of initial obligation of patients approved for charity care		971, 5 ⁻	18 0	971, 518	21 00		
21.00	times line 20)	; (TITIE T	7/1, 3	0	7/1, 510	21.00		
22. 00	Partial payment by patients approved for charity care			0 0	0	22. 00		
23. 00	Cost of charity care (line 21 minus line 22)		971, 5 ⁻	-	-			
			,		,			
0.1.00					1.00	0.4.00		
24. 00	Does the amount in line 20 column 2 include charges for patient		na a Length o	or stay limit	N	24. 00		
25. 00	imposed on patients covered by Medicaid or other indigent care program?							
26. 00						25. 00 26. 00		
26.00								
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin	,	s line 27)		6, 806, 810			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (11)		,	28)	2, 858, 568			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(11110		. 20)	3, 830, 086			
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			5, 843, 883			
200	. 00 Total uniterimbul sed and uncompensated care cost (Title 19 plus Title 30)							

		AYETTE REGIONAL				u of Form CMS-	2552-TC
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JF EXPENSES	Provi der	F	eriod: rom 10/01/2013	Worksheet A	
				Т	o 09/30/2014	Date/Time Pre 2/25/2015 10:	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	37 aiii
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	100.00/	2, 377, 831				1.00
4. 00 5. 00	OO400	190, 996 2, 102, 593	5, 933, 524 6, 045, 559			6, 216, 820 7, 589, 905	1
7. 00	00700 OPERATION OF PLANT	399, 358	2, 258, 422		·		
7. 01	00701 OPERATION OF PLANT	0	0	C	700,000		1
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	22, 674 561, 309	137, 986			161, 178	1
10.00	O0900 HOUSEKEEPI NG O1000 DI ETARY	507, 916	129, 634 391, 966	1		705, 392 359, 240	
11. 00	01100 CAFETERI A	0	0	0777,002		553, 041	1
13. 00	01300 NURSING ADMINISTRATION	345, 457	77, 457	1		431, 825	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY	83, 192	1, 086, 377				
16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	444, 008 670, 251	3, 978, 797 422, 178				1
	INPATIENT ROUTINE SERVICE COST CENTERS	3.37=3.1	,,,,,	., ., ., .,		., .=0,]
30.00	03000 ADULTS & PEDI ATRI CS	1, 529, 803	178, 446	,		1, 347, 543	1
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	878, 955 656, 223	58, 958 659, 190				
41. 00	04100 SUBPROVI DER – TPF	432, 199	144, 041			581, 326	
42. 00	04200 SUBPROVI DER	0	0	C C		0	1
43.00	04300 NURSERY	0	0	C	389, 080	389, 080	43.00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	822, 340	1, 379, 479	2, 201, 819	15, 303	2, 217, 122	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	022, 340	1, 3/9, 4/9	2, 201, 619	15, 303	2, 217, 122	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 054, 506	1, 547, 969	2, 602, 475	23, 799	2, 626, 274	
57. 00	05700 CT SCAN	0	0	C	0	0	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	0	58. 00 59. 00
60.00	06000 LABORATORY	742, 720	1, 092, 081	1, 834, 801	18, 458	1, 853, 259	1
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	371, 772	43, 908	1			1
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	853, 271 142, 680	99, 921 8, 501	1		967, 403 154, 684	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	142,000	0, 301	131, 101		0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	c	69, 090	69, 090	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
74. 00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	U	(<u>C</u>	0	0	74.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 125, 330	929, 003	2, 054, 333	19, 988	2, 074, 321	91.00
	04040 CLINIC	6, 481, 398	2, 653, 999	9, 135, 397	138, 645	9, 274, 042	
	04044 BI C	929, 080	618, 271		1	1, 576, 006	
93. 02	04041 UCI C	0	0	C	0	0	
93. 03 93. 04	04042 CI C 04043 RI C	0	0		0	0	70.00
93. 05	04950 PODI ATRY	12, 748	255	13, 003	0	13, 003	1
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	423, 476	32, 580	· ·		463, 333	1
	09910 CORF 10100 HOME HEALTH AGENCY	801, 403	122, 205	923, 608	_	0 873, 597	
101.00	SPECIAL PURPOSE COST CENTERS	001, 100	122, 200	720,000	30,011	070,077	101.00
	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		79, 696	79, 696	66, 032		
118.00		22, 585, 658	32, 488, 234				
	NONREI MBURSABLE COST CENTERS						
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0		190. 00 191. 00
	19101 FMH DIAGNOSTIC CENTE	185, 137	15, 432	200, 569	4, 240		
	19102 WELLNESS	92, 684	109, 802			204, 083	191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	27, 391	3, 214			31, 498	
	19201 RFE 19202 MARKETI NG	74, 969	-199 314, 542	l .		-199 365, 804	192. 01
	19203 FOUNDATION	0	314, 342	007, 011	1, 476		192. 02
192. 04	19204 BROOKVILLE CLINIC		0	C	0	0	192. 04
	19205 ATOD	0	0	C	0		192.05
192. 06 192. 07	19206 HEART CENTER 19207 WVCP	1, 496, 302	585, 498	2, 081, 800	34, 989		192. 06 192. 07
	19210 OCCUPATI ONAL MED	0	1, 575				192. 08
-	·	'					

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 10/01/2013 o 09/30/2014		narod
				0 09/30/2014	2/25/2015 10:	37 am_
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
192. 09 19209 HOME MEDICAL EQUIPMENT	0	0	(0	0	192. 09
192. 10 19211 HOSPI TALI ST	303, 143	901, 089	1, 204, 232	6, 878	1, 211, 110	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	24, 765, 284	34, 419, 187	59, 184, 471	0	59, 184, 471	200. 00

4.00	GENERAL SERVI CE COST CENTERS 1. 00	-1, 296, 181 0 -244, 676 -2, 288 0 0 0 -240, 563 -2, 692	For Allocation 7.00 1,081,650 6,216,820 7,345,229 1,689,112 980,000 161,178 705,392 359,240 312,478	1. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 10. 00
	1. 00	6. 00 -1, 296, 181 0 -244, 676 -2, 288 0 0 0 0 -240, 563 -2, 692	7. 00 1, 081, 650 6, 216, 820 7, 345, 229 1, 689, 112 980, 000 161, 178 705, 392 359, 240 312, 478	4. 00 5. 00 7. 00 7. 01 8. 00 9. 00
	1.00	-1, 296, 181 0 -244, 676 -2, 288 0 0 0 0 -240, 563 -2, 692	1, 081, 650 6, 216, 820 7, 345, 229 1, 689, 112 980, 000 161, 178 705, 392 359, 240 312, 478	4. 00 5. 00 7. 00 7. 01 8. 00 9. 00
4.00	4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 7. 01 00701 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 -244, 676 -2, 288 0 0 0 0 -240, 563 -2, 692	6, 216, 820 7, 345, 229 1, 689, 112 980, 000 161, 178 705, 392 359, 240 312, 478	4. 00 5. 00 7. 00 7. 01 8. 00 9. 00
5.00	5. 00	-244, 676 -2, 288 0 0 0 0 -240, 563 -2, 692	7, 345, 229 1, 689, 112 980, 000 161, 178 705, 392 359, 240 312, 478	5. 00 7. 00 7. 01 8. 00 9. 00
7. 00 00700 00700 00FPARTI ON OF PLANT -2,288 1,689, 112 7,7 10 00701 00FPARTI ON OF PLANT 0 0980, 000 0.0000 7,7 1,00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00	7. 00	-2, 288 0 0 0 0 0 -240, 563 -2, 692	1, 689, 112 980, 000 161, 178 705, 392 359, 240 312, 478	7. 00 7. 01 8. 00 9. 00
7. 01 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701 00701	7. 01 00701 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 0 0 0 -240, 563 -2, 692	980, 000 161, 178 705, 392 359, 240 312, 478	7. 01 8. 00 9. 00
8. 00	8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 0 0 -240, 563 -2, 692	161, 178 705, 392 359, 240 312, 478	8. 00 9. 00
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NPATI ENT ROUTI NE SERVICE COST CENTERS 30 1, 347, 543 31.				16.00
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40. 00 04000 SUBPROVI DER - I PF 0 1, 327, 948 40. 41. 00 04100 SUBPROVI DER - I RF 0 581, 326 41. 42. 00 04200 SUBPROVI DER 0 0 0 42. 43. 00 04300 SUBPROVI DER 0 0 389, 080 42. 43. 00 04300 SUBPROVI DER 0 389, 080 43. 43. 44. 44. 45. 45. 45. 45. 45. 45. 45. 45		0	1, 347, 543	30. 00
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52. 00 05200 DELIVERY ROM & LABOR ROOM 0 0 52. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 626, 274 54. 55. 57. 00 05700 CT SCAN 0 0 0 55. 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 55. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 58. 60. 01 06000 LABORATORY 0 0 0 60. 60. 01 06001 BLOOD LABORATORY 0 0 0 60. 65. 00 06500 RESPI RATORY THERAPY -240 421, 880 65. 66. 00 06600 PHYSI CAL THERAPY -162, 103 805, 300 66. 70. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71. 02 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 69, 090 72. 74. 00 07300 RURGS CHARGED TO PA			007/000	10.00
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93. 04 04043 RI C 0 0 93.	· · · · · · · · · · · · · · · · · · ·	0	0	93. 02
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	93. 04 04043 RTC 93. 05 04950 PODI ATRY	0	12 003	93. 04 93. 05
93. 05 04950 PODI ATRY 0 13, 003 93.			13,003	93.03
		-40, 335	422, 998	95. 00
			1	99. 10
		0	873, 597	101. 00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109.		1 0		109. 00
		0		110.00
		0	O	111.00
		0		116. 00
		-10, 731, 034	44, 316, 492	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.				190. 00
		0	0	191. 00
		0	204, 809	191. 01
		0	204, 083	191. 02
	1 1	0		192. 00
		0	1	192. 01
				192. 02
			1,4/6	192. 03 192. 04
		0		192. 04
		0	l ő	192. 06
192. 07 19207 WVCP 0 2, 116, 789 192.		0		192. 07
		1	1 575	192. 08
	192. 08 19210 OCCUPATI ONAL MED		1	
192. 10 19211 H0SPI TALI ST 0 1, 211, 110 192.			0	192. 09 192. 10

Health Financial Systems FA	AYETTE REGIONAL	. HEALTH SYSTEM	In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 150064	Peri od:	Worksheet A	
			From 10/01/2013 To 09/30/2014	Date/Time Prep	ared:
			07/30/2014	2/25/2015 10: 3	
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7. 00			
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		1	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	-10, 731, 034	48, 453, 437		2	200. 00

Peri od: Worksheet A-6
From 10/01/2013
To 09/30/2014 Date/Time Prepared: 2/25/2015 10: 37 am Provider CCN: 150064

					/2015 10:37 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	A - CAFETERIA				
1.00	CAFETERI A	1100	31 <u>2, 1</u> 50	240, 891	1. 00
	0		312, 150	240, 891	
	B - NURSERY				
1.00	NURSERY	43.00	<u>343, 1</u> 10	<u>45, 9</u> 70	1. 00
	0		343, 110	45, 970	
	C - COACH RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	92, 300	0	1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	126, 585	0	2. 00
3.00	OPERATION OF PLANT	7. 00	13, 620	0	3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	518	0	4. 00
5.00	HOUSEKEEPI NG	9. 00	14, 449	0	5. 00
6.00	DI ETARY	10. 00	12, 399	0	6. 00
7.00	NURSING ADMINISTRATION	13. 00	8, 911	0	7. 00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	2, 214	0	8. 00
9.00	PHARMACY	15. 00	7, 917	0	9. 00
10. 00	MEDICAL RECORDS & LIBRARY	16. 00	28, 488	0	10.00
11. 00	ADULTS & PEDIATRICS	30. 00	28, 374	0	11. 00
12. 00	INTENSIVE CARE UNIT	31. 00	12, 770	0	12. 00
13. 00	SUBPROVI DER - I PF	40. 00	12, 535	0	13. 00
14. 00	SUBPROVI DER - I RF	41. 00	5, 086	0	14. 00
15. 00	OPERATING ROOM	50. 00	15, 303	0	15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 00	23, 799	0	16. 00
17. 00	LABORATORY	60. 00	18, 458	0	17. 00
18. 00	RESPIRATORY THERAPY	65. 00	6, 440	0	18. 00
19. 00	PHYSI CAL THERAPY	66. 00	14, 211	0	19. 00
20. 00	CARDI AC REHAB	69. 01	3, 503	0	20. 00
21. 00	EMERGENCY	91. 00	19, 988	0	21. 00
22. 00	CLINIC	93. 00	138, 645	0	22. 00
23. 00	BI C	93. 01	28, 655	0	23. 00
24. 00	AMBULANCE SERVICES	95.00	7, 277	0	24. 00
25. 00	HOME HEALTH AGENCY	101.00	16, 021	0	25. 00
26. 00	FMH DIAGNOSTIC CENTE	191. 01	4, 240	0	26.00
27. 00	WELLNESS	191. 02	1, 597	0	27. 00
28. 00	PHYSICIANS' PRIVATE OFFICES	192.00	893	0	28. 00
29. 00	MARKETI NG	192. 02	1, 983	0	29. 00
30.00	FOUNDATION WVCP	192. 03 192. 07	1, 476 34, 989	0	30. 00 31. 00
31. 00 32. 00					32.00
32.00	HOSPI TALI ST	1 <u>92.</u> 10	6, 878	0	32.00
	D - MARKETING		710, 522	U	
1. 00	ADMINISTRATIVE & GENERAL	5.00	5, 070	20, 620	1. 00
1.00	ADMINISTRATIVE & GENERAL		5, 070	$-\frac{20,620}{20,620}$	1.00
	E - HOSPI CE		3,070	20, 620	
1.00	HOSPI CE	116.00	66, 032	0	1.00
1.00	HOSPICE		66, 032	<u>o</u>	1.00
	F - HOSPITAL UTILITIES		00, 032	U	
1 00	OPERATION OF PLANT	7. 01		000 000	1 00
1. 00	OF LANI	— <u> </u>		<u>980, 0</u> 00 980, 000	1.00
	G - IMPLANTABLE DEVICES		U	980, 000	
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	69, 090	1. 00
1.00	PATIENTS	72.00	٩	09, 090	1.00
	0	+		69, 090	
500 00	Grand Total: Increases		1, 436, 884	1, 356, 571	500. 00
550.00	or and Total. Thereases	l l	1, 730, 004	1, 330, 371	1 300. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 10/01/2013 | To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: | 2/25/2015 10: 37 am Provider CCN: 150064

						2/25/2015 10:37 am
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - CAFETERIA					
1.00	DI ETARY	10.00	312, 150	240, 891	0	1. 00
	0	— — — —	312, 150	240, 891		1
	B - NURSERY		0.27.00	2.0,07.		
1.00	ADULTS & PEDIATRICS	30.00	343, 110	45, 970	0	1.00
1.00	0	30.00				1.00
	_		343, 110	45, 970		
	C - COACH RECLASS		740 500			4.00
1.00	ADMINISTRATIVE & GENERAL	5. 00	710, 522	0		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0	1	3.00
4.00		0.00	0	0	0	4. 00
5.00		0.00	0	0	0	5. 00
6.00		0.00	o	0	0	6. 00
7. 00		0.00	O	0	1	7. 00
8. 00		0.00	Ö	0		8.00
9. 00		0.00	o	0		9.00
10. 00		0.00	0	0	l .	10.00
				-	1	· · · · · · · · · · · · · · · · · · ·
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14.00		0.00	0	0	0	14. 00
15.00		0.00	0	0	0	15. 00
16.00		0.00	o	0	0	16.00
17. 00		0.00	o	0	1	17. 00
18. 00		0.00	o	0	l .	18.00
					1	· · · · · · · · · · · · · · · · · · ·
19. 00		0.00	0	0		19.00
20. 00		0.00	0	0		20.00
21.00		0.00	0	0	I I	21. 00
22.00		0.00	0	0		22. 00
23.00		0.00	0	0	0	23. 00
24.00		0.00	o	0	o	24. 00
25.00		0.00	o	0	0	25. 00
26. 00		0.00	o	0		26.00
27. 00		0.00	Ö	0	0	27. 00
28. 00		0.00	o	0		28.00
			0	-	0	
29. 00		0.00		0	1	29. 00
30.00		0.00	0	0	۱	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
	0		710, 522			
	D - MARKETING					
1.00	MARKETI NG	192. 02	5, 070	20, 620	0	1.00
	0	— ·····				
	E - HOSPI CE		0, 0, 0	20, 020		
1.00	HOME HEALTH AGENCY	101.00	66, 032	0	0	1.00
1.00	HOWE HEALTH AGENCY					1.00
	U S HOODI TAL LITLE S		66, 032	0		
	F - HOSPITAL UTILITIES					
1.00	OPERATION OF PLANT		0	98 <u>0, 0</u> 00		1.00
	0		0	980, 000		
	G - IMPLANTABLE DEVICES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	69, 090	0	1.00
	0	— — — +	 _	69, 090		
500 00	Grand Total: Decreases		1, 436, 884	1, 356, 571		500.00
300.00	Joi and Total . Decl eases	ı I	1, 430, 004	1, 550, 571	ı I	1 300. 00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150064 Peri od: Worksheet A-7 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/25/2015 10:37 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 798, 220 52, 417 52, 417 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 2, 396, 694 1, 643, 692 3.00 54, 665, 064 2, 396, 694 Building Improvements 0 4.00 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 24, 225, 509 1, 355, 657 1, 355, 657 808, 146 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 80, 688, 793 3, 804, 768 3, 804, 768 2, 451, 838 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 80, 688, 793 3, 804, 768 10.00 3, 804, 768 0 2, 451, 838 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 55, 418, 066 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 24, 773, 020 0 6.00 7.00 HIT designated Assets 0 7.00

82, 041, 723

82, 041, 723

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

Heal th	Financial Systems	AYETTE REGIONAL	AYETTE REGIONAL HEALTH SYSTEM		In Lieu of Form CMS-2552-1		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 10/01/2013 To 09/30/2014		pared:
						2/25/2015 10:	37 am
		SUMMARY OF CAPITAL					
	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	RKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 120, 102	0	1, 257, 72	9 0	0	1. 00
3.00	Total (sum of lines 1-2)	1, 120, 102	0	1, 257, 72	9 0	0	3. 00
SUMMARY OF 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	RKSHEET A. COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 377, 831				1. 00
3.00	Total (sum of lines 1-2)	0	2, 377, 831				3. 00

	FAYETTE REGIONAL				eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet A-7 Part III Date/Time Pre 2/25/2015 10:	pared:
	COM	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)	instructions)	Insurance	
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	55, 418, 066	0	55, 418, 06	6 1. 000000	0	1. 00
3.00 Total (sum of lines 1-2)	55, 418, 066		55, 418, 06			3. 00
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF				
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7.00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS		7.00	0.00	7. 00	10.00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 1, 081, 650	0	1.00
3.00 Total (sum of lines 1-2)	0	0		1, 081, 650	l e	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)	,	Other Capi tal -Relate	Total (2) (sum 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	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	1, 257, 729	0		0 -1, 257, 729	1, 081, 650	1. 00
3.00 Total (sum of lines 1-2)	1, 257, 729	0		0 -1, 257, 729	1, 081, 650	3. 00
	•	•	•	•	•	•

				То	09/30/2014	Date/Time Prep 2/25/2015 10:3	
				Expense Classification on V	Worksheet A	2/23/2013 10.	37 411
				To/From Which the Amount is t	o 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	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		C	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	1. (
	(chapter 2)						
. 00	Investment income - CAP REL		C	*** Cost Center Deleted ***	2. 00	0	2. (
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3. (
	(chapter 2)		_			-	
00	Trade, quantity, and time discounts (chapter 8)		C		0. 00	0	4.
00	Refunds and rebates of		C		0. 00	0	5.
00	expenses (chapter 8) Rental of provider space by		C		0. 00	0	6.
00	suppliers (chapter 8)		C		0.00	O	0.
00	Tel ephone servi ces (pay		C		0. 00	0	7. (
	stations excluded) (chapter 21)						
00	Television and radio service		C		0. 00	0	8.
00	(chapter 21) Parking Lot (chapter 21)		C		0.00	0	9.
0.00	Provi der-based physici an	A-8-2	-5, 377, 769		0.00	0	
1. 00	adjustment Sale of scrap, waste, etc.		C		0. 00	0	11.
1.00	(chapter 23)		C		0.00	U	11.
2. 00	Related organization	A-8-1	C			0	12.
3. 00	transactions (chapter 10) Laundry and linen service		C		0. 00	0	13.
. 00	Cafeteria-employees and guests		C		0. 00	0	14.
. 00	Rental of quarters to employee and others		C		0. 00	0	15.
. 00	Sale of medical and surgical		C		0. 00	0	16.
	supplies to other than						
7. 00	patients Sale of drugs to other than		C		0.00	0	17.
	patients					_	
3. 00	Sale of medical records and abstracts	A	-11, 194	MEDICAL RECORDS & LIBRARY	16. 00	0	18.
9. 00	Nursing school (tuition, fees,		C		0. 00	0	19.
). 00	books, etc.) Vending machines		C		0.00	0	20.
. 00	Income from imposition of		C		0.00	0	•
	interest, finance or penalty						
2. 00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.
	overpayments and borrowings to						
00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPIRATORY THERAPY	65. 00		23.
. 00	therapy costs in excess of	7, 0, 0		REST FIGURE FILEION F	00.00		20.
00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
. 00	therapy costs in excess of	A-0-3	C	THISTORE THERAIT	00.00		24.
00	limitation (chapter 14) Utilization review -			*** Cost Center Deleted ***	114 00		25
5. 00	physicians' compensation		C	cost center bereted	114. 00		25.
	(chapter 21)			NEW 015 551 000T0 51 50 1			٠,
. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		C	NEW CAP REL COSTS-BLDG &	1. 00	0	26.
. 00	Depreciation - CAP REL		C	*** Cost Center Deleted ***	2. 00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19. 00		28.
. 00	Physicians' assistant		C	Sost Some Bereted	0.00	0	
. 00	Adjustment for occupational	A-8-3	C	*** Cost Center Deleted ***	67. 00		30.
	therapy costs in excess of limitation (chapter 14)						
. 99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.
. 00	instructions) Adjustment for speech	A-8-3	(*** Cost Center Deleted ***	68. 00		31.
. 50	pathology costs in excess of		C	3551 5557 251 5154	33.00		
00	limitation (chapter 14) CAH HIT Adjustment for		C		0. 00	0	32.
00	Depreciation and Interest		C		0.00	U	32.

					0 09/30/2014	2/25/2015 10:	
				Expense Classification on	Worksheet A	272372013 10.	57 dili
				To/From Which the Amount is			
					,		
	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	А	-1, 257, 729	NEW CAP REL COSTS-BLDG &	1.00	14	33. 00
				FLXT			
33. 01	EKG FEES BILLING SVC-OTHER REV	В		RESPIRATORY THERAPY	65.00	0	33. 01
33. 02	CASH OVER/SHORT	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 02
38. 00	VENDOR REBATE/REFUND-OTHER REV		-108, 617	ADMINISTRATIVE & GENERAL	5. 00	11	
39. 00	PURCHASE DISC EARNED-OTHER REV			ADMINISTRATIVE & GENERAL	5. 00	0	
40.00	CAFETERIA SALES-OTHER REV	В		CAFETERI A	11.00	0	40. 00
41.00	CAFÉ VEND MACHIN-OTHER REV	В	-7, 329	CAFETERI A	11.00	0	41. 00
42.00	EDUCATION & TRAINING-OTHER REV			NURSING ADMINISTRATION	13. 00	0	42. 00
43.00	EMPLOYEE DRUG SALES-OTHER REV	В		PHARMACY	15. 00	0	43. 00
45.00	AQUATIC THERAPY-OTHER REV	В		PHYSI CAL THERAPY	66.00	0	45. 00
45. 01	OCCUPATIONAL MED-OTHER REV	В	-2, 530	PHYSI CAL THERAPY	66.00	0	45. 01
45. 02	PHY TH SCHOOL REV-OTHER REV	В		PHYSI CAL THERAPY	66.00	0	45. 02
45. 03	PHYSI CAL NI GHT-OTHER REV	В	·	PHYSI CAL THERAPY	66. 00	0	
45. 05	HELPLINE -OTHER REV	В	-40, 335	AMBULANCE SERVICES	95.00	0	45. 05
45. 07	EMPLOYEE HEALTH OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 07
45. 08	PFS BILLING SVC -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 09	THHA DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
45. 10	ANESTHESI A OFFSET	A		OPERATING ROOM	50.00	0	45. 10
45. 11	TELEVI SI ON	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 11
45. 12	TELEVISION ELECTRICITY	A	·	OPERATION OF PLANT	7.00	0	45. 12
45. 13	24TH ST OLD DEPRECIATION	A	-18, 346	NEW CAP REL COSTS-BLDG &	1.00	9	45. 13
				FI XT			
45. 14	24TH ST NEW DEPRECIATION	A	-20, 106	NEW CAP REL COSTS-BLDG &	1.00	9	45. 14
				FIXT			
45. 15	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 .00
45. 16	ER PURCHASED SERVICES	A		EMERGENCY	91. 00	0	1 .00
45. 17	PHARMACY DRUG REBATE-OTHER REV			PHARMACY	15. 00	0	45. 17
45. 18	340B REVENUE	В	-1, 370, 595	1	15. 00	0	45. 18
45. 19	PHARMACY STUDENT REIMB-OTHER	В	-500	PHARMACY	15. 00	0	45. 19
F0 0-	REV		40 704				
50. 00	TOTAL (sum of lines 1 thru 49)		-10, 731, 034				50. 00
	(Transfer to Worksheet A,						
(4) =	column 6, line 200.)			010 0 1 15 1			<u> </u>

⁽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.
(2) Additional adjustments are applicable and applicable and subportints thereof.

⁽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

Provider CCN: 150064

					'	09/30/2014	Date/lime Pre 2/25/2015 10:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physi ci an/Prov i der Component	or am
	1.00	2.00	2.00	4.00	Г 00	/ 00	Hours	
1. 00	1.00	2.00 OPERATING ROOM	3. 00 379, 913	4. 00 347, 551	5. 00 32, 362	6. 00 182, 900	7. 00 169	1. 00
2.00	93. 01		20, 580	20, 580	32, 302	162, 900	0	2. 00
3.00	93. 01		20, 580	20, 580	0	-		3. 00
4. 00	93. 01		175, 794	83, 648	92, 146	_		4. 00
5. 00	93. 01		235, 940	162, 620	73, 320	142, 500	780	5. 00
6. 00		CLI NI C	131, 570	131, 570	73, 320		0	6. 00
7. 00		CLI NI C	265, 845	265, 845	0			7. 00
8. 00		CLI NI C	95, 895	95, 895	0	0	Ö	8. 00
9. 00		CLI NI C	196, 308	196, 308	0	0	l o	9. 00
10. 00		CLINIC	370, 302	370, 302	0	Ö	o	10. 00
11. 00		CLINIC	425, 006	425, 006	0	Ö	o	11. 00
12. 00		CLINIC	51, 264	51, 264	0	0	o	12. 00
13. 00		CLINIC	305, 003	305, 003	0	0	o	13.00
14.00	93. 00	CLINIC	102, 682	102, 682	0	0	o	14.00
15. 00	93. 00	CLINIC	248, 170	248, 170	0	0	o	15.00
16.00	93. 00	CLI NI C	103, 013	103, 013	0	0	o	16.00
17.00	93. 00	CLI NI C	336, 124	336, 124	0	0	0	17.00
18. 00	93. 00	CLI NI C	97, 191	97, 191	0	0	0	18.00
19. 00		CLINIC	302, 556	302, 556	0	0	0	19.00
20.00		CLINIC	88, 130	88, 130	0	0	0	20.00
21. 00		CLINIC	116, 059	116, 059	0		0	21. 00
22. 00		CLINIC	199, 336	199, 336	0		0	22. 00
23. 00		CLINIC	88, 252	88, 252	0		·	23. 00
24. 00		CLI NI C	8, 077	8, 077	0	0	0	24. 00
25. 00		CLINIC	52, 744	52, 744	0		0	25. 00
26. 00		CLINIC	2, 356	2, 356	0	0	0	26. 00
27. 00		CLI NI C	2, 130	2, 130	0	0	0	27. 00
28. 00		CLINIC	115, 661	115, 661	0	0	0	28. 00
29. 00		CLINIC	87, 740	87, 740	0	0	0	29. 00
30. 00		CLI NI C	148, 683	148, 683	0	0	0	30.00
31. 00		CLI NI C	187, 080	187, 080	0) 0	0	31. 00
32. 00 33. 00		CLI NI C CLI NI C	217, 404 307, 750	217, 404 307, 750	0	0	0	32. 00 33. 00
200.00	93.00	CLINIC	5, 485, 256	5, 287, 428		U	1, 521	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physi ci an Cost	200.00
	WKSt. A LINC #							
		l denti fi er	Li mi t	Unadjusted RCE	Memberships &	Component Share of col.	of Malpractice	
						Component	of Malpractice	
	1. 00	l denti fi er 2.00		Unadjusted RCE	Memberships & Continuing	Component Share of col.	of Malpractice	
1.00	50. 00	I denti fi er 2.00 OPERATI NG ROOM	Limit	Unadjusted RCE Limit	Membershi ps & Conti nui ng Educati on 12.00	Component Share of col. 12 13.00	of Mal practi ce I nsurance 14.00	1. 00
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						10 09/30/2014	Date/lime Prepared: 2/25/2015 10:37 am
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment	
		l denti fi er	Component	Limit	Di sal I owance		
			Share of col.				
	1. 00	2.00	15. 00	16. 00	17. 00	18.00	
1. 00		OPERATING ROOM	0	14, 861	17, 50		1.00
2.00	93. 01	BIC	0	0	(20, 580	2. 00
3.00	93. 01	BIC	0	0	(20, 698	3. 00
4.00	93. 01	BIC	0	39, 188	52, 958	136, 606	4. 00
5.00	93. 01		0	53, 438	19, 882	182, 502	5. 00
6.00		CLINIC	0	0	(131, 570	6. 00
7.00		CLINIC	0	0	(265, 845	7. 00
8.00		CLINIC	0	0	(95, 895	8. 00
9.00		CLINIC	0	0	(1,70,000	9. 00
10.00		CLINIC	0	0	(10.00
11. 00		CLINIC	0	0	(.=-,	11. 00
12.00		CLINIC	0	0	(0.720.	12. 00
13.00		CLINIC	0	0	(000,000	13. 00
14.00		CLINIC	0	0	(14. 00
15.00		CLINIC	0	0		2 .0, ., 0	15. 00
16.00		CLINIC	0	0			16. 00
17. 00		CLINIC	0	0	(0007.2.7	17. 00
18. 00		CLINIC	0	0	(97, 191	18. 00
19. 00		CLINIC	0	0	(002,000	19. 00
20.00		CLINIC	0	0	(007.00	20. 00
21. 00		CLINIC	0	0	(21. 00
22.00		CLINIC	0	0	(1,	22. 00
23. 00		CLINIC	0	0	(,	23. 00
24.00		CLINIC	0	0	(8, 077	24. 00
25. 00		CLINIC	0	0	(7 02,	25. 00
26. 00		CLINIC	0	0	(2, 356	26. 00
27.00		CLINIC	0	0	(-,	27. 00
28. 00		CLINIC	0	0	(28. 00
29. 00		CLINIC	0	0	(87, 740	29. 00
30.00		CLINIC	0	0	(148, 683	30. 00
31. 00		CLINIC	0	0	(187, 080	31.00
32.00		CLINIC	0	0	(217, 404	32.00
33. 00		CLINIC	0	0	(307, 750	33.00
200.00			0	107, 487	90, 34	5, 377, 769	200. 00

| Peri od: | Worksheet B | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150064

					To	09/30/2014	Date/Time Prep 2/25/2015 10:	
				CAPI TAL			2/23/2013 10.	37 4111
				RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
			for Cost	FLXT	BENEFITS		& GENERAL	
			Allocation (from Wkst A		DEPARTMENT			
			col. 7)					
			0	1.00	4. 00	4A	5. 00	
		AL SERVICE COST CENTERS	,					
1.00	1	NEW CAP REL COSTS-BLDG & FIXT	1, 081, 650					1.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	6, 216, 820 7, 345, 229			7, 817, 878	7, 817, 878	4. 00 5. 00
7. 00		OPERATION OF PLANT	1, 689, 112			2, 217, 188		7. 00
7. 01		OPERATION OF PLANT	980, 000	l		980, 000		7. 01
8.00		LAUNDRY & LINEN SERVICE	161, 178	ł	5, 893	168, 167		8. 00
9.00	1	HOUSEKEEPI NG	705, 392			856, 786		9. 00
10.00	1	DIETARY	359, 240	l		419, 077	1	10.00
11. 00 13. 00	1	CAFETERI A	312, 478	l	1	403, 352		11. 00 13. 00
14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	429, 133 1, 102, 693	l e		519, 181 1, 131, 577		14. 00
15. 00		PHARMACY	2, 927, 227			3, 049, 014		15. 00
16.00	1	MEDICAL RECORDS & LIBRARY	1, 109, 723	l		1, 295, 339		16. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDI ATRI CS	1, 347, 543	l		1, 697, 204		30. 00
31.00		INTENSIVE CARE UNIT SUBPROVIDER - IPF	950, 683	l		1, 202, 109		31.00
40. 00 41. 00	1	SUBPROVIDER - IPF	1, 327, 948 581, 326	l		1, 518, 986 717, 918		40. 00 41. 00
42. 00		SUBPROVI DER	0 301, 320	25, 474		717, 910	130, 120	42. 00
43. 00	1	NURSERY	389, 080	1	-	489, 617		43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	837, 082	66, 818	212, 852	1, 116, 752	1	50.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	2, 626, 274	59, 623	274, 006	2, 959, 903	0 569, 453	52. 00 54. 00
57. 00		CT SCAN	0 2,020,274	0 0	0	2, 737, 703	0	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	1	LABORATORY	1, 853, 259	1		2, 065, 763		
60. 01 65. 00	1	BLOOD LABORATORY RESPIRATORY THERAPY	421, 880	0 8, 967	-	526, 954	0 101, 380	60. 01 65. 00
66. 00		PHYSI CAL THERAPY	805, 300	l		1, 045, 437		66. 00
69. 01		CARDI AC REHAB	154, 684	7, 970		199, 800		69. 01
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	69, 090	l e		69, 090		
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0		0	0	73. 00 74. 00
7 1. 00		TIENT SERVICE COST CENTERS			<u> </u>			7 1. 00
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	0	0	89. 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 239, 811	21, 569	291, 034	1, 552, 414	298, 667	91. 00 92. 00
93. 00		CLINIC	4, 621, 711	40, 743	1, 682, 210	6, 344, 664	1, 220, 649	
93. 01			1, 215, 620			1, 458, 988		
93. 02	04041	UCI C	0	0		0	0	93. 02
	04042		0	0	0	0	0	
	04043		12.003	0		17. 242	0	93. 04
93. 05		PODI ATRY REI MBURSABLE COST CENTERS	13, 003	0	3, 239	16, 242	3, 125	93. 05
95.00		AMBULANCE SERVICES	422, 998	0	109, 458	532, 456	102, 439	95. 00
99. 10	09910	CORF	0	0	0	0	0	
101.00		HOME HEALTH AGENCY	873, 597	10, 458	190, 935	1, 074, 990	206, 816	101. 00
100.00		AL PURPOSE COST CENTERS PANCREAS ACQUISITION				0	0	100.00
		INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	1	ISLET ACQUISITION	0	0	0	0		111.00
		HOSPI CE	145, 728	Ö	16, 779	162, 507		
118.00		SUBTOTALS (SUM OF LINES 1-117)	44, 316, 492	940, 311	5, 655, 272	43, 609, 353	6, 885, 892	118. 00
100.00		I MBURSABLE COST CENTERS	1				1 0	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0	0		0		190. 00 191. 00
		FMH DIAGNOSTIC CENTE	204, 809	-		252, 931		
		WELLNESS	204, 083	ł		228, 041		
		PHYSICIANS' PRIVATE OFFICES	31, 498			76, 392		
192.01			-199 265 904	ł	_	-199 207 200		192. 01
		MARKETI NG FOUNDATI ON	365, 804 1, 476	l		387, 309 2, 960		192. 02 192. 03
		BROOKVILLE CLINIC	0	0		2, 700	0	192. 04
192.05			0	0	О	0		192. 05

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTI	ΞM	In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi de	r CCN: 150064	From 10/01/2013	Worksheet B Part I Date/Time Prepared: 2/25/2015 10:37 am
		CAPITAL RELATED COST	S		

					2/25/2015 10:	37 am
		CAPITAL RELATED COSTS				
Cost 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 HEART CENTER	0	2, 520	0	2, 520	485	192. 06
192. 07 19207 WVCP	2, 116, 789	56, 352	389, 113	2, 562, 254	492, 949	192. 07
192. 08 19210 OCCUPATI ONAL MED	1, 575	0	0	1, 575	303	192. 08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 19211 HOSPI TALI ST	1, 211, 110	0	78, 779	1, 289, 889	248, 160	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	40, 412	0	40, 412	7, 775	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)	48, 453, 437	1, 081, 650	6, 221, 072	48, 453, 437	7, 817, 878	202. 00

				1	0 09/30/2014	Date/lime Pre 2/25/2015 10:	pared: 37 am
	Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	JOSUS DE LOS CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA CONTROLOS DE LA C	7. 00	7. 01	8. 00	9. 00	10.00	
1. 00	GENERAL SERVICE COST CENTERS 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	2, 643, 751	l				7.00
7. 01 8. 00	00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 427	1, 168, 541 3, 248	1			7. 01 8. 00
9. 00	00900 HOUSEKEEPI NG	20, 558	1				9. 00
10.00	01000 DI ETARY	28, 040	20, 572	20, 542	11, 613	580, 470	10. 00
11.00	01100 CAFETERIA	46, 677	34, 245	0	19, 331	0	11.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	29, 012	21, 285	0	0 12, 016	0	13. 00 14. 00
15. 00	01500 PHARMACY	28, 073	1	1	11, 627	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	32, 565	1	0	13, 487	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1/5 044	404 000	10.050	(0.40)	050.077	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	165, 241 100, 317	121, 232 73, 600	1		259, 967 38, 028	
40. 00	04000 SUBPROVI DER - I PF	85, 244	73,000	0		36, 329	
41. 00	04100 SUBPROVI DER - I RF	102, 909	75, 501	11, 812		23, 641	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	53, 932	39, 568	B 0	22, 336	0	43. 00
50. 00	05000 OPERATING ROOM	269, 934	198, 043	17, 275	111, 791	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	O	0		0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	240, 865	176, 715	25, 607	99, 756	0	54.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59.00
60.00	06000 LABORATORY	77, 092	56, 560	o o	31, 928	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	36, 225	26, 577	1	15, 003	0	65. 00
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	79, 597 32, 197	58, 398 23, 622			0	66. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20, 022	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0) 0	0	0	74. 00
88. 00	08800 RURAL HEALTH CLINIC	0	С	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) o	0	0	89. 00
91.00	09100 EMERGENCY	87, 134	63, 927	33, 788	36, 087	0	91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 CLINIC	164, 593	0	121	77, 536	0	92. 00 93. 00
93. 01	04044 BI C	229, 474		0	95, 038	0	93. 01
93. 02	04041 UCI C	0	0	0	0	0	93. 02
	04042 CI C	0	0	0	0	0	93. 03
93. 04 93. 05	04043 RI C 04950 PODI ATRY	0	0		0	0	
75. 05	OTHER REIMBURSABLE COST CENTERS	J		,,	J	<u> </u>	73.03
	09500 AMBULANCE SERVICES	0	0	0	0		95. 00
	09910 CORF 10100 HOME HEALTH AGENCY	42.250	0	0	17 400		99. 10
101.00	SPECIAL PURPOSE COST CENTERS	42, 250		5, 798	17, 498	0	101. 00
	10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	D11100 ISLET ACQUISITION D11600 HOSPICE	0	0	0	0		111. 00 116. 00
118. 00		1, 956, 356	1, 052, 664	204, 506	809, 255	357, 965	
	NONREI MBURSABLE COST CENTERS	1,133,333	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		331, 233	33.7.133	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH 19101 FMH DIAGNOSTIC CENTE	0		0	0		191. 00 191. 01
	2 19102 WELLNESS	108, 523			37, 357		191. 01
	19200 PHYSICIANS' PRIVATE OFFICES	160, 220	l e	3, 071			192. 00
	1 19201 RFE	0	0	0	0		192. 01
	2	13, 086	1	1	5, 420 1, 956		192. 02 192. 03
	19204 BROOKVILLE CLINIC	4, 481 0	3, 287	1	1, 856 0		192. 03
192.05	5 19205 ATOD	0) o	o	0	192. 05
	19206 HEART CENTER	10, 182	7, 470	618			192.06
	7 19207 WVCP 3 19210 OCCUPATI ONAL MED	227, 649		0	92, 766	222, 505 0	192. 07 192. 08
	19209 HOME MEDICAL EQUIPMENT				0		192. 09
	19211 HOSPI TALI ST	0	[o	0	0		192. 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 10/01/2013	Worksheet B Part I Date/Time Prepared: 2/25/2015 10:37 am

						2/25/2015 10:	3/ am_
	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	163, 254	0	0	40, 036	(194. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	(201.00
202. 00	TOTAL (sum lines 118-201)	2, 643, 751	1, 168, 541	208, 195	1, 057, 263	580, 470	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared: | Provider CCN: 150064

			10	09/30/2014	Date/lime Pre 2/25/2015 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, <u>u</u>
		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	13.00	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 00701 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						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	581, 205					11. 00
13.00 01300 NURSING ADMINISTRATION	8, 937	628, 003				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	4, 036		1, 415, 629			14. 00
15. 00 01500 PHARMACY	15, 395		0	3, 739, 472		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	25, 921	0	0	0	1, 640, 413	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	45, 744	83, 732	0	٥	76, 021	30.00
31. 00 03100 NTENSI VE CARE UNI T	32, 478	59, 443	Ö	ő	35, 698	31. 00
40. 00 04000 SUBPROVI DER - I PF	22, 575	41, 330	0	o	34, 206	40.00
41. 00 04100 SUBPROVI DER - RF	15, 740	28, 797	0	o	16, 067	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	11, 009	20, 143	0	0	6, 722	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	41, 358	75, 707	O	ol	142, 475	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	41, 330	73, 707	0	o	142, 473	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	36, 187	66, 247	0	o	329, 078	54.00
57.00 05700 CT SCAN	0	0	0	O	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	29, 699	54, 370	0	0	253, 389	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	18, 141	33, 213	0	0	0 46, 231	60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY	22, 844	41, 837	0	0	42, 475	66.00
69. 01 06901 CARDI AC REHAB	4, 697	8, 594	0	o	3, 965	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 415, 629	o	46, 532	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3, 739, 472	165, 573	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	ol	0	89. 00
91. 00 09100 EMERGENCY	32, 041	0	Ō	ō	181, 768	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 00 04040 CLI NI C	85, 546	0	0	0	169, 780	93. 00
93. 01 04044 BI C	0	0	0	0	51, 444	93. 01
93. 02 04041 UCI C 93. 03 04042 CI C	0	0	0	0	0	93. 02 93. 03
93. 04 04042 CTC 93. 04 04043 RI C	0	0	0	0	0	93. 03
93. 05 04950 PODI ATRY	685	ő	0	ő	2, 142	93. 05
OTHER REIMBURSABLE COST CENTERS			- 1		,	
95. 00 09500 AMBULANCE SERVICES	20, 728	37, 928	0	0	17, 003	
99. 10 09910 CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	26, 488	48, 492	0	0	12, 832	101.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	O	0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	ol		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	o		111. 00
116. 00 11600 H0SPI CE	2, 256	0	0	0	7, 012	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	502, 505	628, 003	1, 415, 629	3, 739, 472	1, 640, 413	118. 00
NONREI MBURSABLE COST CENTERS				ام		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	U O		190. 00 191. 00
191. 01 19101 FMH DI AGNOSTI C CENTE	0	0	0	0		191. 00
191. 02 19102 WELLNESS	0	o	0	o		191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	192. 00
192. 01 19201 RFE	0	0	0	0		192. 01
192. 02 19202 MARKETI NG	2, 165		0	0		192. 02
192. 03 19203 FOUNDATI ON 192. 04 19204 BROOKVI LLE CLI NI C	2, 318	0	0	0		192. 03 192. 04
192. 04 19204 BROOKVILLE CLINIC 192. 05 19205 ATOD	0	0	0	O A		192. 04 192. 05
192. 06 19206 HEART CENTER	0	ol	0	ol		192. 06
192. 07 19207 WVCP	71, 006	o	Ö	o	0	192. 07
192. 08 19210 OCCUPATI ONAL MED	0	o	0	o		192. 08
192. 09 19209 HOME MEDI CAL EQUI PMENT	0	0	0	0	0	192. 09

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 10/01/2013 Part I To 09/30/2014 Date/Time Prepared: 2/25/2015 10: 37 am

					2/25/2015 10:	37 am_
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	3, 211	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)	581, 205	628, 003	1, 415, 629	3, 739, 472	1, 640, 413	202.00

				lo 09/30/2014 Date/lime 2/25/2015	
Cost Center Description	Subtotal	Intern &	Total		
	F	Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVI CE COST CENTERS		T			
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
7.00 00700 OPERATION OF PLANT					7.00
7. 01 00701 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					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					10.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 892, 450	0	2, 892, 450		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 832, 124	0	1, 832, 12		31.00
40. 00 04000 SUBPROVI DER - 1 PF	2, 066, 210	0	2, 066, 210	0	40. 00
41. 00 04100 SUBPROVI DER - RF	1, 173, 125	0	1, 173, 12		41. 00
42. 00 04200 SUBPROVI DER	0	0		0	42.00
43. 00 04300 NURSERY	737, 524	0	737, 52	4	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	2, 188, 186	ol	2, 188, 18	6	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 100, 100	0			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 503, 811	o	4, 503, 81		54.00
57. 00 05700 CT SCAN	0	O			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	2, 966, 231	0	2, 966, 23	1	60.00
60. 01 06001 BLOOD LABORATORY	002.724	0	002.72	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	803, 724 1, 546, 655	0	803, 72 1, 546, 65		65. 00 66. 00
69. 01 06901 CARDI AC REHAB	326, 261	0	326, 26		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 462, 161	o	1, 462, 16		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 382	0	82, 38:		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 905, 045	0	3, 905, 04	5	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	(0	74. 00
OUTPATIENT SERVICE COST CENTERS		ما			- 00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	88. 00 89. 00
91. 00 09100 EMERGENCY	2, 285, 826	0	2, 285, 82	٥ د	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 203, 020	0	2, 203, 020		92. 00
93. 00 04040 CLI NI C	8, 062, 889	Ö	8, 062, 889	9	93. 00
93. 01 04044 BI C	2, 115, 637	0	2, 115, 63	7	93. 01
93. 02 04041 UCI C	0	0	(0	93. 02
93. 03 04042 CI C	0	0	(0	93. 03
93. 04 04043 RI C 93. 05 04950 PODI ATRY	0	0	22.10	0	93. 04
OTHER REIMBURSABLE COST CENTERS	22, 194	U	22, 19	4	93. 05
95. 00 09500 AMBULANCE SERVICES	710, 554	O	710, 55	4	95. 00
99. 10 09910 CORF	0	o			99. 10
101.00 10100 HOME HEALTH AGENCY	1, 435, 164	0	1, 435, 16	4	101. 00
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUISITION	0	0	(0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	(0	110.00
111. 00 11100 I SLET ACQUI SI TI ON 116. 00 11600 HOSPI CE	203, 040	0	203. 040		111. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41, 321, 193	0	41, 321, 19		118.00
NONREI MBURSABLE COST CENTERS	41, 321, 173	<u> </u>	41, 321, 17	5	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190. 00
191. 00 19100 RESEARCH	0	0	(o	191. 00
191.01 19101 FMH DIAGNOSTIC CENTE	301, 592	O	301, 59		191. 01
191. 02 19102 WELLNESS	417, 794	0	417, 79		191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	416, 255	O	416, 25		192. 00
192. 01 19201 RFE 192. 02 19202 MARKETI NG	-199 492, 095	ol .	-19 ¹ 492, 09		192. 01 192. 02
192. 02 19202 MAKKETT NG 192. 03 19203 FOUNDATI ON	15, 471	0	492, 099 15, 47		192. 02
192. 04 19204 BROOKVI LLE CLI NI C	0	o o	15, 47	ol	192. 04
192. 05 19205 ATOD		Ö		o	192. 05
192.06 19206 HEART CENTER	25, 492	О	25, 49		192. 06
192. 07 19207 WVCP	3, 669, 129	0	3, 669, 12	9	192. 07

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 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

				2/25/2015 10:	37 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25. 00	26.00		
192. 08 19210 OCCUPATI ONAL MED	1, 878	0	1, 878		192. 08
192. 09 19209 HOME MEDICAL EQUIPMENT	0	0	0		192. 09
192. 10 19211 HOSPI TALI ST	1, 541, 260	0	1, 541, 260		192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	251, 477	o	251, 477		194. 00
200.00 Cross Foot Adjustments	0	l ol	0		200. 00
201.00 Negative Cost Centers	0	l ol	0		201.00
202.00 TOTAL (sum lines 118-201)	48, 453, 437	o	48, 453, 437		202. 00

Health Financial Systems

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

Period:
From 10/01/2013
To 09/30/2014

Part II
Date/Time Prepared:
2/25/2015 10: 37 am

CAPITAL
RELATED COSTS

						2/25/2015 10:	37 am_
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 252		4, 252		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	85, 458		265		5. 00
7.00	00700 OPERATION OF PLANT	0	423, 135		72		7. 00
7. 01	00701 OPERATION OF PLANT	0	1 00/	1 4	0		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	1, 096		100	355	8.00
9. 00 10. 00	01000 DI ETARY	0	5, 089		100		9.00
11. 00	01100 CAFETERI A	0	6, 941 11, 554		36 54		10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	11, 334	1	62		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	7, 182		15		14. 00
15. 00	01500 PHARMACY	Ö	6, 949		79		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö		1	122		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	40, 903		211		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	24, 832	1	155		31. 00
40. 00	04000 SUBPROVI DER - I PF	0	21, 101	1	116		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	25, 474	1	76		41. 00
42. 00	04200 SUBPROVI DER	0	0		0		42. 00
43. 00	04300 NURSERY	0	13, 350	13, 350	60	1, 033	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	66, 818	66, 818	146	2, 356	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	00,810	00, 818	0		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	59, 623		188	-	54. 00
57. 00	05700 CT SCAN	0	07,020		0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l o	ol ol	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	o c	o	0	0	59. 00
60.00	06000 LABORATORY	0	19, 083	19, 083	132	4, 359	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	8, 967		66		65. 00
66.00	06600 PHYSI CAL THERAPY	0	19, 703		151		66. 00
69. 01	06901 CARDI AC REHAB	0	7, 970		25		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	1	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	0		72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0		1	0		74.00
7 1. 00	OUTPATIENT SERVICE COST CENTERS			<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	0	0	0	0	0	89. 00
91. 00	09100 EMERGENCY	0	21, 569	21, 569	199	3, 276	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92. 00
93.00	04040 CLI NI C	0	40, 743	1	1, 145		93. 00
93. 01	04044 BI C	0	0	0	167		93. 01
	04041 UCI C 04042 CI C	0	0	0	0	0	
	04042 GTC	0		1	0	0	
	04950 PODI ATRY	Ö		Ö	2	34	93. 05
	OTHER REIMBURSABLE COST CENTERS		•			•	
95.00		0	C	0	75	1, 123	
	09910 CORF	0	_		0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	10, 458	10, 458	131	2, 268	101. 00
100.00	SPECIAL PURPOSE COST CENTERS			J			100.00
	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	11100 I SLET ACQUISITION	0		0	0		111.00
	11600 H0SPI CE	0			11		116. 00
118.00		0	940, 311	940, 311	3, 865		
	NONREI MBURSABLE COST CENTERS	_			.,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19101 FMH DIAGNOSTIC CENTE	0	0	0	33		191. 01
	2 19102 WELLNESS	0	0	0	16		191. 02
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	37, 707		5		192. 00
	19201 RFE		2 220	2 220	0		192. 01 192. 02
	2		3, 239 1, 109	1	13 0		192. 02 192. 03
	19204 BROOKVILLE CLINIC		1, 109	1	0		192. 03
	19205 ATOD	0		·	0		192. 04
	19206 HEART CENTER	0	2, 520		0		192. 06
				'			

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 10/01/2013	Worksheet B Part II Date/Time Pre 2/25/2015 10:	
		CAPI TAI				

					2/25/2015 10:	<u>3/ am </u>
		CAPITAL RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	Subtotal		ADMI NI STRATI VE	
	Assigned New	FLXT		BENEFITS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
192. 07 19207 WVCP	0	56, 352	56, 352	266	5, 406	192. 07
192. 08 19210 OCCUPATI ONAL MED	0	0	0	0	3	192. 08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 19211 HOSPI TALI ST	0	0	0	54	2, 722	192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	40, 412	40, 412	0	85	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, 081, 650	1, 081, 650	4, 252	85, 723	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

Peri od: Worksheet B From 10/01/2013 Part II To 09/30/2014 Date/Time Prepared:

2/25/2015 10:37 am Cost Center Description OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **PLANT** PLANT LINEN SERVICE 9.00 10.00 7.00 7.01 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7 00 427, 885 7 00 7.01 00701 OPERATION OF PLANT 2,068 7. 01 00800 LAUNDRY & LINEN SERVICE 716 8.00 2, 177 8.00 9.00 00900 HOUSEKEEPI NG 3.327 27 10.351 9.00 C 01000 DI ETARY 12, 764 10.00 10.00 4.538 36 215 114 01100 CAFETERI A 7,554 189 0 11.00 11.00 61 C 13 00 01300 NURSING ADMINISTRATION 0 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 118 14.00 14 00 4 696 38 0 15.00 01500 PHARMACY 4,544 36 0 114 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 5.270 42 132 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 26.744 215 505 670 5.716 31.00 03100 INTENSIVE CARE UNIT 16, 236 130 184 407 836 31.00 04000 SUBPROVIDER - IPF 13, 797 40.00 C 346 799 40.00 04100 SUBPROVI DER - I RF 41.00 16, 656 520 41.00 134 124 417 04200 SUBPROVI DER 42.00 r C 0 0 42.00 04300 NURSERY 43.00 43.00 8,729 70 219 0 ANCILLARY SERVICE COST CENTERS 1, 093 50.00 05000 OPERATING ROOM 43,689 350 181 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 38.983 313 268 977 0 54.00 05700 CT SCAN 57.00 57.00 0 0 C 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0 C 0 0 Λ 58.00 59.00 05900 CARDIAC CATHETERIZATION C 0 0 0 59.00 06000 LABORATORY 60.00 12, 477 100 0 313 0 60.00 06001 BLOOD LABORATORY 0 60.01 C 0 0 60.01 06500 RESPIRATORY THERAPY 65.00 5,863 47 0 147 0 65.00 66.00 06600 PHYSI CAL THERAPY 12,883 103 230 323 0 66.00 06901 CARDI AC REHAB 69.01 5, 211 42 17 131 0 69.01 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω O 0 71 00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 89.00 91 00 09100 EMERGENCY 14, 102 353 91 00 113 353 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 CLI NI C 26, 639 759 93.00 93.00 0 93. 01 04044 BI C 37, 140 0 0 930 93.01 0 04041 UCI C 93 02 93 02 0 0 Ω 0 0 93.03 04042 CI C 0 0 0 0 0 93.03 93.04 04043 RI C 0 0 0 0 0 93.04 04950 PODI ATRY 93.05 93.05 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 99. 10 |09910 CORF 0 99. 10 0 0 101.00 10100 HOME HEALTH AGENCY 0 171 0 101.00 6,838 61 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 0 1111.00 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 316, 632 1,863 2, 139 7, 923 7, 871 118. 00 118.00 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 C 0 0 0 191.00 0 191. 01 191. 01 19101 FMH DIAGNOSTIC CENTE 0 Ω 0 0 191. 02 19102 WELLNESS 0 191. 02 17.564 0 0 366 192.00 19200 PHYSICIANS' PRIVATE OFFICES 25, 931 169 32 650 0 192, 00 192. 01 19201 RFE 0 192. 01 192. 02 19202 MARKETI NG 2, 118 17 0 53 0 192. 02 192. 03 19203 FOUNDATI ON 0 18 0 192, 03 725 6 0 192. 04 19204 BROOKVILLE CLINIC 0 0 0 0 192. 04 192. 05 19205 ATOD 0 0 0 192. 05 0 C 192.06 19206 HEART CENTER 1.648 41 0 192.06 13 6 0 192, 07 19207 WVCP C 4, 893 192. 07 36, 845 908 192. 08 19210 OCCUPATIONAL MED 0 0 0 0 192. 08 0 192. 09 19209 HOME MEDICAL EQUIPMENT 0 192. 09 0 0 0 192. 10 19211 HOSPI TALI ST 0 0 0 192. 10

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared:

						2/25/2015 10:	37 am
	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	26, 422	0	0	392	C	194. 00
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	C	201. 00
202.00	TOTAL (sum Lines 118-201)	427, 885	2. 068	2. 177	10. 351	12. 764	202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2013 | Part II |
| To 09/30/2014 | Date/Time Prepared: | 2/25/2015 10:37 am

COST CENTER* DESCRIPTION DAMPS DAMPS DESCRIPTION						09/30/2014	2/25/2015 10:	
Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series Series S		Cost Center Description	CAFETERI A			PHARMACY	MEDI CAL	
CHIRML SERVICE CONT CONT CONTENS 11.00 15.00 16.00				ADMINISTRATION				
1.00 00000 DOTOLOGICAL PURE LOSIFS BLOG & INTY 4.00 0.00000 DOTOLOGICAL PURE PROPERTY 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00			11.00	13. 00		15. 00		
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2,00 00000 DARRIGH OR OF PLANT								1
7. 01 0.0701 DOPESATION OF PLANT								•
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10.00 01000 DETRAY		1						•
11.00 01100 CAFETERIA 20,263 1,469 11,500 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 13,101 14,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,101 15,	9.00	00900 HOUSEKEEPI NG						9. 00
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14.00 01400 CENTRAL SERVICES & SUPPLY			1	1				1
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93. 04 04043 RIC 0 0 0 0 0 0 93. 04 93. 05 04950 PODIATRY 24 0 0 0 0 23 93. 05 04950 PODIATRY 04 0 0 0 0 0 97. 00 09500 AMBULANCE SERVICES 723 89 0 0 0 179 99. 10 09910 CORF 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 923 113 0 0 0 135 101. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 110. 00 10900 PANCREAS ACQUI SITI 0N 0 0 0 0 0 0 111. 00 11000 INTESTI NAL ACQUI SITI 0N 0 0 0 0 0 0 111. 00 11000 ISLET ACQUI SITI 0N 0 0 0 0 0 0 0 116. 00 1069PICE 79 0 0 0 0 0 0 111. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 17,519 1,469 14,578 18,758 17,264 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 191. 01 19101 FMH DI AGNOSTI C CENTE 0 0 0 0 0 0 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 01 192. 01 19201 RFE 0 0 0 0 0 0 0 192. 01 192. 02 19202 MARKETI NO 0 0 0 0 0 192. 03 192. 04 19204 BROKVILLE CLINIC 0 0 0 0 0 192. 04 192. 05 19205 19205 ATOD 0 0 0 0 0 0 192. 05 192. 06 19200 HARRET CENTER 0 0 0 0 0 0 192. 05 192. 06 19200 HARRET CENTER 0 0 0 0 0 0 192. 05 192. 06 19200 HARRET CENTER 0 0 0 0 0 0 192. 05 192. 06 19200 HARRET CENTER 0 0 0 0 0 0 192. 05 192. 07 19201 19201 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 100			0	0	0	0	0	93. 02
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110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 110.00			,					
111. 00 11100 15LET ACQUI SI TI ON 0 0 0 0 0 111. 00 116. 00 11600 HOSPI CE 79 0 0 0 74 118. 00 SUBTOTALS (SUM OF LINES 1-117) 17, 519 1, 469 14, 578 18, 758 17, 264 118. 00 NONREI MBURSABLE COST CENTERS 17, 264 119. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 191. 01 19100 RESEARCH 0 0 0 0 0 191. 00 191. 01 19101 FMH DI AGNOSTI C CENTE 0 0 0 0 0 191. 01 191. 02 19102 WELLNESS 0 0 0 0 0 191. 02 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 192. 01 19201 RFE 0 0 0 0 0 192. 01 192. 02 19202 MARKETI NG 75 0 0 0 0 192. 01 192. 03 19203 FOUNDATI ON 81 0 0 0 0 192. 02 192. 04 19204 BROOKVI LLE CLI NI C 0 0 0 0 192. 03 192. 05 19205 ATOD 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 06 192. 08 19210 OCCUPATI ONAL MED 0 0 0 0 192. 08 192. 08 19210 OCCUPATI ONAL MED			0	0	0	0		
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 17, 519 1, 469 14, 578 18, 758 17, 264 118. 00 NONREI MBURSABLE COST CENTERS			0	0	0	0		1
118. 00 SUBTOTALS (SUM OF LINES 1-117) 17, 519 1, 469 14, 578 18, 758 17, 264 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 1900 190			70	0	0	O O		1
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190. 00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 1910 RESEARCH 0 0 0 0 0 0 191. 00 191. 00 191. 01 1910 FMH DIAGNOSTI C CENTE 0 0 0 0 0 191. 01 1910 WELLNESS 0 0 0 0 0 0 191. 02 19102 WELLNESS 0 0 0 0 0 0 192. 02 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 01 192. 01 1920 RFE 0 0 0 0 0 192. 01 192. 02 19202 MARKETI NG 75 0 0 0 0 192. 02 192. 03 19203 FOUNDATI ON 81 0 0 0 0 192. 03 192. 04 19204 BROOKVI LLE CLI NI C 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 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 07 192. 08 19210 OCCUPATI ONAL MED	110.00		17,017	1, 107	11,070	10, 700	17,201	1110.00
191. 01 19101 FMH DI AGNOSTI C CENTE	190.00		0	0	0	0	0	190. 00
191. 02 19102 WELLNESS			0	o	0	o	0	191. 00
192. 00 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 1920			0	0	0	0		
192. 01 19201 RFE			0	0	0	0		
192. 02 MARKETI NG 75 0 0 0 192. 02 192. 03 19203 FOUNDATI ON 81 0 0 0 0 192. 03 192. 04 19204 BROOKVI LLE CLI NI C 0 0 0 0 0 0 192. 04 192. 05 19205 ATOD 0 0 0 0 0 0 192. 05 192. 06 19206 HEART CENTER 0 0 0 0 0 192. 05 192. 07 19207 WVCP 2, 476 0 0 0 0 192. 07 192. 08 19210 OCCUPATI ONAL MED 0 0 0 0 0 192. 08			0	0	0	0		
192. 03 19203 FOUNDATI ON			75		0	0		
192. 04 19204 BROOKVI LLE CLINI C					0	Ol Ol		
192. 05 19205 ATOD				l ől	o	ol		
192. 07 19207 WVCP			0	0	0	ō		1
192. 08 19210 OCCUPATI ONAL MED 0 0 0 192. 08	192.06	19206 HEART CENTER	0	o	0	o	0	192. 06
			2, 476	0	0	0		
192. 09 1 0 0 0 0 0 192. 09			0	0	0	0		
	192.09	17207 HOME MEDI CAL EQUI PMENT	1 0	<u> </u> 0	0	O	0	1192.09

Health Financial Systems	FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 1500	From 10/01/2013	Worksheet B Part II Date/Time Prepared:

						2/25/2015 10:	37 am_
	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	112	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)	20, 263	1, 469	14, 578	18, 758	17, 264	202. 00

| Peri od: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150064

				Τ̈́	To 09/30/2014 Date/Time Pro	
	Cost Center Description	Subtotal	Intern &	Total	272372013 10	. 57 aiii
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	CENEDAL CEDALCE COCT CENTEDO	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS OO100 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 8. 00	OO701 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE					7. 01 8. 00
9. 00	00900 HOUSEKEEPING					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS	81, 138				30.00
40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	46, 964 40, 609	1			31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	45, 702	1			41. 00
42.00	04200 SUBPROVI DER	C	0	C		42. 00
43. 00	04300 NURSERY	23, 963	0	23, 963	3	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	117, 756	0	117, 756	<u> </u>	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	117,730	o o			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	111, 437	0	111, 437	7	54.00
57. 00	05700 CT SCAN	C	-	1)	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	C	1	1)	58. 00 59. 00
60. 00	06000 LABORATORY	40, 300	1	·		60.00
60. 01	06001 BLOOD LABORATORY	C	0)	60. 01
65.00	06500 RESPI RATORY THERAPY	17, 400	l e	,		65. 00
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	36, 941 14, 044		36, 941 14, 044		66. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 069	l .			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	146	1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	20, 506				73. 00
74. 00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	C	0	<u> </u>)	74. 00
88. 00	08800 RURAL HEALTH CLINIC		0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	C)	89. 00
91. 00	09100 EMERGENCY	43, 001	0	43, 001	1	91. 00
92. 00 93. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O4040 CLINIC	07 422	0	87, 432		92. 00 93. 00
93. 00	04040 CETNIC	87, 432 41, 858	1			93. 00
	04041 UCI C	C	0	, , , , , , , , , , , , , , , , , , ,		93. 02
	04042 CI C	C	1)	93. 03
	04043 RI C 04950 PODI ATRY	83)	93. 04 93. 05
93.03	OTHER REIMBURSABLE COST CENTERS	03	<u> </u>	03)	93.03
95.00	09500 AMBULANCE SERVICES	2, 189	0	2, 189)	95. 00
	09910 CORF	01.000	1			99. 10
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	21, 098	0	21, 098	3	101. 00
109. 00	10900 PANCREAS ACQUISITION	C	0	С		109. 00
	11000 INTESTINAL ACQUISITION	C	0	c)	110. 00
	11100 I SLET ACQUI SI TI ON	C	0)	111.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	507 808, 143				116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	000, 143	,,	000, 140	,	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		1		190. 00
	19100 RESEARCH	C				191.00
	19101 FMH DIAGNOSTIC CENTE 19102 WELLNESS	567 18, 427	1	567 18, 427		191. 01 191. 02
	19102 WELLNESS 19200 PHYSI CLANS' PRI VATE OFFI CES	64, 655		64, 655		191. 02
192. 01	19201 RFE	C	0	C C		192. 01
	19202 MARKETI NG	6, 332		6, 332		192. 02
	19203 FOUNDATION	1, 945	0	1, 945		192. 03
	19204 BROOKVI LLE CLI NI C 19205 ATOD) 0))	192. 04 192. 05
192.06	19206 HEART CENTER	4, 233	o o	4, 233	3	192. 06
192. 07	19207 WVCP	107, 146	0	107, 146	اد	192. 07

Health Financial Systems	AYETTE REGIONAL	. HEALTH SYSTEM	I	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150064	From 10/01/2013	Worksheet B Part II Date/Time Prepared: 2/25/2015 10:37 am
Cost Center Description	Subtotal	Intern &	Total		

					2/25/2015 10:	37 am_
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26.00		
192. 08 19210	OCCUPATIONAL MED	3	0	3		192. 08
192. 09 19209	HOME MEDICAL EQUIPMENT	0	0	0		192. 09
192. 10 19211	HOSPI TALI ST	2, 888	0	2, 888		192. 10
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	67, 311	0	67, 311		194. 00
200. 00	Cross Foot Adjustments	0	0	0		200. 00
201. 00	Negative Cost Centers	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	1, 081, 650	0	1, 081, 650		202. 00

	ALLOCATION - STATISTICAL BASIS	ATETTE REGIONAL		CCN: 150064 P	eri od:	Worksheet B-1	
				F T	rom 10/01/2013 o 09/30/2014	Date/Time Pre	pared:
		CADLTAL				2/25/2015 10:	37 am
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS	404, 700		T			1 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 591	24, 481, 988				1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	31, 974	1, 523, 726	1	40, 635, 758		5. 00
7. 00	00700 OPERATION OF PLANT	158, 316	412, 978	1	_, ,		
7. 01 8. 00	00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 410	0 23, 192	1			
9. 00	00900 HOUSEKEEPI NG	1, 904	575, 758	1	856, 786		
10.00	01000 DI ETARY	2, 597	208, 165		419, 077		
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	4, 323	312, 150		403, 352	4, 323 0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 687	354, 368 85, 406		,	-	
	01500 PHARMACY	2, 600	451, 925	1			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 016	698, 739	C	1, 295, 339	3, 016	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	15, 304	1, 215, 067	1 0	1, 697, 204	15, 304	30.00
31. 00	03100 NTENSI VE CARE UNI T	9, 291	891, 725		1, 202, 109	9, 291	
	04000 SUBPROVI DER - I PF	7, 895	668, 758		., ,		1
41.00	04100 SUBPROVI DER -	9, 531	437, 285	C		9, 531 0	
43.00	04300 NURSERY	4, 995	343, 110	1	-		1
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	25, 000	837, 643	C			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	22, 308	1, 078, 305	1	2, 959, 903	0 22, 308	
57. 00	05700 CT SCAN	0	0	d	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	0	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	7, 140	761, 178		0 2, 065, 763	0 7, 140	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	7, 140	701, 170			7, 140	1
65.00	06500 RESPI RATORY THERAPY	3, 355	378, 212		,		65. 00
66. 00 69. 01	O6600 PHYSI CAL THERAPY O6901 CARDI AC REHAB	7, 372 2, 982	867, 482	1	1, 045, 437 199, 800		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 982	146, 183 0		199, 800	2, 982 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	o c	69, 090	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	<u> </u>	0	<u> </u> C	U	0	74. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	1		0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 070	1 145 210				
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 070	1, 145, 318		1, 552, 414	8, 070	91. 00 92. 00
	04040 CLI NI C	15, 244	6, 620, 043	C	6, 344, 664	15, 244	
93. 01	04044 BI C	0	957, 735	C	1, 458, 988		
	04041 UCI C 04042 CI C	0	0		0	0	
93. 04	1	O	Ö	C	0	Ö	
93. 05	04950 PODI ATRY	0	12, 748	C	16, 242	0	93. 05
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	430, 753	С	532, 456	0	95. 00
	09910 CORF	0	430, 733	ď		0	1
101.00	10100 HOME HEALTH AGENCY	3, 913	751, 392	C	1, 074, 990	3, 913	101. 00
100 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION		0		0	0	109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00	11100 ISLET ACQUISITION	0	0	o c	0	0	111. 00
	11600 HOSPI CE	0	66, 032	1	162, 507		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	351, 818	22, 255, 376	-7, 817, 878	35, 791, 475	181, 190] 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
	19100 RESEARCH	0	100 277	O	0		191.00
	19101 FMH DIAGNOSTIC CENTE 19102 WELLNESS		189, 377 94, 281	1	252, 931 228, 041		191. 01 191. 02
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	14, 108	28, 284	- c	76, 392	14, 839	192. 00
	19201 RFE	0	0	1			192. 01
	19202 MARKETI NG 19203 FOUNDATI ON	1, 212 415	71, 882 1, 476	l .	387, 309 2, 960		192. 02 192. 03
192.04	19204 BROOKVILLE CLINIC	0	0		2, 700	0	192. 04
	19205 ATOD	0	0	d c	0	0	192. 05

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

			T	o 09/30/2014	Date/Time Pre 2/25/2015 10:	
	CAPI TAL	<u> </u>				
	RELATED COSTS					
Cost Center Description	NEW BLDG &		Reconciliation	ADMI NI STRATI VE		
	FLXT	BENEFITS		& GENERAL	PLANT	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
		SALARI ES)				
	1.00	4. 00	5A	5. 00	7. 00	
192.06 19206 HEART CENTER	943	0	0	2, 520		192. 06
192. 07 19207 WVCP	21, 084	1, 531, 291	0	2, 562, 254	21, 084	192. 07
192. 08 19210 OCCUPATI ONAL MED	0	0	0	1, 575		192. 08
192. 09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0		192. 09
192. 10 19211 H0SPI TALI ST	0	310, 021	0	1, 289, 889		192. 10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	15, 120	0	0	40, 412	15, 120	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, 081, 650	6, 221, 072		7, 817, 878	2, 643, 751	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 672721	0. 254108		0. 192389	10. 797255	203. 00
204.00 Cost to be allocated (per Wkst. B,		4, 252		85, 723	427, 885	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 000174		0. 002110	1. 747511	205. 00

	Financial Systems	FAYETTE REGIONAL		CCN: 1500/4 D		u of Form CMS-	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 10/01/2013	Worksheet B-1	
				Т	o 09/30/2014	Date/Time Pre 2/25/2015 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	37 aiii
	·	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	HOURS)	
		FEET) 7. 01	LAUNDRY) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT	147, 513					7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	410	1	00/ 400			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 904 2, 597		236, 432 2, 597			9.00
11. 00	01100 CAFETERI A	4, 323		4, 323		741, 558	
13.00	01300 NURSI NG ADMI NI STRATI ON	C	0	C	o	11, 403	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 687		2, 687		5, 150	1
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	2, 600 3, 016		2, 600 3, 016		19, 643 33, 073	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,010	,	0,010	<u> </u>	33, 070	10.00
30. 00	03000 ADULTS & PEDIATRICS	15, 304	1	15, 304		58, 365	1
31. 00 40. 00	03100 I NTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF	9, 291	5, 851	9, 291		41, 439	1
41. 00	04100 SUBPROVI DER - TPF	9, 531	3, 920	7, 895 9, 531		28, 804 20, 083	1
42. 00	04200 SUBPROVI DER	C	0	C	0	0	42. 00
43.00	04300 NURSERY	4, 995	0	4, 995	0	14, 046	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	25, 000	5, 733	25, 000	O	52, 768	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	25,000		25,000	1	0 32, 708	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	22, 308	8, 498	22, 308	0	46, 171	
57. 00	05700 CT SCAN	C	0	C	0	0	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION					0	58. 00 59. 00
60.00	06000 LABORATORY	7, 140	o o	7, 140	Ö	37, 893	
60. 01	06001 BLOOD LABORATORY	C	ή "	C	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	3, 355		3, 355		23, 146	
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	7, 372 2, 982		7, 372 2, 982		29, 146 5, 993	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 702	1	2, 702	1	0, 770	l
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	С	-	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	C	0		-	0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS		JI O		il Ol	0	74.00
88. 00	08800 RURAL HEALTH CLINIC	C	0	C	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.070	1	0.070	T .	0	89.00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 070	11, 213	8, 070	0	40, 881	91. 00 92. 00
	04040 CLINIC	C	40	17, 339	o	109, 146	
	04044 BI C	C	0	21, 253	o	0	
	04041 UCI C 04042 CI C	C	0	0	0	0	
93. 03	04042 CTC				0	0	
	04950 PODI ATRY	C	o	d	o o	874	1
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES 09910 CORF	C	1	[1	26, 447 0	
	10100 HOME HEALTH AGENCY		1	-	1		101.00
	SPECIAL PURPOSE COST CENTERS			-,	-		
	10900 PANCREAS ACQUISITION	C	0	C	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION				0		110. 00 111. 00
	11600 H0SPI CE			Ö	o		116.00
118.00		132, 885	67, 868	180, 971	39, 187	641, 145	
400.00	NONREI MBURSABLE COST CENTERS						1400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH			1	0		190. 00 191. 00
	19101 FMH DIAGNOSTIC CENTE	ď	o o	d	o o		191. 01
	19102 WELLNESS	C	0	8, 354			191. 02
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RFE	12, 058	1, 019	14, 839 C	1		192. 00 192. 01
	19201 RFE	1, 212		1, 212	1		192. 01
192. 03	19203 FOUNDATI ON	415		415		2, 957	192. 03
	19204 BROOKVI LLE CLINI C	C	0	C	0		192.04
	19205 ATOD 19206 HEART CENTER	943	205	943			192. 05 192. 06
	19207 WVCP	743	0	20, 745	1	90, 597	192. 07
192. 08	19210 OCCUPATI ONAL MED		0	C	<u> </u> 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	Peri od: Worksheet B-1 From 10/01/2013
		To 09/30/2014 Date/Time Prepared:

				'	0 07/30/2014	2/25/2015 10:	
	Cost Center Description	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 1920	9 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192. 09
192. 10 1921	1 HOSPI TALI ST	0	0	0	0	4, 097	192. 10
194. 00 0795	OTHER NONREIMBURSABLE COST CENTERS	0	0	8, 953	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,	1, 168, 541	208, 195	1, 057, 263	580, 470	581, 205	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 921614	3. 013301	4. 471742	9. 134786	0. 783762	203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 068	2, 177	10, 351	12, 764	20, 263	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 014019	0. 031509	0. 043780	0. 200866	0. 027325	205. 00
	11)						

		FAYETTE REGIONAL				eu of Form CMS-2	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 10/01/2013		
					To 09/30/2014	Date/Time Prep 2/25/2015 10:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES & SUPPLY	(100%)	RECORDS & LI BRARY		
		(FTE' S)	(100%)		(GROSS		
		13. 00	14. 00	15. 00	CHARGES) 16.00		
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT						7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	21 045					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	21, 045	100				14. 00
15. 00	01500 PHARMACY	944	0	10			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		0 108, 214, 369		16. 00
30. 00	03000 ADULTS & PEDIATRICS	2, 806	0		0 5, 014, 882		30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 992	0		0 2, 354, 889	l	31. 00
40.00	04000 SUBPROVI DER - I PF	1, 385	0		0 2, 256, 477		40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	965 0	0		0 1, 059, 924 0 0		41. 00 42. 00
43. 00	04300 NURSERY	675	0		0 443, 440		43. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2 527		ı	0 200 721		FO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 537	0	1	0 9, 398, 721 0 0		50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 220	0	1	0 21, 709, 014		54. 00
57. 00	05700 CT SCAN	0	0		0		57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0 0		58. 00 59. 00
60. 00	06000 LABORATORY	1, 822	Ö		0 16, 715, 425		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0		60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 113 1, 402	0		0 3, 049, 772 0 2, 801, 964		65. 00 66. 00
69. 01	06901 CARDI AC REHAB	288	0		0 261, 536		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100		0 3, 069, 589		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0 10, 922, 436		72. 00 73. 00
74. 00	07400 RENAL DI ALYSI S	Ö	0		0 0		74. 00
00.00	OUTPATIENT SERVICE COST CENTERS			1	0 0		00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		88. 00 89. 00
91. 00	09100 EMERGENCY	o	0		0 11, 990, 762		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				11 100 01/		92.00
93. 00	04040 CLI NI C 04044 BI C	0	0		0 11, 199, 916 0 3, 393, 602		93. 00 93. 01
93. 02	04041 UCI C	o	0		0 0		93. 02
93. 03	04042 CI C	0	0		0		93. 03
93. 04 93. 05	04043 RI C 04950 PODI ATRY		0		0 0 141, 329		93. 04 93. 05
	OTHER REIMBURSABLE COST CENTERS	-					
	09500 AMBULANCE SERVICES 09910 CORF	1, 271	0		0 1, 121, 670		95. 00
	10100 HOME HEALTH AGENCY	0 1, 625	0	1	0 0 846, 466		99. 10 101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0		0 0		109. 00 110. 00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION		0		0 0		110.00
116.00	11600 H0SPI CE	O	0		0 462, 555		116. 00
118. 00	,	21, 045	100	10	0 108, 214, 369		118. 00
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		0 0		190. 00
191.00	19100 RESEARCH	o	0		0 0		191. 00
	19101 FMH DIAGNOSTIC CENTE	0	0		0 0		191. 01
	2 19102 WELLNESS 19200 PHYSICIANS' PRIVATE OFFICES		0		0 0		191. 02 192. 00
	19201 RFE	o	0		0 0		192. 01
	19202 MARKETI NG	0	0	1	0 0		192. 02
	3 19203 FOUNDATION 1 19204 BROOKVILLE CLINIC	0	0		0 0		192. 03 192. 04
	19205 ATOD		0		o o		192. 05
	19206 HEART CENTER	0	0	1	0 0		192. 06
192.07	7 19207 WVCP	l O	0	1	υ 0	<u> </u>	192. 07

Heal th Financial	Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 10/01/2013		
					To 09/30/2014	Date/Time Pre	pared:
						2/25/2015 10:	37 am
Cos	t Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		

				'	0 07/30/2014	2/25/2015 10:	
	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		
192. 08 19210	OCCUPATIONAL MED	0	0	0	0		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,	628, 003	1, 415, 629	3, 739, 472	1, 640, 413		202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	29. 840960	14, 156. 290000	37, 394. 720000	0. 015159		203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 469	14, 578	18, 758	17, 264		204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 069803	145. 780000	187. 580000	0. 000160		205. 00
	11)						

						2/25/2015 10:	37 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Ādj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 892, 450		2, 892, 45	o lo	2, 892, 450	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 832, 124		1, 832, 12		1, 832, 124	
40. 00	04000 SUBPROVI DER - I PF	2, 066, 210		2, 066, 21		2, 066, 210	
41. 00	04100 SUBPROVI DER - I RF	1, 173, 125		1, 173, 12		1, 173, 125	
42. 00	04200 SUBPROVI DER	1, 170, 120				0, 170, 120	42. 00
43. 00	04300 NURSERY	737, 524		737, 52		737, 524	
43.00	ANCI LLARY SERVICE COST CENTERS	737, 324		737, 32	+ 0	737, 324	43.00
50. 00	05000 OPERATING ROOM	2, 188, 186		2, 188, 18	6 17, 501	2, 205, 687	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 100, 100		2, 100, 10	17,301	2, 203, 087	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 503, 811		4 502 01	1 0		54.00
54.00		4, 503, 811		4, 503, 81	0	4, 503, 811	
	05700 CT SCAN	0				0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	2, 966, 231		2, 966, 23		2, 966, 231	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	803, 724	0			803, 724	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 546, 655	0	1, 546, 65		1, 546, 655	
69. 01	06901 CARDI AC REHAB	326, 261		326, 26		326, 261	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 462, 161		1, 462, 16	1 0	1, 462, 161	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	82, 382		82, 38	2 0	82, 382	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 905, 045		3, 905, 04	5 0	3, 905, 045	73.00
74.00	07400 RENAL DIALYSIS	0			0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			o	0	89. 00
91.00	09100 EMERGENCY	2, 285, 826		2, 285, 82	6 0	2, 285, 826	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	552, 460		552, 46	o	552, 460	92.00
93.00	04040 CLI NI C	8, 062, 889		8, 062, 88	9 0	8, 062, 889	93.00
93. 01	04044 BI C	2, 115, 637		2, 115, 63		2, 188, 477	93. 01
93. 02	04041 UCI C	0			o o	0	93. 02
93. 03	04042 CI C	0			0	0	93. 03
		0				0	93. 04
	04950 PODI ATRY	22, 194		22, 19	-	22, 194	1
70.00	OTHER REIMBURSABLE COST CENTERS	22/			٠,	22, 171	70.00
95 00	09500 AMBULANCE SERVICES	710, 554		710, 55	4 0	710, 554	95. 00
	09910 CORF	7 10, 334		710, 33	<u>, </u>	710, 334	99. 10
	10100 HOME HEALTH AGENCY	1, 435, 164		1, 435, 16	1	1, 435, 164	
101.00	SPECIAL PURPOSE COST CENTERS	1, 435, 104		1, 435, 10	+	1, 435, 104	101.00
100.00	10900 PANCREAS ACQUISITION					0	109. 00
	11000 NTESTINAL ACQUISITION						1109.00
	11100 SLET ACQUI SI TI ON	202 240		202.04			111.00
	11600 H0SPI CE	203, 040		203, 04		203, 040	
200.00	,	41, 873, 653	0	, ,			
201.00		552, 460		552, 46		552, 460	
202.00	Total (see instructions)	41, 321, 193	0	41, 321, 19	3 90, 341	41, 411, 534	202. 00

Title XVII Hospital PPS Cost Center Description Inpatient Outpatient Iotal (Col. o Cost Outpatient Inpatient Ratio Ratio Inpatient Ratio R				'	0 09/30/2014	2/25/2015 10:	
Inpatient Outpetient Total (col 6 cost or Other Ratio Inpatient Action Cost or Other Ratio Inpatient Ratio Cost or Other Ratio Inpatient Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio Cost			Ti tl	e XVIII	Hospi tal		
INPATI ENT. ROUTINE SERVI CE COST CENTERS 4.483,740 4.483,740 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	<u> </u>		Charges		·		
INPATI ENT ROUTINE SERVICE COST CENTERS	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS 4,483,740				+ col. 7)	Ratio	I npati ent	
INPATE INT ROUTH NE_SERVICE COST_CENTERS 3.0.00 33.0.00 33.0.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.0							
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31 00 03100 INTERSIVE CARE UNIT 2, 138, 972 2, 138, 972 31, 00 04 00 04000 SUBPROVIDER PF 2, 256, 477 2, 256, 477 40, 00 41, 00 04 100 05 SUBPROVIDER 1, 059, 924 1, 059, 924 41, 00 42, 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 04 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00 05 00							
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43, 40 04300 NURSERY 443, 440 443, 440 443, 440	1	1, 059, 924		1, 059, 924			
ANCILLARY SERVICE COST CENTERS		0		C			
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S2.00 05.200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		4 3// 354		0.504.504	0.054004		
S4.00 OS400 RADIOLOGY - DI AGNOSTIC 1,769,682 19,939,332 21,709,014 0.207463 0.000000 54.00	1	1	6, 814, 845	8, 581, 596			
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		١	10 000 000	04 700 044			
58.00 05800 MARNETIC RESONANCE I MAGINC (MRI) 0 0 0 0 0 0 0 0 0		1, 769, 682	19, 939, 332	21, 709, 014			
59.00 05900 CARDIAC CATHETER ZATION 0 0 0 0 0 0 0 0 0		0	0				
60. 00 06000 LABORATORY 2,601,369 14,114,056 16,715,425 0.177455 0.000000 60.01 60.01 06000 BLOD LABORATORY 1,150,444 1,884,342 3,034,786 0.264837 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 1,150,444 1,884,342 3,034,786 0.264837 0.000000 65.00 66.00 06500 RESPIRATORY THERAPY 1,033,635 1,768,329 2,801,964 0.551990 0.000000 66.00 17,00 000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000		0	0				
60.01 06001 BLOOD LABORATORY 0		2 (01 2(0	14 114 057	1/ 715 405			
65.00 06500 RESPIRATORY THERAPY 1,150,444 1,884,342 3,034,786 0,264837 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 1,033,635 1,768,329 2,801,964 0.551990 0.000000 66.00 67.10 06901 CARDIJAC REHAB 0 261,536 261,536 1.247480 0.000000 71.00 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,161,192 1,757,609 2,918,801 0.500946 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,154,250 7,768,186 10,922,436 0.357525 0.000000 72.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0.000000 0.000000 74.00 07400 RENAL DIALYSIS 0 0 0 0 0.000000 0.000000 75.00 07400 RENAL DIALYSIS 0 0 0 0 0 76.00 07400 RENAL DIALYSIS 0 0 0 0 0 77.00 09200 09800 REPRALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 78.00 09300 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 79.00 09100 EMERGENCY 1,626,494 10,364,268 11,990,762 0.190632 0.000000 93.00 79.00 04040 LUIC 0 0 747,059 747,059 747,059 0.739513 0.000000 93.00 79.01 04044 BIC 0 0 0 0 0 0 0 79.02 04041 UCI C 0 0 0 0 0 0 79.03 04042 CLINIC 0 0 0 0 0 0 0 79.04 04040 CLINIC 0 0 0 0 0 0 79.05 04040 CLINIC 0 0 0 0 0 0 79.07 04040 CLINIC 0 0 0 0 0 79.08 04040 CLINIC 0 0 0 0 0 0 79.09 04040 CLINIC 0 0 0 0 0 79.00 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 04040 0		2,601,369	14, 114, 056	16, /15, 425			
66.00 06600 PHYSI CAL THERAPY 1,033,635 1,768,329 2,801,964 0,551990 0.000000 66.00 69.01 06901 CARDI AC REHAB 0 0 261,536 261,536 261,536 1.247480 0.000000 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,161,192 1,757,609 2,918,801 0.500946 0.000000 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 49,838 100,950 150,788 0.546343 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,154,250 7,768,186 10,922,436 0.357525 0.000000 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0.000000 0.000000 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0.000000 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 91.00 09100 EMERGENCY 1,626,494 10,364,268 11,990,762 0.190632 0.000000 93.00 92.00 09200 085ENVATION BEDS (NON-DISTINCT PART) 0 0 747,059 0.739513 0.000000 92.00 93.01 04040 CLINIC 0 0 2,693,403 2,693,403 2,993569 0.000000 93.00 93.01 04044 BIC 0 0 2,911,651 2,911,651 0.726611 0.000000 93.00 93.02 04041 UCI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 150 444	1 004 242	2 024 706			
69.01 0.6901 CARDIAC REHAB 0 261, 536 2.61, 536 1. 247480 0. 000000 69.01							
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 838 100, 950 150, 788 0.546343 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 154, 250 7, 768, 186 10, 922, 436 0.357525 0.000000 73. 00 0 0 0 0 0 0 0 0 0		1 4					
73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 154, 250 7, 768, 186 10, 922, 436 0. 357525 0. 000000 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0. 000000 74. 00 0000000 0. 0000000 74. 00 0000000 0. 0000000 75. 00 0000000 0. 0000000 76. 00 0000000 0. 0000000 77. 00 0000000 0. 0000000 78. 00 00000000000000000000000000000000							
74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0							
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88.00			7, 700, 100	10, 722, 430			
88. 00		9		1	0. 000000	0.00000	7 1. 00
89. 00		0	0				88. 00
91.00 09100 EMERGENCY 1, 626, 494 10, 364, 268 11, 990, 762 0. 190632 0. 000000 91. 00 92.00 09200 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500		0	0	d			
92. 00		1, 626, 494	10, 364, 268	11, 990, 762	0. 190632	0.000000	
93. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	747, 059	747. 059	0. 739513	0.000000	92. 00
93. 02		O					
93. 03	93. 01 04044 BI C	O	2, 911, 651	2, 911, 651	0. 726611	0.000000	93. 01
93. 04	93. 02 04041 UCI C	0	0	d	0. 000000	0.000000	93. 02
93. 05 0.4950 PODI ATRY 145 141, 184 141, 329 0. 157038 0. 000000 93. 05	93. 03 04042 CI C	O	0	ol c	0. 000000	0.000000	93. 03
OTHER REI MBURSABLE COST CENTERS 95. 00	93. 04 04043 RI C	0	0) c	0. 000000	0.000000	93. 04
95. 00	93. 05 04950 PODI ATRY	145	141, 184	141, 329	0. 157038	0.000000	93. 05
99. 10	OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY 0 846, 466 846, 466 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 110. 00 111.00 INTESTINAL ACQUISITION 0 0 0 0 111. 00 111.00 111.00 ISLET ACQUISITION 0 0 0 0 0 111. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 1	95. 00 09500 AMBULANCE SERVICES	0	1, 121, 670	1, 121, 670	0. 633479	0. 000000	95. 00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 1109. 00 110. 00 11000 INTESTI NAL ACQUISITION 0 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 111. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 1	99. 10 09910 CORF	0	0	C			99. 10
109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 111. 00 116. 00 11600 HOSPICE 0 462, 555 462, 555 116. 00 200. 00 Subtotal (see instructions) 24, 696, 353 73, 697, 441 98, 393, 794 200. 00 201. 00 Less Observation Beds 201. 00		0	846, 466	846, 466)		101. 00
110. 00							
111. 00 11100 ISLET ACQUISITION	1	0	0) C			
116. 00 11600 HOSPI CE		0	0) C			
200.00 Subtotal (see instructions) 24,696,353 73,697,441 98,393,794 200.00 201.00		0	0	C			
201.00 Less Observation Beds 201.00		0					
		24, 696, 353	73, 697, 441	98, 393, 794			
202. 00 Total (see Enstructions) 24, 696, 353 73, 697, 441 98, 393, 794		04 (0/ 353	70 (07	00 000 70			
	202.00 IOTAL (See Instructions)	24, 696, 353	/3, 69/, 441	J 98, 393, 794	H I		1202.00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064
Period: From 10/01/2013 To 09/30/2014 Date/Time Prepared:

2/25/2015 10:37 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVIDER - IRF 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. 257025 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.207463 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 CARDIAC CATHETERIZATION 0.000000 59.00 60. 00 | 06000 | LABORATORY 0.177455 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06500 RESPIRATORY THERAPY 65.00 0. 264837 65.00 06600 PHYSI CAL THERAPY 66.00 0.551990 66, 00 06901 CARDI AC REHAB 69.01 1. 247480 69 01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.500946 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.546343 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.357525 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 91.00 09100 EMERGENCY 0.190632 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 739513 92.00 93. 00 04040 CLINIC 2. 993569 93.00 04044 BI C 93.01 0.751628 93.01 93. 02 | 04041 | UCI C 0.000000 93.02 04042 CI C 0.000000 93.03 93.03 04043 RIC 93 04 0.000000 93.04 04950 PODI ATRY 93.05 0.157038 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 633479 95.00 99. 10 09910 CORF 99. 10 101.00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111. 00 116. 00 11600 HOSPI CE 116. 00 Subtotal (see instructions) 200.00 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 202.00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/25/2015 10:37 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 2, 892, 450 2, 892, 450 2, 892, 450 03100 INTENSIVE CARE UNIT 1, 832, 124 1, 832, 124 0 1, 832, 124 31.00 04000 SUBPROVIDER - IPF 0 40.00 2,066,210 2, 066, 210 2, 066, 210 04100 SUBPROVI DER - I RF 0 41.00 1, 173, 125 1, 173, 125 1, 173, 125 04200 SUBPROVI DER 42.00 C 0 Λ 43.00 04300 NURSERY 737, 524 737, 524 737, 524 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 188, 186 2, 188, 186 17.501 2, 205, 687 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 503, 811 4, 503, 811 0 4, 503, 811 o 05700 CT SCAN 57.00 0 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 06000 LABORATORY 60.00 2, 966, 231 2, 966, 231 0 2, 966, 231 06001 BLOOD LABORATORY 60 01 0 65.00 06500 RESPIRATORY THERAPY 803, 724 803, 724 803, 724 06600 PHYSI CAL THERAPY 1, 546, 655 1, 546, 655 0 1, 546, 655 66.00 0 69.01 06901 CARDI AC REHAB 326, 261 326, 261 326, 261 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 1, 462, 161 1, 462, 161 1, 462, 161

					10 09/30/2014	2/25/2015 10:	
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati 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, 483, 740		4, 483, 74			30. 00
31. 00	03100 INTENSIVE CARE UNIT	2, 138, 972		2, 138, 97			31. 00
40. 00	04000 SUBPROVI DER - I PF	2, 256, 477		2, 256, 47			40. 00
41. 00	04100 SUBPROVI DER - I RF	1, 059, 924		1, 059, 92			41. 00
42. 00	04200 SUBPROVI DER	0			0		42. 00
43. 00	04300 NURSERY	443, 440		443, 44	0		43. 00
	ANCILLARY SERVICE COST CENTERS			0.504.50			
50.00	05000 OPERATI NG ROOM	1, 766, 751	6, 814, 845	1		l e	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	10.000.000	l .	0.000000	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 769, 682	19, 939, 332	i e			
57. 00	05700 CT SCAN	0	Ü		0.000000	0.000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Ü		0.000000	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2 (01 2(0	14 114 057	1/ 715 40	0.000000	0.000000	
60.00	06000 LABORATORY	2, 601, 369	14, 114, 056	16, 715, 42			
60. 01	06001 BLOOD LABORATORY	1 150 444	1 004 040	2 024 70	0.000000	0.000000	
65. 00	06500 RESPIRATORY THERAPY	1, 150, 444	1, 884, 342			0.000000	
66. 00 69. 01	06600 PHYSI CAL THERAPY 06901 CARDI AC REHAB	1, 033, 635	1, 768, 329			0. 000000 0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1 141 102	261, 536			0.00000	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 161, 192	1, 757, 609 100, 950			0.00000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	49, 838 3, 154, 250	7, 768, 186			•	
74.00	07400 RENAL DIALYSIS	3, 154, 250	7, 700, 100	1	0. 337323	0.00000	
74.00	OUTPATIENT SERVICE COST CENTERS	ı o		1	0.00000	0.00000	74.00
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, 626, 494	10, 364, 268	1		0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	747, 059	1 '		0. 000000	
93. 00	04040 CLINIC		2, 693, 403			0. 000000	
93. 01	04044 BI C	0	2, 911, 651			0. 000000	
93. 02	04041 UCI C	0	_, ,	1	0.000000	0.000000	
93. 03	04042 CI C	o	0	i	0. 000000		
93. 04	04043 RI C	0	0	,	0. 000000	l e	
93. 05	04950 PODI ATRY	145	141, 184	141, 32		l	
	OTHER REIMBURSABLE COST CENTERS	'	·		<u>'</u>	<u> </u>	
95.00	09500 AMBULANCE SERVICES	0	1, 121, 670	1, 121, 67	0. 633479	0.000000	95. 00
99. 10	09910 CORF	0	O		0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	846, 466	846, 46	6		101. 00
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0		0		110. 00
	11100 ISLET ACQUISITION	0	0		0		111. 00
	11600 H0SPI CE	0	462, 555	462, 55	5		116. 00
200.00		24, 696, 353	73, 697, 441	98, 393, 79	4		200. 00
201.00							201. 00
202.00	Total (see instructions)	24, 696, 353	73, 697, 441	98, 393, 79	4		202. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064 Period: Worksheet C From 10/01/2013 To 09/30/2014 Date/Time Prepared: 2/25/2015 10: 37 am

Cost Center Description	
Ratio	
INPATI ENT ROUTINE SERVICE COST CENTERS	Cost Center Description
IMPATIENT ROUTINE SERVICE COST CENTERS 3	· ·
30.00 03000 ADULTS & PEDI ATR CS 3 3 40.00 04000 SUBPROVI DER - I PF 4 41.00 04100 SUBPROVI DER - I PF 4 42.00 04200 SUBPROVI DER - I RF 4 44.00 04200 SUBPROVI DER - I RF 4 44.00 04200 SUBPROVI DER 4 48.00 04300 NURSERY 4 48.00 04300 NURSERY 4 48.00 04300 NURSERY 4 48.00 04300 NURSERY 5 60.00 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 600000 6000000 6000000 6000000 6000000 6000000 6000000 60000000 60000000 60000000 60000000 60000000 600000000	
31	INPATIENT ROUTINE SERVICE COST CENTERS
A0, 00 04000 SUBPROVI DER - I PF 4 4 4 4 00 4 4 00 4 4	00 03000 ADULTS & PEDIATRICS
11 00	00 03100 INTENSIVE CARE UNIT
A2. 00 04200 SUBPROVI DER	00 04000 SUBPROVI DER - I PF
43.00 04300 NURSERY	00 04100 SUBPROVI DER - I RF
ANCILLARY SERVICE COST CENTERS 50.00	00 04200 SUBPROVI DER
SO 00 05000 05PERATING ROOM 0.000000 5 5 5 5 5 5 5 5	00 04300 NURSERY
S2 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 5	ANCILLARY SERVICE COST CENTERS
S4 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55 57 00 0 0 0 0 0 0 0 0 0	00 05000 OPERATING ROOM
57.00 05700 CT SCAN 0.000000 5 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 5 58.00 05900 CARDIAC CATHETERIZATION 0.000000 5 6 6 6 6 6 6 6 6 6	00 05200 DELIVERY ROOM & LABOR ROOM
57.00 05700 CT SCAN 0.000000 5 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 5 58.00 05900 CARDIAC CATHETERIZATION 0.000000 5 6 6 6 6 6 6 6 6 6	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 559.00 05900 CARDIAC CATHETERIZATION 0.000000 660.00 06000 LABORATORY 0.000000 660.00 06000 LABORATORY 0.000000 660.00 06000 LABORATORY 0.000000 660.00 06500 RESPIRATORY THERAPY 0.000000 660.00 06500 RESPIRATORY THERAPY 0.000000 660.00 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 06000 060000 060000 060000 060000 060000 0600000 0600000 0600000 0600000 0600000 0600000 060000000 06000000 06000000 06000000 060000000 060000000 060000000 0600000000	
59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	+ I
60. 00 06000 LABORATORY 0. 000000 66 0. 01 06001 BLODD LABORATORY 0. 0000000 66 0. 01 06001 BLODD LABORATORY 0. 0000000 66 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	
60. 01 06001 BLOOD LABORATORY 0.000000 6 6 6 6 0 06500 RESPIRATORY THERAPY 0.000000 6 6 0 06600 PHYSI CAL THERAPY 0.000000 6 6 0 06600 PHYSI CAL THERAPY 0.000000 6 6 0 06600 PHYSI CAL THERAPY 0.000000 6 0 0 0 0 0 0 0	
65. 00	
66. 00	
69. 01 06901 CARDI AC REHAB 0.000000 6 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 74. 00 07400 RENAL DIALYSIS 0.000000 770 000000 74. 00 000000 74. 00 000000 75. 00 000000 75. 00 000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 00000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000 75. 0000000000	· · · · · · · · · · · · · · · · · · ·
71. 00	· · · · · · · · · · · · · · · · · · ·
72. 00	
73. 00	
74. 00 07400 RENAL DIALYSIS 0.000000 7400 RENAL DIALYSIS 0.000000 888. 00 08800 RURAL HEALTH CLINIC 0.000000 899. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 991. 00 09100 EMERGENCY 0.000000 992. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 993. 00 04040 CLINIC 0.000000 993. 01 04044 BIC 0.000000 993. 02 04041 UCIC 0.000000 993. 03 04042 CIC 0.000000 993. 04 04043 RIC 0.000000 993. 05 04950 PODIATRY 0.000000 993. 05 04950 PODIATRY 0.000000 993. 05 04950 PODIATRY 0.000000 993. 06 04050 PODIATRY 0.000000 993. 07 05 04950 PODIATRY 0.0000000 993. 07 05 05 05 05 05 05 05 05 05 05 05 05 05	
SECIAL PURPOSE COST CENTERS OUTPATIENT SERVICE COST CENTERS	
88. 00	
89. 00	
91. 00	· · · · · · · · · · · · · · · · · · ·
92. 00	1
93. 00	
93. 01 04044 BI C	
93. 02	
93. 03	
93. 04 04043 RI C 0. 000000 9 9 9 0. 000000 9 9 9 0. 000000 9 9 0. 000000 9 9 0. 000000 9 0. 000000 9 0. 000000 0. 000000 0. 000000 9 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	
93. 05	
0THER REIMBURSABLE COST CENTERS 95. 00 99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	
95. 00	
99. 10 09910 CORF 9 101.00 10100 HOME HEALTH AGENCY 10 SPECIAL PURPOSE COST CENTERS 9 10 10 10 10 10 10 10	
101.00 HOME HEALTH AGENCY 10 SPECIAL PURPOSE COST CENTERS	
SPECIAL PURPOSE COST CENTERS	
109. 00 10900 PANCREAS ACQUISITION 10	
110. 00 11000 INTESTINAL ACQUISITION	
111. 00 11100 I SLET ACQUI SI TI 0N	
116. 00 11600 HOSPI CE	+ I
200.00 Subtotal (see instructions)	
201.00 Less Observation Beds	+ I
202.00 Total (see instructions)	. ou Total (see Instructions)

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS			Period: From 10/01/2013 To 09/30/2014		pared: 37 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	81, 138	1, 609	79, 52	9 3, 233	24. 60	30.00
31.00 INTENSIVE CARE UNIT	46, 964		46, 96	4 908	51. 72	31.00
40. 00 SUBPROVI DER - I PF	40, 609	0	40, 60	9 1, 319	30. 79	40.00
41. 00 SUBPROVI DER - I RF	45, 702	0	45, 70	2 851	53. 70	41.00
42. 00 SUBPROVI DER	C	0		o o	0.00	42. 00
43. 00 NURSERY	23, 963		23, 96	3 421	56. 92	43.00
200.00 Total (lines 30-199)	238, 376		236, 76	7 6, 732		200.00
Cost Center Description	I npati ent	Inpati ent		<u> </u>		
'	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 336	32, 866				30.00
31.00 INTENSIVE CARE UNIT	552	28, 549	,			31.00
40. 00 SUBPROVI DER - I PF	961	29, 589				40.00
41. 00 SUBPROVI DER - I RF	567	30, 448				41.00
42. 00 SUBPROVI DER	C	0	1			42.00
43. 00 NURSERY	i o	0	,			43. 00
200.00 Total (lines 30-199)	3, 416	121, 452				200.00
	-/	1 1217 102	1			

Heal th	Financial Systems	FAYETTE REGIONAL	HEAL	TH SYSTEM		In Lie	u of Form CMS-	2552-10
APPOR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS		Provi der		Peri od: From 10/01/2013	Worksheet D Part II	
						To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Tota	l Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(fron	n 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	
·	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	117, 756	5	8, 581, 596	0. 01372	22 541, 596	7, 432	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C		0	0.00000	00	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	111, 437	7 2	21, 709, 014	0.00513	1, 631, 378	8, 374	54.00
57.00	05700 CT SCAN			0	0.00000	00	0	57.00
		1	. I	_	1		_	l

Health Financial Systems	FAYETTE REGIONAL	_ HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Peri od: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)		
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30.00 03000 ADULTS & PEDIATRICS	0	0		0	0	
31. 00 03100 INTENSIVE CARE UNIT	0	0	1	0	0	0 00
40. 00 04000 SUBPROVI DER - I PF	0	0	1	0	0	
41. 00 04100 SUBPROVI DER - I RF	0) 0	1	0 0	0	
42. 00 04200 SUBPROVI DER	0	0		0	0	
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description		Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
		7.00		col . 8)		
LANDATI ENT. DOUTLING OFFICE OF COOT OFFITEDO	6. 00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.000	0.00				00.00
30. 00 03000 ADULTS & PEDI ATRI CS	3, 233	1				30.00
31. 00 03100 I NTENSI VE CARE UNI T	908					31. 00
40. 00 04000 SUBPROVI DER - PF	1, 319	1				40. 00
41. 00 04100 SUBPROVI DER - RF	851			7 0		41. 00
42. 00 04200 SUBPROVI DER	0	0.00	1	0		42. 00
43. 00 04300 NURSERY	421	1	1	0		43. 00
200.00 Total (lines 30-199)	6, 732	4	3, 41	6 0		200. 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	Provider CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared:

				'	0 07/30/2014	2/25/2015 10:	
				e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1	1	1		
	05000 OPERATI NG ROOM	0	0	C	0	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
	05700 CT SCAN	0	0	C	0	0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
		0	0	C	0	0	60. 00
	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06901 CARDI AC REHAB	0	0	C	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	C	0	0	00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
	09100 EMERGENCY	0	0	C	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0	0	92. 00
	04040 CLI NI C	0	0	C	0	0	93. 00
	04044 BI C	0	0	C	0	0	93. 01
93. 02	04041 UCI C	0	0	C	0	0	93. 02
	04042 CI C	0	0	C	0	0	93. 03
93. 04	04043 RI C	0	0	C	0	0	93. 04
93. 05	04950 PODI ATRY	0	0	C	0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	(c	0	0	200. 00

	AYETTE REGIONAL				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provi der		Period: From 10/01/2013	Worksheet D Part IV	
THROUGH COSTS				To 09/30/2014	Date/Time Pre	nared·
				10 07/00/2011	2/25/2015 10:	37 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		1,		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7.00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS	_	1	1			
50. 00 05000 OPERATI NG ROOM	0	8, 581, 596			541, 596	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	21, 709, 014			1, 631, 378	
57. 00 05700 CT SCAN	0	0	0. 00000		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00 06000 LABORATORY	0	16, 715, 425			1, 797, 312	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	3, 034, 786			802, 114	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 801, 964			118, 592	
69. 01 06901 CARDI AC REHAB	0	261, 536			0	07.0.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 918, 801			508, 708	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	150, 788	0.00000	0. 000000	16, 339	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 922, 436			1, 304, 995	
74. 00 07400 RENAL DIALYSIS	0	0	0.00000	0. 000000	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
91. 00 09100 EMERGENCY	0	11, 990, 762			928, 879	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	747, 059			0	92. 00
93. 00 04040 CLI NI C	0	2, 693, 403	0.00000		0	93. 00
93. 01 04044 BI C	0	2, 911, 651			0	93. 01
93. 02 04041 UCI C	0	0	0.00000	0. 000000	0	93. 02
93 03 04042 00		l o	0 00000	n nonnonl	0	03 U3

0. 000000 0. 000000

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0

141, 329

85, 580, 550

0. 000000 0. 000000

0.000000

0.000000

0 93. 03

0 93.04

7, 649, 913 200. 00

93. 05 0

95.00

93. 03 04042 CI C 93. 04 04043 RI C

200.00

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

Total (lines 50-199)

Health Financial Systems	FAYETTE REGIONAL HEAL	_TH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared:

					2/25/2015 10	37 am
		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, 218, 499	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, 954, 047	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, 082, 217	0			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0			60. 01
65. 00 06500 RESPIRATORY THERAPY	0	1, 026, 224	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0			66. 00
69. 01 06901 CARDI AC REHAB	0	0	0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	517, 623	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 450, 988	0			73. 00
74. 00 07400 RENAL DIALYSIS	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, 602, 021	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	568, 742	2 0			92.00
93. 00 04040 CLI NI C	0	1, 260, 578	0			93. 00
93. 01 04044 BI C	0	279, 387	0			93. 01
93. 02 04041 UCI C	0	0	0			93. 02
93. 03 04042 CI C	0	0	0			93. 03
93. 04 04043 RI C	0	0	0			93. 04
93. 05 04950 PODI ATRY	0	10, 676	0			93. 05
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	20, 971, 002	0			200. 00
	•					•

Health Financial Systems		FAYETTE REGIONAL HEAI	LTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 150064	Peri od: From 10/01/2013	Worksheet D Part V

					rom 10/01/2013	Part V	
					Го 09/30/2014	Date/Time Pre 2/25/2015 10:	pared:
			Ti +I	e XVIII	Hospi tal	PPS	37 alli
			11 (1	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9		Subject To	Subject To		
		1 41 1 7 001. 7		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	11.00	2.00	0.00	1.00	0.00	
	05000 OPERATING ROOM	0. 254986	2, 218, 499		2 0	565, 686	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 207463		30	2, 685	1, 442, 707	54.00
	05700 CT SCAN	0. 000000)	0	0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	l .		0	0	59. 00
	06000 LABORATORY	0. 177455			0	369, 500	
	06001 BLOOD LABORATORY	0. 000000			0	007,000	60. 01
	06500 RESPIRATORY THERAPY	0. 264837	1, 026, 224]	0	271, 782	
	06600 PHYSI CAL THERAPY	0. 551990			0	271,702	1
	06901 CARDI AC REHAB	1. 247480	l e		0	i o	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 500946	l e		1 48	259, 301	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 546343			1 10	257, 301	1
	07300 DRUGS CHARGED TO PATIENTS	0. 357525		260	23, 969		
	07400 RENAL DIALYSIS	0. 000000		1	23, 707	1, 233, 014	
	OUTPATIENT SERVICE COST CENTERS	0.00000		1	5 0		74.00
	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	l e			o O	89. 00
	09100 EMERGENCY	0. 190632	2, 602, 021	1	0	496, 028	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 739513		1	0	420, 592	
	04040 CLINIC	2. 993569		1	907	3, 773, 627	93. 00
	04044 BI C	0. 726611	279, 387		1 60	203, 006	
	04041 UCI C	0. 000000		,) 00	203, 000	1
	04042 CI C	0. 000000	l e]	0	l o	93. 03
	04043 RI C	0. 000000]		0	1
	04950 PODI ATRY	0. 157038		1	1 0	1, 677	
	OTHER REIMBURSABLE COST CENTERS	0. 137030	10,070	1	11 0	1,077	75.05
	09500 AMBULANCE SERVICES	0. 633479		T (95. 00
200.00	Subtotal (see instructions)	0.033477	20, 971, 002	1		9, 037, 720	
201.00	Less PBP Clinic Lab. Services-Program		20, 7, 1, 002]	27,009	7,037,720	201.00
201.00	Only Charges						251.00
202. 00	Net Charges (line 200 +/- line 201)		20, 971, 002	36-	4 27, 669	9, 037, 720	202 00
_000	1 2 900 (200)	I		1 00	2.,007	.,,	1-52.00

Health Financial Systems	FAYETTE REGIONAL HEA	ALTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150064	Peri od: From 10/01/2013	Worksheet D

To 09/30/2014 Date/Time Prepared: 2/25/2015 10:37 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 6 0 0 0 0 0 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 557 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 0 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66 00 66.00 69.01 06901 CARDI AC REHAB 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 24 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 93 73.00 8, 570 73.00 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 88. 00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04040 CLI NI C 93.00 207 2, 715 93.00 04044 BI C 93.01 93.01 44 0 93.02 04041 UCI C 0 93.02 93. 03 04042 CI C 0 93.03 0 93.04 04043 RI C 0 93.04 04950 PODI ATRY 93.05 0 0 93.05 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 309 11, 910 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 309 11, 910 202.00

	AYETTE REGIONAL				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150064	Peri od: From 10/01/2013	Worksheet D Part II	
		Component	CCN: 15S064	To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
		Ti tl	e XVIII	Subprovi der -	PPS	<u> </u>
				IPF		
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	117, 756				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	111, 437	21, 709, 014			254	
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	40, 300	16, 715, 425			226	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	
65. 00 06500 RESPIRATORY THERAPY	17, 400		l .			65. 00
66. 00 06600 PHYSI CAL THERAPY	36, 941				362	
69. 01 06901 CARDI AC REHAB	14, 044				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 069				12	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	146				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 506				534	
74. 00 07400 RENAL DI ALYSI S	0) 0	0. 00000	00 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	_	_	1	T	г	
88.00 08800 RURAL HEALTH CLINIC	0	1			1	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0. 00000		0	89. 00
91. 00 09100 EMERGENCY	43, 001				l	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,			0	
93. 00 04040 CLI NI C	87, 432				0	93. 00
93. 01 04044 BI C	41, 858	1			0	
93. 02 04041 UCI C	0	0	0.0000		0	93. 02
93. 03 04042 CI C	0	0	0.00000		0	93. 03
93. 04 04043 RI C	0	0	0.00000		0	
93. 05 04950 PODI ATRY	83	141, 329	0. 00058	B7 0	0	93. 05
OTHER REIMBURSABLE COST CENTERS			1			05 00
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (Lines 50-199)	545, 973	85, 580, 550		514, 461	1 /01	95. 00 200. 00
200.00 10tal (111165 50-177)	1 545, 973	05, 560, 550	1	314, 401	1,001	1200.00

Health Fina	ancial Systems F <i>i</i>	AYETTE REGIONAL	HEALTH SYSTEM		In lie	u of Form CMS-	2552_10
	ENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 150064	Peri od:	Worksheet D	2332 10
THROUGH CO		92 92 17.00		CCN: 15S064	From 10/01/2013 To 09/30/2014	Part IV	pared: 37 am
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0	0		0 0	0	
	DO DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
	DO RADI OLOGY-DI AGNOSTI C	0	0		0	0	
	OO CT SCAN	0	0		0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
	OO CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
-	DO LABORATORY	0	0		0	0	
	D1 BLOOD LABORATORY	0	0		0	0	
	DO RESPI RATORY THERAPY	0	0		0 0	0	65.00
	OO PHYSI CAL THERAPY	0	0		0 0	0	
	D1 CARDI AC REHAB	0	0		0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	DO I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	DO DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	OO RENAL DIALYSIS	0	0		0 0	0	74. 00
	PATIENT SERVICE COST CENTERS			I			00 00
	OO RURAL HEALTH CLINIC	0	0		0 0	0	
	DO FEDERALLY QUALIFIED HEALTH CENTER DO EMERGENCY	0	0		0 0	0	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
	40 CLINIC	0	0		0	0	
	44 BLC	0	0		0	0	
	41 UCI C		0			0	
	12 CI C		0		0 0	0	
93. 04 0404			0		0 0	0	
	50 PODI ATRY		0		0 0	0	
	ER REIMBURSABLE COST CENTERS	<u> </u>	0		<u> </u>	0	1 /3. 03
	OO AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	o	0		0 0	0	200.00
1		-1	_	1	1	•	

Heal th	Financial Systems F.	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
APP0R1	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 10/01/2013 To 09/30/2014	Part IV Date/Time Pre 2/25/2015 10:	pared: 37 am
	Title XVIII Subprovider - PPS						
					IPF		
	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)		
	ANOLILARY OF BUILDE	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS		0.504.507			- 10	
50. 00	05000 OPERATING ROOM	0				12	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0. 00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 709, 014			49, 443	
57. 00	05700 CT SCAN	0	0	0. 00000		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	
60.00	06000 LABORATORY	0	16, 715, 425			93, 639	
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000		0	
65. 00	06500 RESPI RATORY THERAPY	0	3, 034, 786			3, 673	1
66. 00	06600 PHYSI CAL THERAPY	0	2, 801, 964			27, 457	
69. 01	06901 CARDI AC REHAB	0	261, 536			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 918, 801	0. 000000		2, 230	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				284, 567	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0. 00000	0.000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		T	T			
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 00000		0	89. 00
91.00	09100 EMERGENCY	0	,			53, 440	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	747, 059			0	
93. 00	04040 CLI NI C	0	2, 693, 403			0	
93. 01	04044 BI C	0	2, 911, 651			0	93. 01
93. 02	04041 UCI C	0	0	0. 00000		0	
93. 03	04042 CI C	0	0	0. 00000		0	
93. 04	04043 RI C	0	0	0. 00000		0	93. 04
93. 05	04950 PODI ATRY	0	141, 329	0. 00000	0.000000	0	93. 05
	OTHER REIMBURSABLE COST CENTERS		<u> </u>	1			
95.00	09500 AMBULANCE SERVICES		05 500 550			E44 ***	95. 00
200.00	Total (lines 50-199)	0	85, 580, 550	1		514, 461	J200. 00

Health Financial Systems	FAYETTE REGIONAL HEA	ALTH 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 10/01/2013	
		Component CCN: 15S064	To 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
		Title XVIII	Subprovi der -	PPS

			liti	e XVIII	Subprovider - IPF	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			
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	()	0		50.00
	DELIVERY ROOM & LABOR ROOM	0	()	0		52. 00
	RADI OLOGY-DI AGNOSTI C	0	(0		54.00
	CT SCAN	0	()	0		57. 00
	MAGNETIC RESONANCE I MAGING (MRI)	0	()	0		58. 00
	CARDI AC CATHETERI ZATI ON	0	(0		59. 00
	LABORATORY	0	()	0		60.00
	BLOOD LABORATORY	0	()	0		60. 01
	RESPI RATORY THERAPY	0	()	0		65. 00
	PHYSI CAL THERAPY	0	()	0		66. 00
	CARDI AC REHAB	0	()	0		69. 01
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	()	0		71. 00
	IMPL. DEV. CHARGED TO PATIENTS	0	()	0		72. 00
	DRUGS CHARGED TO PATIENTS	0	()	0		73. 00
	RENAL DIALYSIS	0)	0		74. 00
	ATIENT SERVICE COST CENTERS			J	al		
	RURAL HEALTH CLINIC	0	C		0		88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0	(0		89. 00
91.00 09100		0	(0		91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0	(0		92.00
93. 00 04040		0	(0		93.00
93. 01 04044 93. 02 04041		0	(0		93. 01 93. 02
93. 02 0404 93. 03 04042		0	(0		93. 02
93. 03 04042		0	(0		93. 03
		0	C	1	0		93. 04
	PODLATRY RELMBURSABLE COST CENTERS	ı o		4	U <u> </u>		43.00
	AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50-199)	0	C		0		200.00
200.00	Total (TITIES 30-199)	١	(4	이		1200.00

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150064	Peri od:	Worksheet D	2002 .0
		Component	CCN: 15T064	From 10/01/2013 To 09/30/2014	Part II Date/Time Pre 2/25/2015 10:	pared: 37 am
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(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	117, 756	1			0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	1	0.0000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	111, 437	21, 709, 014			60	
57. 00 05700 CT SCAN	0	0	0.00000		0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	40.000	0	0.00000		0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	40, 300	16, 715, 425	0. 0024° 0. 00000		101	60. 00 60. 01
65. 00 06500 RESPI RATORY THERAPY	17, 400	2 024 704			0 151	65. 00
66. 00 06600 PHYSI CAL THERAPY	36, 941				6, 385	
69. 01 06901 CARDI AC REHAB	14, 044				0, 363	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 069				92	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 007				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	20, 506				166	
74. 00 07400 RENAL DI ALYSI S	20, 300		•		0	1
OUTPATIENT SERVICE COST CENTERS		1	0.0000	,0 0		7 1. 00
88. 00 08800 RURAL HEALTH CLINIC	1 0	0	0.00000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
91. 00 09100 EMERGENCY	43, 001	11, 990, 762	0. 00358	791	3	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	747, 059	0.00000	00	0	92.00
93. 00 04040 CLI NI C	87, 432	2, 693, 403	0. 03246	0	0	93.00
93. 01 04044 BI C	41, 858	2, 911, 651	0. 01437	76 0	0	93. 01
93. 02 04041 UCI C	0	0	0.00000	0 0	0	93. 02
93. 03 04042 CI C	0	0	0.00000	00	0	93. 03
93. 04 04043 RI C	0	0	0.00000		0	
93. 05 04950 PODI ATRY	83	141, 329	0. 00058	B7 0	0	93. 05
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	545, 973	85, 580, 550	1	671, 144	6, 958	200. 00

111-4-	Figure 1 Contract	AVETTE DECLONAL	UEALTH CVCTEM		I = 1 : -	£ F CNC	2552 40
	Financial Systems FA ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	AYETTE REGIONAL		CCN: 150064	Period:	u of Form CMS- Worksheet D	2552-10
THROUGH		VICE OTHER TAGE		CCN: 15T064	From 10/01/2013 To 09/30/2014	Part IV Date/Time Pre 2/25/2015 10:	pared: 37 am
		Ti tl	e XVIII	Subprovi der – I RF	PPS	_	
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	O5000 OPERATING ROOM	0	0		0	0	
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	1
	D5400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
	05700 CT SCAN	0	0		0	0	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	1
	06000 LABORATORY	0	0		0	0	
	06001 BLOOD LABORATORY	0	0		0	0	
	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0		0	0	
	06901 CARDI AC REHAB	0	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
	D7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
	07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
	DUTPATIENT SERVICE COST CENTERS	1		1			
	D8800 RURAL HEALTH CLINIC	0	0		0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
	D9100 EMERGENCY	0	0		0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	1
	04040 CLI NI C	0	0		0	0	
	04044 BI C	0	0		0	0	
	04041 UCI C	0	0		0	0	93. 02
	04042 CI C	0	0		0	0	
	04043 RIC	0	0		0 0	0	
-	04950 PODI ATRY] 0	0		0 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						05.00
	09500 AMBULANCE SERVICES		_			_	95. 00
200. 00	Total (lines 50-199)	0	0	I	0 0	0	200. 00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2332 10
THROUGH COSTS				From 10/01/2013	Part IV	
		Component	t CCN: 15T064	To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
	4) 6. 00	7.00	0.00	7)	40.00	
ANCILLARY SERVICE COST CENTERS	6.00	7.00	8. 00	9. 00	10. 00	
50. 00 05000 OPERATING ROOM	0	8, 581, 596	0.00000	0. 000000	11	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM					0	
54. 00 05200 DELI VERY ROUM & LABOR ROUM 54. 00 05400 RADI OLOGY-DI AGNOSTI C					11, 605	
57. 00 05700 CT SCAN		21, 709, 014	0.00000		0	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.00000		0	59.00
60. 00 06000 LABORATORY		16, 715, 425			41, 762	
60. 01 06001 BLOOD LABORATORY		10, 713, 423	0.00000		41, 702	1
65. 00 06500 RESPIRATORY THERAPY		3, 034, 786			26, 407	65. 00
66. 00 06600 PHYSI CAL THERAPY		2, 801, 964			484, 299	
69. 01 06901 CARDI AC REHAB		261, 536			0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 918, 801	0. 00000		17, 841	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS			•		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				88, 428	1
74. 00 07400 RENAL DI ALYSI S	0				0	1
OUTPATIENT SERVICE COST CENTERS		'				
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89. 00
91. 00 09100 EMERGENCY	0	11, 990, 762	0.00000	0. 000000	791	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	747, 059	0.00000		0	92.00
93. 00 04040 CLI NI C	0	2, 693, 403	0.00000	0. 000000	0	93. 00
93. 01 04044 BI C	0	2, 911, 651			0	93. 01
93. 02 04041 UCI C	0	0	0.00000		0	
93. 03 04042 CI C	0	0	0.00000		0	
93. 04 04043 RI C	0	0	0.00000		0	93. 04
93. 05 04950 PODI ATRY	0	141, 329	0.00000	0. 000000	0	93. 05
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVI CES	_	05 500			,_,	95. 00
200.00 Total (lines 50-199)	0	85, 580, 550	1		671, 144	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	Provi der CCN: 150064	Peri od: From 10/01/2013	Worksheet D
THOUGH COSTS		Component CCN: 15T064		
		Title XVIII	Subprovi der -	PPS

			11 (I E AVIII	IRF	PP3	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IN		
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	3 - 1	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	(0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	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	(0	0		60.00
60. 01	06001 BLOOD LABORATORY	0	(0	0		60. 01
65.00	06500 RESPI RATORY THERAPY	0	(0	0		65.00
66.00	06600 PHYSI CAL THERAPY	0	(0	0		66.00
69. 01	06901 CARDI AC REHAB	0	(0	0		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0	0		73. 00
74.00	07400 RENAL DIALYSIS	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
	09100 EMERGENCY	0	(0	0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0	0		92. 00
93.00	04040 CLI NI C	0	(0	0		93. 00
93. 01	04044 BI C	0	(0	0		93. 01
	04041 UCI C	0	(0	0		93. 02
	04042 CI C	0	(0	0		93. 03
93. 04	04043 RI C	0	(0	0		93. 04
93. 05	04950 PODI ATRY	0	(0	0		93. 05
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	(0	0		200. 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 10/01/2013	Worksheet D-1	
			Date/Time Pre 2/25/2015 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1 00	

		Title XVIII	Hospi tal	PPS	37 aiii
	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,	9 ,		3, 491	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vate room days	3, 233 0	3.00
0.00	do not complete this line.	, you have omly pro	tato toom dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			2, 603	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	131 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	258	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 336	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	oom days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instructi				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	234	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e 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 after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			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 Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	217. 31	17. 00
	reporting period	J			
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	222. 37	18. 00
19. 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				20.00
21. 00	0 Total general inpatient routine service cost (see instructions)				21.00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportino	g period (line 6	57, 371	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportio	na 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)			57, 371	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		2, 835, 079	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			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 minu		tions)	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 an 27 minus line 36)	d private room cost di	rrerentiai (iine	2, 835, 079	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see i			876. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			1, 171, 565	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 1, 171, 565	40.00
41.00	Trotal Trogram general Impatrent routine service cost (IIIIe 39 +	11116 40)	I	1, 171, 505	41.00

OMPUT	Financial Systems FA ATION OF INPATIENT OPERATING COST	YETTE REGIONAL				Peri od:	worksheet D-1	
						From 10/01/2013 To 09/30/2014	Date/Time Pre	
			-	Title X\	/111	Hospi tal	2/25/2015 10: 3 PPS	37 am
	Cost Center Description	Total Inpatient Cost	Total Inpatient [Days Di er	rerage Per m (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
2 00	NUDCEDY (+!+I V 0 VIVI)	1. 00	2. 00		3.00	4.00	5. 00	42.0
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.0	0 0	0	42.0
3. 00	INTENSIVE CARE UNIT	1, 832, 124		908	2, 017. 7	6 552	1, 113, 804	43. 0
4. 00	CORONARY CARE UNIT							44.0
5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)							47. 0
	Cost Center Description						1 00	
8. 00	Program inpatient ancillary service cost (Wk:	st D_3 col 3	line 200	`			1. 00 1, 981, 892	48. 0
9. 00	Total Program inpatient costs (sum of lines						4, 267, 261	
	PASS THROUGH COST ADJUSTMENTS							
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from Wks	st. D, sum	of Parts I and	61, 415	50.0
1. 00	Pass through costs applicable to Program inpa	atient ancillar	y services	(from V	Vkst. D, s	um of Parts II	34, 724	51.0
	and IV)							
2. 00 3. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		lated non	-nhvei ci	an anocth	etist and	96, 139 4, 171, 122	1
5. 00	medical education costs (line 49 minus line !	9 1	. a cou, Holl	μπy31 Cl			+, 1/1, 122] 33.0
	TARGET AMOUNT AND LIMIT COMPUTATION							
4. 00 5. 00	Program discharges Target amount per discharge						1	54. C
6. 00	Target amount (line 54 x line 55)						0.00	1
7. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amoun	t (line	56 minus	line 53)	0	57.0
8. 00	Bonus payment (see instructions)			· · · · ·			0	
9. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1990	s, upda	ted and co	mpounded by the	0. 00	59.0
0. 00	Lesser of lines 53/54 or 55 from prior year						0.00	1
1. 00	If line 53/54 is less than the lower of lines						0	61.0
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see it		s (iiiies s	4 X 60),	01 1% 01	the target		
2. 00	Relief payment (see instructions)	,					0	
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)				0	63.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the cos	st reporti	ng period (See	0	64.0
	instructions)(title XVIII only)							
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of ti	ne cost	reporti ng	period (See	52, 035	65.0
6. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus lii	ne 65)(1	title XVII	l only). For	52, 035	66.0
7 00	CAH (see instructions)		D 1	24 6 11				
7. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December .	31 OF T	ie cost re	porting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31	of the $$	cost repo	rting period	0	68. 0
0 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (couting costs (lino 67 i l	lino 60				69.0
7. 00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u> </u>			07.0
0. 00	Skilled nursing facility/other nursing facili	-			(line 37)			70. C
1. 00 2. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ li	ine 2)				71. C
3. 00	Medically necessary private room cost applications		(line 14:	x line 3	35)			73.0
4. 00	Total Program general inpatient routine servi	ce costs (line	72 + line	73)	,			74.0
5. 00	Capital-related cost allocated to inpatient	routine service	costs (fr	om Works	sheet B, P	art II, column		75. C
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)						76.0
7. 00	Program capital-related costs (line 9 x line	76)						77.0
8. 00	Inpatient routine service cost (line 74 minus	,	may i dam ma	oondo)				78.0
9. 00 0. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				ne 78 min	us line 79)		79. (80. (
1. 00	Inpatient routine service cost per diem limi		20	ζ		- ,		81. 0
2.00	Inpatient routine service cost limitation (li		•					82. 0
3. 00 4. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		S)					83. 0 84. 0
	Utilization review - physician compensation		ns)					85. 0
	Total Program inpatient operating costs (sum	of lines 83 th						86.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						/22	07.
7 00	LIGHAL ODSERVATION DEG MAVS ISSE INSTRUCTIONS	1					, 6301	87.0
7. 00 8. 00	Adjusted general inpatient routine cost per of		line 2)				876. 92	88 0

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	
				From 10/01/2013 Fo 09/30/2014		
	_	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	81, 138	2, 835, 079	0. 028619	552, 460	15, 811	90.00
91.00 Nursing School cost	0	2, 835, 079	0. 000000	552, 460	0	91.00
92.00 Allied health cost	0	2, 835, 079	0. 000000	552, 460	0	92.00
93.00 All other Medical Education	0	2, 835, 079	0.00000	552, 460	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM		In Lieu of F	Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN:	: 150064 Peri od: From 10/		sheet D-1
	Component CCI	N: 15S064 To 09/		/Time Prepared: /2015 10:37 am
	Ti tle XV	/III Subprov		PPS

PAPET A.L. REPOVED RECONDUCTION PAPET A.L. REPOVED RECONDUCTION PAPET A.L. REPOVED RECONDUCTION REPORT A.L. REPOVED RECONDUCTION A.L. REPOVED REPOVED RECONDUCTION A.L. REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVED REPOVE			TI LIE AVIII	I PF	FF3	
NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME NAME		Cost Center Description				
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and neberon days) 1,319 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days 0 3.00						
do not complete finis line. 4. 00 Sella-privater room days (sectualing saring-bed and observation bed days) through Becember 31 of the cost 1 0 5.00 lotal saring bed SW type inpatient days (including private room days) after December 31 of the cost 2 0 6.00 reporting period (if calendar year, onter 0 on this line) 7. 00 Total saring-bed M type inpatient days (including private room days) after December 31 of the cost 3 0 7.00 reporting period (if calendar year, onter 0 on this line) 8. 00 Total saring-bed M type inpatient days (including private room days) after December 31 of the cost 3 0 8.00 Total saring-bed M type inpatient days (including private room days) after December 31 of the cost 3 0 8.00 Total saring-bed M type inpatient days (including private room days) after December 31 of the cost 3 0 8.00 Total saring-bed M type inpatient days applicable to the Program (excluding swing-bed and neabour days) after 3 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
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31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average semi-private room per diem charge (line 30 ÷ line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 066, 210 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.000 0000 31.00 0.000 32.00 0.000 32.00 0.000 33.00 0.000 34.000 35.00 9.000 Private room cost differential (line 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 210 2, 066, 2	29. 00	Private room charges (excluding swing-bed charges)				
Average private room per diem charge (line 29 ÷ line 3) 32.00 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 066, 210) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32			ino 20)			
Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 066, 210) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	The 28)			
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,066,210 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,066,210 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 2,066,210 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00				i ons)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 066, 210 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 2, 066, 210 2, 066, 210 37. 00 37. 00 37. 00 40. 00		, , ,	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,566.50 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,505,407 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	ferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,566.50 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,505,407 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,		_, 555, 210	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,566.50 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,505,407 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,505,407 39.00 40.00	38 00			I	1 566 50	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					· ·	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,505,407 41.00	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, 505, 407	41. 00

		YETTE REGIONAL						eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST				CCN: 150064	Fi	eriod: rom 10/01/2013		
			'	Componen ⁻	t CCN: 15S064	To	09/30/2014	Date/Time Prep 2/25/2015 10:	
				Ti tl	e XVIII	:	Subprovider - IPF	PPS	
	Cost Center Description	Total		otal	Average Pe		Program Days	Program Cost	
		Inpatient Cost	Inpati	ent Days	Diem (col. col. 2)	1 ÷		(col. 3 x col. 4)	
		1.00	2	2. 00	3.00		4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		С	0	. 00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0		C	0	. 00	0	0	43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT								44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT								45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)								47. 00
	Cost Center Description							1. 00	
48. 00	Program inpatient ancillary service cost (Wks							156, 051	•
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)((see in	nstructio	ons)			1, 661, 458	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	servi	ces (from	ı Wkst. D, sı	um c	of Parts I and	29, 589	50. 00
51. 00		ationt ancillar	rv carv	icas (fr	com Wkst D	CIII	n of Darts II	1, 601	51. 00
	and IV)		y ser	VI CC3 (II	OIII WKSt. D,	Jui	01 141 (3 11		
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		al atad	non nhi	cicion onos:	that	tist and	31, 190 1, 630, 268	1
55.00	medical education costs (line 49 minus line 5		erateu,	non-pny	rsi ci ali alles	the	irst, and	1, 030, 200	33.00
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges							0	54. 00
	Target amount per discharge							0.00	
56.00	Target amount (line 54 x line 55)	ng cost and to			ino E/ minu	:	no F2)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	arget a	alliourit (i	THE 30 IIITHUS	5 11	ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi n	ց 1996, ւ	updated and o	comp	oounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report, up	odated	by the m	narket baske	t		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter	the less	ser of 50% of	f th		0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		ts (III	nes 54 X	60), or 1% (OT 1	ine target		
62.00	Relief payment (see instructions)			,				0	1
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ucti ons	5)				0	63. 00
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 3	31 of the	cost repor	ting	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	ber 31	of the c	ost reporti	na r	period (See	0	65. 00
	instructions)(title XVIII only)				·	٠.			
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 pr	us iine 6	ob)(title XV	111	only). For	0	66. 00
67. 00	,	e costs through	n Decer	mber 31 c	of the cost i	repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	Decembe	er 31 of	the cost rep	port	ing period	0	68. 00
40.00	(line 13 x line 20)	souting goots (/l: no /	(7. line	. (0)				40.00
υ 9 . UU	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU		•					0	69. 00
70.00	Skilled nursing facility/other nursing facili)			70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7	,	iiie /(- iine	۷)				71. 00 72. 00
73.00	Medically necessary private room cost applica								73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r					Par	t II, column		74. 00 75. 00
7/ 00	26, line 45)			•			·		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line								76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus								78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					i nus	s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on			,		,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .						82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins	structions)	,						84. 00
85. 00 86. 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum			85)					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	ii ougii	55)					
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		- line	2)				0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see			۷)					89.00
								•	

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	
		Component	CCN: 15S064	From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	40, 609	2, 066, 210	0. 01965	4 0	0	90.00
91.00 Nursing School cost	0	2, 066, 210	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 066, 210	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 066, 210	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 10/01/2013	Worksheet D-1
	Component CCN: 15T064	To 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
	Title XVIII	Subprovi der -	PPS

		litie XVIII	I RF	PPS	
	Cost Center Description		110	1	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		851	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed			851	2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		- 21 -6 +6	851	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through beceinbe	er 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7.00	Total swing-bed NF type inpatient days (including private room	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	days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	uays) arter becember s	i or the cost	U	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	567	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		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ento		days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e 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 (0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(excidating swring bed	uays)	0	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	through December 31 c	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	a. to. Booombo. o. o.		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
	reporting period	C. D. I. O. C.			
20. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			1, 173, 125	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
24 00	x line 20)			0	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I)	ine 21 minus line 26)		0 1, 173, 125	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	The 21 minus Time 20)		1, 170, 120	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	Tine 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	,	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 di	fferential (line	1, 173, 125	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 378. 53	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			781, 627	
40.00	Medically necessary private room cost applicable to the Program	` ,		0 781, 627	
41. 00	Total Program general inpatient routine service cost (line 39 +	11110 40)	ļ	/81,02/	41.00

Period and COX 150004 Period 20	Heal th	Financial Systems FA	AYETTE REGIONAL HE	ALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
Total	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der CCN			Worksheet D-1	
Cost Center Description				Component CC	CN: 15T064 To	09/30/2014		
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and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1,069,068 53.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1,069,068 54.00 Program discharges 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Target amount per discharge 58.00 Target amount per discharge 69.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 69.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 69.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 69.00 Relief payment (see instructions) 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Relief payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instructions) 60.00 Target payment (see instruc				·				
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56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted in patient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket amount (line 56), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 61.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 63.00 PROGRAM INPAILER INT MOUTHS SWIN SED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) this way in the cost instructions) and the cost instructions (line XVIII only). For CAM (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (line XVIII only). For CAM (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 67.00 Total Hedicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 7 + line 2) 70.00 Skill-bed nursing facility/tother nursing facility/tother nursing facility/tother nursing facility/tother lines 73) 70.00 Skill-bed		Program di scharges						
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61.00 If line 53/54 is less than the lower of lines 55. \$9 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 PROGRAM INPATIENT ROUTINE SWI NO BED COST 64.00 Mallowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Sk lilled nursing facility/forther nursing facility/fc/MF routine service cost (line 37) 70.00 Total program routine service cost (line 9 x line 71) 70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 70.00 Program routine service cost (line 74 minus line 77) 70.00 Program routine service cost (line 9 x line 76) 71.00 Program routine service cost (line 9 x line 76) 72.00 Program routine service cost (line 9 x line 76) 73.00 Program routine service cost (line 9 x line 76) 74.00 Program inpatient routine service costs (from provider records)	60.00		cost report updat	ed by the mark	et basket		0.00	60 00
amount (line 56), otherwise enter zero (see instructions) 62. 00 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 64. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66. 00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 67. 00 Title Vor XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68. 00 Total title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70. 00 Allowable Inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70. 00 All INTERVENTIAL SWING SWING FACILITY, OTHER NURSING FACILITY, AND ICE/MR ONLY 70. 00 All INTERVENTIAL SWILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/MR ONLY 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 78. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00		If line 53/54 is less than the lower of line	s 55, 59 or 60 ent	er the Lesser	of 50% of th			
Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00								
PROGRAM INPATIENT ROUTINE SWING BED COST			ent (see instructi	ons)				
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Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 069.00	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dece	ember 31 of the	cost report	ing period	0	68. 00
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87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 0.00 88.00	86. 00			ıgn 85)				86.00
		1		ne 2)				
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Health Financial Systems FA	YETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T064	From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	45, 702	1, 173, 125	0. 03895	7 0	0	90.00
91.00 Nursing School cost	0	1, 173, 125	0.00000	0	0	91.00
92.00 Allied health cost	0	1, 173, 125	0.00000	0	0	92.00
93.00 All other Medical Education	0	1, 173, 125	0.00000	0 0	0	93. 00

Health Financial Systems	FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150064	Peri od: From 10/01/2013	Worksheet D-1	
			To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					1

	Title XIX Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 491	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 233	2.00
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, 603	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
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)	258	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period 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	127	9. 00
10. 00	newborn days) 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) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or 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)	421	15. 00
16. 00	Nursery days (title V or XIX only)	34	16. 00
	SWING BED ADJUSTMENT	2.	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	217. 31	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	222. 37	18. 00
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
21. 00	reporting period Total general inpatient routine service cost (see instructions)	2, 892, 450	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	57, 371	23. 00
24. 00	x line 18) 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) 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)	F7 271	27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	57, 371 2, 835, 079	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	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 ÷ line 28)	0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	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 27 minus line 36)	2, 835, 079	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)	876. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	111, 369	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)	111, 369	41. 00

		AYETTE REGIONAL					eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	'ı der	CCN: 150064	Peri od: From 10/01/2013		
						To 09/30/2014	Date/Time Pre 2/25/2015 10:	
			T	Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total I npati ent	Davs	Average Per Diem (col 1	Program Days	Program Cost (col. 3 x col.	
					col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1. 00 737, 524	2. 00	421	3. 00 1, 751. 8	4. 00	5. 00 59, 563	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			421	1, 751. 6	54 54	59, 503	42.00
43.00	INTENSIVE CARE UNIT	1, 832, 124		908	2, 017. 7	76 125	252, 220	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	1							46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 20	0)			174, 540	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)((see instr	uctio	ns)		597, 692	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	servi ces	(from	Wkst D sum	of Parts I and	0	50.00
30.00		atrent routine	3CI VI CC3	(11011	WKSt. D, Sun	or rarts r and		30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry service	s (fr	om Wkst. D, s	um 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 exclu	ding capital re	elated, no	n-phy	sician anesth	etist, and	0	53. 00
		52)						
54.00							0	54.00
							0.00	
56. 00 57. 00		ing cost and ta	arget amou	nt (I	ine 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and te	irget alliot	111 (1	The 50 minus	111le 33)	0	58. 00
59. 00		porting period	endi ng 19	96, u	pdated and co	mpounded by the	0.00	59. 00
60. 00		cost renort ur	ndated by	the m	arket hasket		0.00	60.00
61. 00						the amount by	0	1
			s (lines	54 x	60), or 1% of	the target		
62. 00		i iisti ucti oiis)					0	62. 00
63. 00		ent (see instru	uctions)				0	63. 00
64. 00		ts through Dece	ember 31 c	f the	cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü			•			
65. 00		ts after Decemb	per 31 of	the c	ost reporting	period (See	0	65. 00
66. 00		ne costs (line	64 plus I	ine 6	5)(title XVII	I only). For	0	66. 00
/7.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges 1 arget amount per discharge 2 arget amount (line 54 x line 55) 3 bifference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 4 Bonus payment (see instructions) 4 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 5 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 6 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8 Allowable Inpatient cost plus incentive payment (see instructions) 9 Allowable Inpatient cost plus incentive payment (see instructions) 9 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 10 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 10 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 10 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 10 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 10 Aljouted general inpatient routine service cost (line 67 + line 68) 10 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND LOF/MR ONLY 10 Adjusted general inpatient routine service cost (line 70 + line 2) 10 Program routine service cost (line 9 x line 71)			/7.00				
67. 00		e costs through	i beceiliber	31 0	i the cost re	porting period	0	67. 00
68. 00	1 . · · · · · · · · · · · · · · · · · ·	e costs after [December 3	1 of	the cost repo	rting period	0	68. 00
69 00	1 7	routine costs (Tine 67 +	Line	(68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF	/MR O	NLY		· · · · · · · · · · · · · · · · · · ·	0 / 00
70.00	, , , , , , , , , , , , , , , , , , , ,	,			,			70.00
71.00	, ,		THE 70 ÷	iiie	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic				ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				lorkshoot R D	art II column		74. 00 75. 00
75.00	26, line 45)	routine service	COSTS (1	i Oili W	orksheet b, F	art II, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	. *						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu							77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	orovi der ir	ecord	s)			79. 00
80.00	,		cost limit	ati on	(line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instruction	* .					83. 00
84.00	Program inpatient ancillary services (see in	,	nc)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum							85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	Line 2)				630 876. 92	1
	Observation bed cost (line 87 x line 88) (se	•					552, 460	1
	,							

Health Financial Systems	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 10/01/2013 To 09/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	81, 138	2, 835, 079	0. 02861	9 552, 460	15, 811	90.00
91.00 Nursing School cost	0	2, 835, 079	0.00000	552, 460	0	91.00
92.00 Allied health cost	0	2, 835, 079	0.00000	552, 460	0	92.00
93 00 All other Medical Education	0	2 835 079	0.00000	552 460	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 10/01/2013	Worksheet D-1
	Component CCN: 15SO64		
	Title XIX	Subprovi der -	

			IPF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			1, 319 1, 319	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days)	3 /	room days	1, 319	3. 00
0.00	do not complete this line.	you have omy private	days,		0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			1, 319	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December 31 o	f the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 31 of	the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	lavs) through December 31 of	the cost	0	7. 00
7.00	reporting period	adys) through becomber of or	the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December 31 of t	ne cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding swing	-bed and	243	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		ys)	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	/ (including private room da	ys) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		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 of	only (including private room	days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program	r, enter O on this line)		0	14. 00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed days)		421	
16. 00	Nursery days (title V or XIX only)			34	16.00
17. 00	SWING BED ADJUSTMENT 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	9			18. 00
19. 00	reporting period				19. 00
	Medicaid rate for swing-bed NF services applicable to services reporting period	Ü			
20. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	after December 31 of the cos	t		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporting ne	rind (line	2, 066, 210 0	21. 00 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 peri	od (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reporting per	od (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period	d (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 (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		2, 066, 210	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed charges)		0	28. 00
29. 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 ÷ 1	ine 28)		0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instructions)		0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,		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 differen	tial (line	2, 066, 210	
	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			1, 566. 50	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3)			380, 660	
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)		380, 660	41. 00

	Financial Systems FAYE ATION OF INPATIENT OPERATING COST	ETTE REGIONAL HE		CCN: 150064	Peri od:	u of Form CMS- Worksheet D-1	
Juli U I	S. THENTERY OF EIGHT NO COOT				From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared:
			Ti t	le XIX	Subprovi der - I PF	272072010 10.	or am
	Cost Center Description	Total npatient Costlnp	Total Datient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00		0	0				42.0
	Intensive Care Type Inpatient Hospital Units	-1	_		T		١
3. 00 4. 00	INTENSIVE CARE UNIT	0	0	0. 0	00	0	43. C
5. 00	1						45. 0
6. 00	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1. 00	-
8. 00	Program inpatient ancillary service cost (Wkst	. D-3. col. 3.	ine 200)				48.0
	Total Program inpatient costs (sum of lines 41			ns)		380, 660	
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpat	ient routine se	rvices (from	Wkst. D, sun	m of Parts I and	0	50.0
1. 00	III Pass through costs applicable to Program inpat	ient ancillary	services (fr	om Wkst D <	sum of Parts II	0	51.0
50	and IV)						"
2.00	Total Program excludable cost (sum of lines 50					0	
3. 00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)		ted, non-phy	sıcıan anesth	netist, and	380, 660	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION)					1
	Program di scharges					0	
	Target amount per discharge						55.
6.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operation	n cost and targe	et amount (L	ine 56 minus	line 53)	0 0	1
8. 00	Bonus payment (see instructions)	g cost and targe	or amount (1	THE SO III HAS	11116 33)	Ö	1
9. 00	Lesser of lines 53/54 or 55 from the cost repo	rting period end	ding 1996, u	pdated and co	ompounded by the	0.00	59.
	market basket						
0. 00 1. 00	Lesser of lines 53/54 or 55 from prior year collf line 53/54 is less than the lower of lines				the amount by	0. 00 0	
1.00	which operating costs (line 53) are less than					0	01.0
	amount (line 56), otherwise enter zero (see in	structions)			· ·		
2.00	Relief payment (see instructions)	t (aaa i matsuusti	(ana)			0	
3. 00	Allowable Inpatient cost plus incentive paymen PROGRAM INPATIENT ROUTINE SWING BED COST	t (see instructi	ons)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine costs	through Decembe	er 31 of the	cost reporti	ng period (See	0	64. (
	instructions)(title XVIII only)	6. 5.					
5. 00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	arter December	31 or the c	ost reporting	g period (See	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient routine	costs (line 64	plus line 6	5)(title XVII	I only). For	О	66. 0
	CAH (see instructions)					_	l
7. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through De	ecember 31 o	f the cost re	eporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routine	costs after Dece	ember 31 of	the cost repo	ortina period	0	68. 0
	(line 13 x line 20)			·	3 1		
9. 00	Total title V or XIX swing-bed NF inpatient ro					0	69. (
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, OTHER NURSING FACILITY, OTHER NURSING FACILITY.						70. 0
1. 00	Adjusted general inpatient routine service cos	,					71. (
2. 00	Program routine service cost (line 9 x line 71))		,			72. (
3.00	Medically necessary private room cost applicab	,		ne 35)			73.
4. 00 5. 00	Total Program general inpatient routine service Capital-related cost allocated to inpatient routines	•	,	orksheet R [Part II column		74. (
5. 50	26, line 45)	atine service co	JJ CJ CITOIII W	JI KJINGE D, F	art II, Corumili		, , , ,
6. 00	Per diem capital-related costs (line 75 ÷ line	•					76. (
7.00	Program capital-related costs (line 9 x line 7 Inpatient routine service cost (line 74 minus						77.
3. 00 9. 00	,	,	vi der record	s)			78. 79.
0. 00	Total Program routine service costs for compar				nus line 79)		80.
1. 00	Inpatient routine service cost per diem limita	ti on			,		81.
	Inpatient routine service cost limitation (line						82.
3. 00 4. 00	Reasonable inpatient routine service costs (see Program inpatient ancillary services (see inst						83.
5. 00	Utilization review - physician compensation (s)				85.
6. 00	Total Program inpatient operating costs (sum o	flines 83 thro					86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					1
-							
7. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per di	om (line 27 · li	ne 2)			0 00	87. 0 88. 0

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SY	STEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi	der CCN: 150		eri od:	Worksheet D-1	
		Compo	nent CCN: 159		rom 10/01/2013 o 09/30/2014	Date/Time Pre 2/25/2015 10:	
			Title XIX		Subprovi der -		
					I PF	L	
Cost Center Description	Cost	Routine C	st column	۱1 ÷	Total	Observati on	
		(from line	27) col um	n 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00	2.00	3.0	00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	0		0 0.	000000	0	0	90.00
91.00 Nursing School cost	0		0 0.	000000	0	0	91.00
92.00 Allied health cost	0		0 0.	000000	0	0	92.00
93.00 All other Medical Education	0		0 0.	000000	0	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150064	Peri od: From 10/01/2013	Worksheet D-1
	Component CCN: 15T064	To 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
	Title XIX	Subprovi der -	Cost

Cost Center Description PART 1 - ALL PROVIDER COMPONENTS			TI LIE XIX	IRF	Cost	
NAME ALL PROVIDER COMPONENTS		Cost Center Description			1.00	
NATLENT DAYS		DART I - ALL PROVIDER COMPONENTS			1.00	
100 private room days, (secluding spriyate room days, excluding saving-bed and nebborn days) 100 private room days, (secluding saving-bed and observation bed days). If you have not yor lyate room days, (secluding saving-bed and observation bed days). If you have not you have room days and retroophed SMF (you inpatient days (including private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line) 100 Total saving-bed SMF (you inpatient days) (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 101 Total saving-bed MF (you inpatient days) (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 101 Total saving-bed MF (you inpatient days) (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 101 Total saving-bed MF (you inpatient days) applicable to the Program (excluding saving-bed and period days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 102 Saving-bed SMF (you inpatient days applicable to title XVIII and yi (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 102 Saving-bed SMF (you inpatient days applicable to title XVIII and yi (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 103 Saving-bed SMF (you inpatient days applicable to XVIII and you (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 103 Saving-bed NF (you inpatient days applicable to XVIII and you (including private room days) 104 Saving-bed NF (you inpatient days applicable to XVIII and you (including private room days) 105 Saving-bed NF (you inpatient days applicable to XVIII and you (including private room days) 105 Saving-bed NF (you inpatient days applicable to						
200 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201 201	1.00				851	1.00
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) through December 31 of the cost 0 5.00 lotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 5.00 reporting period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 7.00 reporting period (if callendar year, enter 0 on this line) 8. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1 0 7.00 reporting period (if callendar year, enter 0 on this line) 9. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1 0 7.00 reporting period (if callendar year, enter 0 on this line) 9. 00 Total inputient days including private room days applicable to the Pregram (excluding swing-bed and nestorn days) 10. 00 Saing-bed SNF type inpatient days applicable to it it is XVIII only (including private room days) after 1 1.00 saing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1 1.00 Saing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1 1.00 Saing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1 1.00 Saing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1 1.00 Saing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.00 SNIII only (including private room days) after 1 1.						
	3.00		. IT you have only pri	vate room days,	U	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale indary services the cost reporting period (if cale indary services applicable to the Program (excluding swing-bed swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to the Program (excluding swing-bed and oservation period service) (in the cost reporting period (if cale indary services applicable to the Program (excluding swing-bed and oservations) (in the cost reporting period (if cale indary services applicable to the Program (excluding swing-bed and oservations) (in the cost reporting period (if cale indary services applicable to see instructions) (including private room days) after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services through December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services applicable to services after December 31 of the cost reporting period (if cale indary services after December 31 of the cost reporting period (if cale indary services after December 31 of the cost reporting period (if cale indary services after December 31 of the cost reporting period (if cale indary serv	4.00		days)		851	4. 00
10 10 10 10 10 10 10 10		Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
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		YETTE REGIONAL			0011 450074		Lieu of Form CMS	
COMPUT	ATION OF INPATIENT OPERATING COST				CCN: 150064 CCN: 15T064	Period: From 10/01/20 To 09/30/20		
			001	<u> </u>	le XIX	Subprovi der	2/25/2015 10	
	Cost Contar Decement on	Total	Tota			IRF		
	Cost Center Description	Total Inpatient Cost			col . 2)		(col. 3 x col 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.0	0	3.00	4.00	5.00	0 42.00
	Intensive Care Type Inpatient Hospital Units				-			
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0)	0	0.	00	0	0 43.00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							46. 00 47. 00
47.00	Cost Center Description		1					47.00
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	3 line 2	200)			1.00	0 48.00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS				ns)		45, 49	
50. 00	Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst. D, su	m of Parts I a	ind	0 50.00
51. 00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	ry servic	es (fr	om Wkst. D,	sum of Parts I	1	0 51.00
52. 00	Total Program excludable cost (sum of lines!							0 52.00
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		elated, n	ion-phy	sician anest	hetist, and		0 53.00
54.00	Program di scharges							0 54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.0	0 55.00 0 56.00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	arget amo	ount (I	ine 56 minus	line 53)		0 57.00
58. 00	Bonus payment (see instructions)							0 58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	ending 1	996, u	pdated and c	ompounded by t	he 0.0	0 59.00
60.00	Lesser of lines 53/54 or 55 from prior year of						0.0	
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							'	0 61.00
(2.00	amount (line 56), otherwise enter zero (see i	nstructions)	·			G		0 (2 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instru	uctions)				•	0 62.00 0 63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	amber 31	of the	cost report	ing period (Se		0 64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	3			•	3 1		0 65.00
	instructions)(title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)		·			•		0 66.00
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	-						0 67.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [December	31 of	the cost rep	orting period		0 68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU							0 69.00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/MR rout	tine serv	ice co	st (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ine 70 ÷	· line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applica	able to Program	•		ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)	•			orksheet B,	Part II, colum	ın	74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li							76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus							77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		orovi der	record	s)			79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limi	tati on	(line 78 mi	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem frum Inpatient routine service cost limitation (li		1)					82.00
83.00	Reasonable inpatient routine service costs (ns)					83.00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		ons)					84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th		i)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)							0 87.00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷					0.0	0 88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions))				I	0 89. 00

Health Financial Systems	FAYETTE REGIONA	L 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 10/01/2013		
		Componen	t CCN: 15T064	To 09/30/2014	Date/Time Prep 2/25/2015 10:3	pared:
		Ti +	le XIX	Subprovi der -	Cost	or alli
		111	I C AIA	I RF	COST	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
cost center bescription	COST	(from line 27)		Observati on	Bed Pass	
		(110III 111Ie 27)	COI UIIII 2			
				Bed Cost (from		
				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 Capi tal -related cost	45, 70	1, 173, 125	0. 03895	7 0	0	90.00
91.00 Nursing School cost		1, 173, 125	0.00000	0 0	0	91.00
92.00 Allied health cost		1, 173, 125	0.00000	0 0	0	92.00
93.00 All other Medical Education		1, 173, 125	0.00000	0 0	ol	93. 00

	Financial Systems FAYETTE REGIO ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150064	Peri od:	Worksheet D-3	
				From 10/01/2013 To 09/30/2014	Date/Time Pre	narad:
				10 09/30/2014	2/25/2015 10:	pareu: 37 am
		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)	
	INDATION DOUTING CERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS			1, 708, 692		30.00
31. 00	03100 INTENSIVE CARE UNIT			1, 248, 754		31.00
40.00	04000 SUBPROVI DER - I PF			1, 240, 754		40.00
41. 00	04100 SUBPROVI DER - I RF			6, 650		41.00
42.00	04200 SUBPROVI DER			0, 030		42.00
43. 00	04300 NURSERY					43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATI NG ROOM		0. 25702	25 541, 596	139, 204	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 20746		338, 451	54.00
57.00	05700 CT SCAN		0.00000	00	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	00	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60.00	06000 LABORATORY		0. 1774		318, 942	60.00
60. 01	06001 BLOOD LABORATORY		0.00000		0	60. 01
65. 00	06500 RESPI RATORY THERAPY		0. 26483		212, 429	
66. 00	06600 PHYSI CAL THERAPY		0. 55199		65, 462	1
	06901 CARDI AC REHAB		1. 24748		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50094			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 54634			1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 35752			
74. 00	07400 RENAL DIALYSIS		0.00000	00 0	0	74. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0.0000	20	0	00 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			88. 00 89. 00
91. 00	09100 EMERGENCY		0. 19063			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7395	· ·	177,074	92.00
93. 00	04040 CLINIC		2. 99356		0	
93. 00	04044 BI C		0. 75162		0	93. 00
	04041 UCI C		0.00000		Ö	
93. 03	04042 CI C		0.00000		Ö	93. 03
93. 04	04043 RI C		0. 00000		Ō	93. 04
	04950 PODI ATRY		0. 15703			

95.00

201. 00 202. 00

1, 981, 892 200. 00

7, 649, 913 0

7, 649, 913

200.00

201.00 202.00

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)

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150064	Peri od:	Worksheet D-3	
		Component	CCN: 15S064	From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 10:	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2.00	3. 00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS				2.22	
	DO ADULTS & PEDIATRICS			0		30. C
	DO INTENSIVE CARE UNIT			0		31.0
	OO SUBPROVI DER - I PF			1, 546, 315		40.0
	OO SUBPROVI DER - I RF			0		41.0
	OO SUBPROVI DER			0		42.0
	DO NURSERY					43.0
	LLARY SERVICE COST CENTERS					١
	OO OPERATING ROOM		0. 2570		3	50.0
	DO DELIVERY ROOM & LABOR ROOM		0.0000		0	
	DO RADI OLOGY-DI AGNOSTI C		0. 2074		10, 258	
1	OO CT SCAN		0.0000		0	
	DO MAGNETIC RESONANCE IMAGING (MRI) DO CARDIAC CATHETERIZATION		0. 0000 0. 0000			
1	DO LABORATORY		0.0000			
	D1 BLOOD LABORATORY		0.0000		0,017	1
	00 RESPI RATORY THERAPY		0. 2648		973	
4	DO PHYSI CAL THERAPY		0. 5519		15, 156	1
1	D1 CARDI AC REHAB		1. 2474		0	1
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5009		1, 117	71. (
72. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS		0. 5463	43 0	0	1
73. 00 0730	DO DRUGS CHARGED TO PATIENTS		0. 3575	25 284, 567	101, 740	73.0
	DO RENAL DIALYSIS		0.0000	00 0	0	74.0
	PAȚIENT SERVICE COST CENTERS					
	DO RURAL HEALTH CLINIC		0. 0000		0	
	DO FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	DO EMERGENCY		0. 1906		10, 187	
	OO OBSERVATION BEDS (NON-DISTINCT PART)		0. 7395		0	
	40 CLINIC		2. 9935		0	
	44 BIC		0. 7516		0	
	41 UCI C		0.0000		0	
	42 CT C 43 RT C		0.0000		0	
93. 04 040 ² 93. 05 049!	50 PODI ATRY		0. 0000 0. 1570		0	1
73. US U498	ER REIMBURSABLE COST CENTERS		U. 1570	ათ		73. (
	ON AMBULANCE SERVICES					95. (
200. 00	Total (sum of lines 50-94 and 96-98)			514, 461	156, 051	
200.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0 0	130,031	201. 0
202.00	Net Charges (line 200 minus line 201)	. (. 1110 01)		514, 461		202. 0

IPATTENT A	NCILLARY SERVICE COST APPORTIONMENT		CCN: 150064 t CCN: 15T064	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre	
			e XVIII	Subprovi der -	2/25/2015 10: PPS	
		11 (1	e XVIII	I RF	113	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				charges	2)	
			1.00	2. 00	3. 00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS		'			
. 00 03000	ADULTS & PEDIATRICS			0		30
. 00 03100	INTENSIVE CARE UNIT			0		31
. 00 04000	SUBPROVI DER - I PF			0		40
. 00 04100	SUBPROVI DER - I RF			702, 272		41
	SUBPROVI DER			0		42
	NURSERY					43
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 2570		3	
	DELIVERY ROOM & LABOR ROOM		0.0000		0	
	RADI OLOGY-DI AGNOSTI C		0. 2074		2, 408	
	CT SCAN		0.0000		0	
	MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
	CARDI AC CATHETERI ZATI ON		0.0000		0	
	LABORATORY		0. 1774		7, 411	
	BLOOD LABORATORY		0.0000		0	1 -
	RESPI RATORY THERAPY		0. 2648		6, 994	
	PHYSI CAL THERAPY CARDI AC REHAB		0. 5519 1. 2474		267, 328 0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.5009		8, 937	
	IMPL. DEV. CHARGED TO PATTENTS		0.5463		0, 937	
	DRUGS CHARGED TO PATIENTS		0.3403		31, 615	
- 1	RENAL DIALYSIS		0.0000		0 0	
	TIENT SERVICE COST CENTERS		0.0000	00 0		l ′ -
00 08800	RURAL HEALTH CLINIC		0.0000	00	0	88
	FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	EMERGENCY		0. 1906		151	
00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0. 7395	13 0	0	92
	CLINIC		2. 9935		0	93
. 01 04044	BIC		0. 7516		0	93
02 04041	UCIC		0.0000	00 0	0	93
. 03 04042			0.0000	00 0	0	93
. 04 04043	RIC		0.0000	00 0	0	93
	PODI ATRY		0. 1570	38 0	0	93
	REIMBURSABLE COST CENTERS					
1	AMBULANCE SERVICES					95
0. 00	Total (sum of lines 50-94 and 96-98)			671, 144	324, 847	
1.00	Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201
2. 00	Net Charges (line 200 minus line 201)		1	671, 144		202

Health Financial Systems	FAYETTE REGIONAL HEAL	TU CVCTEM		In Lie	eu of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	TATETIE REGIONAL HEAD		CCN: 150064	Peri od: From 10/01/2013	Worksheet D-3	
		Component		To 09/30/2014		pared: 37 am
		Ti tl	e XVIII	Swing Beds - SNF	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					•	
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
21 OO O2100 LNTENSIVE CARE HALT						21 00

Cost Center Description	Ratio of Cost	Inpati ent	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
LADATE FUE DOUTLINE OFFINE OF COOK OFFITEDO	1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		C)	30. 00
31. 00 03100 INTENSI VE CARE UNI T		C	<u>}</u>	31.00
40. 00 04000 SUBPROVI DER - PF		C)	40. 00
41. 00 04100 SUBPROVI DER - I RF		C)	41.00
42. 00 04200 SUBPROVI DER		C)	42. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 0PERATING ROOM	0. 254986	1	0	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000		0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 207463	6, 356		54.00
57. 00 05700 CT SCAN	0. 000000	C	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	C	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	C	0	59. 00
60. 00 06000 LABORATORY	0. 177455	20, 475		60. 00
60. 01 06001 BL00D LABORATORY	0. 000000	C	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 264837	16, 818		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 551990	106, 174	1	66. 00
69. 01 06901 CARDI AC REHAB	1. 247480	C	0	69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 500946	8, 457	4, 237	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 546343	C	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0. 357525	82, 293	29, 422	73.00
74. 00 07400 RENAL DIALYSIS	0.000000	C	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000		0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89. 00
91. 00 09100 EMERGENCY	0. 190632	122	23	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 739513	C	0	92.00
93. 00 04040 CLI NI C	2. 993569	C	0	93. 00
93. 01 04044 BI C	0. 726611	C	0	93. 01
93. 02 04041 UCLC	0.000000	C	0	93. 02
93. 03 04042 CI C	0.000000	C	0	93. 03
93. 04 04043 RI C	0.000000	C	0	93.04
93. 05 04950 PODI ATRY	0. 157038	C	0	93. 05
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50-94 and 96-98)		240, 696	101, 695	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		C)	201. 00
202.00 Net Charges (line 200 minus line 201)		240, 696	o	202. 00
	·			

	Financial Systems FAYETTE REGIONAL ENT ANCILLARY SERVICE COST APPORTIONMENT	L HEALTH SYSTEM Provider	CCN: 150064	Period:	Worksheet D-3	
				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/25/2015 10:	pared: 37 am
		Ti t	le XIX	Hospi tal	Cost	07 d.iii
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4 00		2)	
	INDATI ENT. DOUTINE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	203, 749		30.00
31. 00	03100 INTENSIVE CARE UNIT			65, 162		31.00
40. 00	04000 SUBPROVI DER - I PF			05, 102		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41. 00
42. 00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY			69, 838		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		l .	07,000		10.00
50. 00	05000 OPERATING ROOM		0. 25498	36 111, 009	28, 306	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 20746		11, 952	
57. 00	05700 CT SCAN		0.00000	00	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	00	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00	06000 LABORATORY		0. 17745		23, 765	60.00
60. 01	06001 BLOOD LABORATORY		0. 00000		0	60. 01
65. 00	06500 RESPI RATORY THERAPY		0. 26483		11, 013	
66. 00	06600 PHYSI CAL THERAPY		0. 55199		7, 344	
69. 01	06901 CARDI AC REHAB		1. 24748		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50094		34, 982	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 54634		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 35752		46, 614	
74. 00	07400 RENAL DI ALYSI S		0. 00000	00 0	0	74. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.00
89. 00 91. 00	09100 EMERGENCY		0. 19063		10, 564	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 73951		10, 304	92.00
93.00	04040 CLINIC		2. 99356		0	
93. 00	04044 BI C		0. 72661		0	93. 01
93. 02	04041 UCI C		0. 00000		0	1
	04042 CI C		0. 00000		0	93. 03
93. 04	04043 RI C		0. 00000		0	93. 04
	04950 PODI ATRY		0. 15703		0	

174, 540 200. 00

613, 055

613, 055

95.00

201. 00 202. 00

200.00

201.00 202.00

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)

NPATI E	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150064	Peri od:	Worksheet D-3	
		Componen-	t CCN: 15S064	From 10/01/2013 To 09/30/2014		
		Ti t	le XIX	Subprovi der - I PF		
	Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS				·	
	D3000 ADULTS & PEDI ATRI CS			0		30.
	D3100 I NTENSI VE CARE UNI T			0		31.
	04000 SUBPROVI DER - I PF			75, 456		40.
	04100 SUBPROVI DER – I RF			0		41
	04200 SUBPROVI DER			0		42
	04300 NURSERY ANCILLARY SERVICE COST CENTERS					43
	D5000 OPERATING ROOM		0.0000	000 24, 727	0	50
	D5200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
	D5400 RADI OLOGY-DI AGNOSTI C		0.0000			
	05700 CT SCAN		0.0000		Ö	1
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	1
. 00	D5900 CARDI AC CATHETERI ZATI ON		0.0000		0	59
	D6000 LABORATORY		0.0000		0	60
0. 01	06001 BLOOD LABORATORY		0.0000	000	0	60
5.00	D6500 RESPI RATORY THERAPY		0.0000	9, 263	0	65
. 00	D6600 PHYSI CAL THERAPY		0.0000	2, 963	0	66
9. 01	D6901 CARDI AC REHAB		0.0000	000	0	69
1.00	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	15, 555	0	71
	D7200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	1
	D7300 DRUGS CHARGED TO PATIENTS		0.0000		0	
	07400 RENAL DI ALYSI S		0.0000	000	0	74
	OUTPATIENT SERVICE COST CENTERS				1 -	١.,
	D8800 RURAL HEALTH CLINIC		0.0000			
	D8900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	09100 EMERGENCY		0.0000		0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.0000		0	1
	04040 CLI NI C 04044 BI C		0. 0000 0. 0000		0	
	04041 UCI C		0.0000		0	
	04042 CLC		0.0000		0	
	04043 RI C		0.0000		-	
	04950 PODI ATRY		0. 0000			
	OTHER REIMBURSABLE COST CENTERS		0.0000	,00		1 ′`
	09500 AMBULANCE SERVICES					95
00.00	Total (sum of lines 50-94 and 96-98)			136, 559	0	200
01.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0.00,007	I	201
02.00	Net Charges (line 200 minus line 201)	. (1	136, 559	I	202

NPALLENI A	NCILLARY SERVICE COST APPORTIONMENT		CCN: 150064 CCN: 15T064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre 2/25/2015 10:	epare
		Ti t	le XIX	Subprovi der -	Cost	31 a
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	D ADULTS & PEDIATRICS			0		30
	DINTENSIVE CARE UNIT			0		31.
	SUBPROVIDER - IPF			0		40
	SUBPROVI DER - I RF			75, 185		41
	SUBPROVI DER			0		42
	NURSERY			0		43
	LLARY SERVICE COST CENTERS DOPERATING ROOM		0. 2549	86 0	0	50
	D DELIVERY ROOM & LABOR ROOM		0. 2549		0	
	D RADI OLOGY-DI AGNOSTI C		0. 0000		0	1
	O CT SCAN		0.0000		0	
	MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
	CARDI AC CATHETERI ZATI ON		0. 0000		0	
	LABORATORY		0. 1774		0	
4	1 BLOOD LABORATORY		0.0000		0	60
6. 00 0650	RESPI RATORY THERAPY		0. 2648	37 0	0	65
	PHYSI CAL THERAPY		0. 5519	90 0	0	66
	1 CARDI AC REHAB		1. 2474	80 0	0	69
1.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5009	46 0	0	71
	ON IMPL. DEV. CHARGED TO PATIENTS		0. 5463		0	
	DRUGS CHARGED TO PATIENTS		0. 3575		0	
1.00 0740	RENAL DIALYSIS		0.0000	00 0	0	74
	ATLENT SERVICE COST CENTERS					4
	RURAL HEALTH CLINIC		0.0000		0	
	O FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	DEMERGENCY		0. 1906		0	
	O OBSERVATION BEDS (NON-DISTINCT PART) O CLINIC		0. 7395 2. 9935		0	
3. 00 04040 3. 01 04040			0. 7266		0	1
- 1	4 BIC 1 UCI C		0.7266		0	
3. 02 0404 3. 03 0404			0.0000		0	
3. 04 0404			0.0000		0	
	PODI ATRY		0. 1570		0	
	R REIMBURSABLE COST CENTERS		0. 1970	<u> </u>		1 ′`
	AMBULANCE SERVICES					1 95
00.00	Total (sum of lines 50-94 and 96-98)			0	0	200
01.00	Less PBP Clinic Laboratory Services-Program only	charges (line 61)		O	_	201
02.00	Net Charges (line 200 minus line 201)	3 . ,	l	O		202

	Financial Systems FAYETTE REG	10NAL HEALTH SYSTEM		Peri od:	u of Form CMS-2 Worksheet D-3	
T INI ATT	ENT ANOTEEART SERVICE GOST ATTORTTONIENT			From 10/01/2013		
		Componen ⁻	t CCN: 15U064	To 09/30/2014	Date/Time Pre 2/25/2015 10:	
		Ti t	le XIX	Swing Beds - SNF		37 dili
	Cost Center Description		Ratio of Cos		Inpati ent	
	· · · · · · · · · · · · · · · · · · ·		To Charges	Program	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 I NTENSI VE CARE UNI T			0		31.00
40. 00	04000 SUBPROVI DER - I PF			0		40. 00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY			0		43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		0.05400	2/	0	F0 00
50.00	05000 OPERATING ROOM		0. 25498		·	
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC		0.00000		-	
54. 00 57. 00	05700 CT SCAN		0. 2074 <i>6</i> 0. 00000		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59. 00	05900 CARDIAC CATHETERIZATION		0.00000		0	
60.00	06000 LABORATORY		0. 17745		0	
60. 01	06001 BLOOD LABORATORY		0. 00000		0	
65. 00	06500 RESPIRATORY THERAPY		0. 26483		0	
66. 00	06600 PHYSI CAL THERAPY		0. 55199		Ö	
69. 01	06901 CARDI AC REHAB		1. 24748		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50094		0	1 ' '
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 54634		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 35752		0	1
74. 00	07400 RENAL DIALYSIS		0.00000		0	74.00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
91.00	09100 EMERGENCY		0. 19063	32 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 73951	0	0	92. 00
93.00	04040 CLI NI C		2. 99356		0	93. 00
93. 01	04044 BI C		0. 72661		0	93. 01
93. 02	04041 UCI C		0.00000	00	0	
93. 03	04042 CI C		0.00000		0	
93. 04	04043 RI C		0.00000		0	
93. 05	04950 PODI ATRY		0. 15703	38 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	CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Pre 2/25/2015 10:	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1		
	DART A LANDATI FAT HOODI TAL OFFINI OFFI INDED DOG	0	1. 00	1. 01	2. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		2 110 20	24		1.00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges		3, 119, 29	0		1.00
1.01	occurring prior to October 1, 2013 (see instructions)					1.01
1.02	DRG amounts other than outlier payments for discharges			0		1. 02
	occurring on or after October 1, 2013 (see instructions)					
1. 03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)			0		1. 03
2.00	Outlier payments for discharges. (see instructions)		22, 0	72		2. 00
2. 01	Outlier reconciliation amount		22,0	0		2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see			0		2. 02
	instructions)					
3.00	Managed Care Simulated Payments			0		3. 00
4. 00	Bed days available divided by number of days in the cost		54. 5	57		4. 00
	reporting period (see instructions) Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the		0.0	00		5.00
	most recent cost reporting period ending on or before					
	12/31/1996. (see instructions)					
6. 00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new		0.0	00		6. 00
	programs in accordance with 42 CFR 413.79(e)					
7.00	MMA Section 422 reduction amount to the IME cap as		0.0	00		7. 00
	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)					
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	00		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	20		8.00
0.00	allopathic and osteopathic programs for affiliated		0. 0	50		0.00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069,					
8. 01	August 1, 2002. The amount of increase if the hospital was awarded FTE cap		0.0	20		8. 01
0.01	slots under section 5503 of the ACA. If the cost report		0. (50		0.01
	straddles July 1, 2011, see instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	20		9.00
7.00	lines (8, 8,01 and 8,02) (see instructions)		0. 0	50		7.00
10.00	FTE count for allopathic and osteopathic programs in the		0.0	00		10. 00
	current year from your records					
11.00	FTE count for residents in dental and podiatric programs.		0.0			11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		0.0			12. 00 13. 00
14. 00	' -		0.0			14. 00
	year ended on or after September 30, 1997, otherwise enter					
	zero.					
15.00	Sum of lines 12 through 14 divided by 3.		0.0			15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital		0.0			16. 00 17. 00
17.00	closure		0. \			17.00
18. 00	Adjusted rolling average FTE count		0.0	00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 00000	00		19. 00
20.00	line 4).		0. 00000	20		20.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0.00000			20.00
22. 00	IME payment adjustment (see instructions)		0.00000	0		22. 00
	Indirect Medical Education Adjustment for the Add-on for Section	on 422 of t	he MMA	,		1
23. 00	Number of additional allopathic and osteopathic IME FTE		0.0	00		23. 00
	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions)		0.0			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.0	50		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 00000	00		26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 00000	00		27. 00
28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
29. 00	Total IME payment (sum of lines 22 and 28)			0		29. 00
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part		7.5	50		20.00
30.00	A patient days (see instructions)		· · · ·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27. 2	22		31.00
32. 00			34.	72		32. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E | From 10/01/2013 | Part A | To 09/30/2014 | Date/Time Prepared: | 2/25/2015 10:37 am Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150064

						2/25/2015 10:	3/ am_
			litl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1. 00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible			243, 093			66. 00
	beneficiaries (see instructions)						
67. 00	Subtotal (line 61 plus line 65 minus lines			3, 531, 225			67.00
07.00	62 and 63)			3, 331, 223			07.00
68. 00	Credits received from manufacturers for			0			68. 00
00.00				0			08.00
	replaced devices applicable to MS-DRG (see						
	instructions)			_			
69. 00	Outlier payments reconciliation (sum of			0			69. 00
	lines 93, 95 and 96). (For SCH see						
	instructions)						
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
	(SPECI FY)						
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			0			70. 92
70. 93	HVBP incentive payment (see instructions)			864			70. 93
70. 94	Hospital readmissions reduction adjustment			-12, 789			70. 94
	(see instructions)			,			
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
70. 70	year (yyyy) (Enter in column 0 the		O	0			70. 70
	corresponding federal year for the period						
70.07	prior to 10/1)		0014	47/ 000			70.07
70. 97	Low volume adjustment for federal fiscal		2014	476, 022			70. 97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
71. 00	Amount due provider (line 67 minus lines 68			3, 995, 322			71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			79, 906			71. 01
72.00	Interim payments			3, 654, 386			72.00
73.00	Tentative settlement (for contractor use			0			73. 00
	only)			_			
74.00	Balance due provider (Program) line 71 minus			261, 030			74. 00
, ,, ,,	lines 71.01, 72 and 73			20.,000			/ 00
75. 00	Protested amounts (nonallowable cost report			36, 239			75. 00
73.00	items) in accordance with CMS Pub. 15-2,			30, 237			75.00
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR						
00 00				_			1 00 00
90. 00	Operating outlier amount from Worksheet E,			0			90. 00
04 00	Part A line 2 (see instructions)						04 00
91. 00	Capital outlier from Worksheet L, Part I,			0			91. 00
	line 2						
92.00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
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
	money (see instructions)						
95.00	Time value of money for operating expenses			0		1	95. 00
	(see instructions)			l			
96. 00	Time value of money for capital related			0			96. 00
70.00	expenses (see instructions)			Ĭ			70.00
	and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t		'	ı	I	I	1

| Period: | Worksheet E | From 10/01/2013 | Part A Exhibit 4 | Date/Time Prepared: | 2/25/2015 10: 37 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150064

							2/25/2015 10:3	37 am_
				Ti tl	e XVIII	Hospi tal	PPS	
	·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	3, 119, 296	0	0	3, 119, 296	3, 119, 296	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1,	1. 01	O	0	0	0	0	1. 01
1. 02	2013 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	0	0	0	0	0	1. 02
1. 03	1, 2013 DRG for Federal specific	1. 03	0	0	0	0	0	1. 03
0.00	operating payment for Model 4 BPCI	0.00	00.070			00.070	00.070	0.00
2. 00	Outlier payments for discharges (see instructions)	2. 00	22, 072	0	0	22, 072	22, 072	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	О	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju	ıstment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0.000000	0.000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	О	0	6. 00
	instructions) Indirect Medical Education Adju	etmont for the	Add on for So	ction 122 of t	ho MMA			
7.00	Amount from Worksheet E Part	27. 00	0. 000000	0.000000		0. 000000		7. 00
7.00	A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
	Di sproporti onate Share Adjustmo	ent						
10.00	Allowable disproportionate	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
	share percentage (see instructions)							
11. 00	Disproportionate share adjustment (see instructions)	34. 00	93, 579	0	0	93, 579	93, 579	11. 00
11. 01	Uncompensated care payments	36.00	410, 976	0	0	410, 976	410, 976	11. 01
	Additional payment for high per	centage of ESF	D beneficiary	di scharges				
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	3, 645, 923	0	0	3, 645, 923	3, 645, 923	13. 00
14. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals		0	0	0	0	0	14. 00
15. 00	only. (see instructions) Total payment for inpatient operating costs SCH and MDH only (see instructions)	49. 00	3, 645, 923	0	0	3, 645, 923	3, 645, 923	15. 00
16. 00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50. 00	245, 660	0	О	245, 660	245, 660	16. 00
17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
18. 00	new technologies Capital outlier reconciliation adjustment amount (see	93. 00	O	0	0	0	0	18. 00
19. 00	instructions) SUBTOTAL			0	О	3, 891, 583	3, 891, 583	19. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM					In Lieu of Form CMS-2552-10		
LOW VOLUME CALCULATION EXHIBIT 4				Provi der	CCN: 150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet E Part A Exhibi Date/Time Pre 2/25/2015 10:	oared:
				Ti tl	e XVIII	Hospi tal	PPS	
	W/S L, line	(Amounts from L)						
	0	1.00		2.00	3. 00	4. 00	5. 00	

			Ti tl	e XVIII	Hospi tal	PPS	07 diii	
		W/S L, line	(Amounts from	11 (1	C XVIII	nospi tui	113	
		117 5 E, 11110	L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	245, 589	0	0	245, 589	245, 589	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	71	0	0	71	71	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (line 20 times line							
	22)							
24.00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0. 0000	0. 0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0	0	0	0	25. 00
	adjustment (line 20 times line							
	24)			_	_			
26. 00	Total prospective capital	12. 00	245, 660	0	0	245, 660	245, 660	26. 00
	payments (sum of lines 20-21,							
	23 and 25)	W/C F D I A	/A					
		W/S E, Part A						
		line 0	Part A) 1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0. 000000	0. 122321	5.00	27. 00
28. 00	Low volume adjustment	70. 96			0.000000	0. 122321	0	28.00
26.00	(transfer amount to W/S E Part				0		U	26.00
	A line)							
29. 00	Low volume adjustment	70. 97				476, 022	476, 022	20.00
29.00	(transfer amount to W/S E Part					470,022	470,022	29.00
	A line)							
100 00	Transfer low volume		Y					100. 00
100.00	adjustments to W/S E Part A.		'					100.00
	adjustments to W/S L rait A.		ı		I	I .		I

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM			In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:	150064	Peri od: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Ti me Prepared: 2/25/2015 10:37 am	
		TI 11 100			DDO	

			077 007 2011	2/25/2015 10: 3	37 am
		Title XVIII	Hospi tal	PPS	
				1.00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			10.010	1 00
1. 00 2. 00	Medical and other services (see instructions)			12, 219	1. 00 2. 00
3.00	Medical and other services reimbursed under OPPS (see instruction PPS payments	15)		9, 037, 720 5, 397, 642	
4. 00	Outlier payment (see instructions)			6, 215	
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	ons)		0. 000	
6.00	Line 2 times line 5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0.000	6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Worksheet D, Part	IV, column 13, line	200	o	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			12, 219	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			28, 033	
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69,	col. 4)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			28, 033	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for paym	ont for sorvices on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for pa				16. 00
10.00	had such payment been made in accordance with 42 CFR 413.13(e)	rymerre for services e	ii a chargebasi s	j J	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)			28, 033	18.00
19.00	Excess of customary charges over reasonable cost (complete only i	fline 18 exceeds li	ne 11) (see	15, 814	19.00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only i	f line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)				21 00
21. 00					21. 00 22. 00
22. 00 23. 00	· · · · · · · · · · · · · · · · · · ·				23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0 5, 403, 857		
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	3, 403, 037	24.00		
25. 00	Deductibles and coinsurance (for CAH, see instructions)			13	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CA	AH, see instructions)		1, 216, 938	26.00
27.00	Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the	sum of lines 22 and	23} (for CAH,	4, 199, 125	27.00
	see instructions)				
28. 00	Direct graduate medical education payments (from Worksheet E-4, I			0	28. 00
29. 00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			4, 199, 125	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			408 4, 198, 717	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			4, 170, 717	32.00
33. 00				0	33. 00
34. 00	Allowable bad debts (see instructions)			132, 568	
35. 00	Adjusted reimbursable bad debts (see instructions)			86, 169	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)		132, 568	
37. 00	Subtotal (see instructions)			4, 284, 886	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			-7	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	
39. 99					39. 99
40. 00					40. 00
40. 01					40. 01 41. 00
41. 00 42. 00	· ·				41.00
43.00	· · · · · · · · · · · · · · · · · · ·				43.00
44. 00					44. 00
00	§115. 2		onaptor 17	0	00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

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

					2/25/2015 10:3	37 am
			e XVIII	Hospi tal	PPS	
		Inpatier	nt 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		3, 592, 61	0	4, 108, 214	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	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	1				
3. 01	ADJUSTMENTS TO PROVIDER	09/30/2014	61, 77		171, 085	3. 01
3. 02			l .	0	0	3. 02
3.03			1	0	0	3. 03
3.04			l	0	0	3. 04
3. 05	Drawit dans to Drawnson			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	1 0	3. 50
3. 51	ADJUSTIMENTS TO PROGRAM		II.	0		3. 50
3. 52			1	0		3. 52
3. 53				0		3. 53
3. 54		•		0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		61, 77		171, 085	3. 99
0. 77	3. 50-3. 98)				171,000	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 654, 38	66	4, 279, 299	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	'	'	"		
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		l .	0	0	5. 50
5. 51			l .	0	0	5. 51
5.52			1	0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		261, 03	0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	0	80, 104	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 915, 41	-	4, 199, 195	7. 00
			3,7.3,11	Contractor	NPR Date	7. 50
				Number	(Mo/Day/Yr)	
	Name of Contractor		0	1. 00	2. 00	8. 00
8. 00						

		Ti tl	e XVIII	Subprovi der - I PF	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		787, 580		0	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 3. 02	ADJUSTMENTS TO PROVIDER				0	3. 01 3. 02
3.02						3. 02
3. 04						3. 04
3. 05					0	3. 05
	Provider to Program			'		
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3.50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3.53			(0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines				0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			,	U	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		787, 580)	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TERMINE TO THOMBER				Ö	5. 02
5.03			C)	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51					0	5. 51
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines				0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			,	U	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVI DER		3		0	6. 01
6.02	SETTLEMENT TO PROGRAM		C		0	6. 02
7.00	Total Medicare program liability (see instructions)		787, 583		0	7. 00
				Contractor Number	NPR Date	
		()	1. 00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			00	2.00	8. 00
				•	. '	

		Titl	e XVIII	Subprovi der -	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		869, 121 0		0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0)	0	3. 02
3.03			0)	0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
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			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		869, 121		0	4. 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0			5. 02 5. 03
5.03	Provider to Program				0	3.03
5. 50	TENTATI VE TO PROGRAM		0	1	0	5. 50
5. 51	TENTATI VE TO TROGRAM				0	5. 51
5. 52			ĺ		ا	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		Ö		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0)	o	6. 01
6.02	SETTLEMENT TO PROGRAM		11, 726		0	6. 02
7. 00	Total Medicare program liability (see instructions)		857, 395		Ō	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

		'			2/25/2015 10:	37 am
				wing Beds - SNF		
		Inpatier	it 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		73, 171		0	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			1	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02					0	3. 02
3. 04					0	3. 03
3. 05					0	3. 05
5. 05	Provider to Program			71	0	3.03
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51					o	3. 51
3. 52					0	3. 52
3.53			(0	3. 53
3.54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		73, 171		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		Ι			5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5.02			(0	5. 02
5.03			(0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER				0	6. 01
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
7. 00	Total Medicare program liability (see instructions)		73, 171		0	7. 00
7.00	Total medicale program trability (see Histructions)		13, 17	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	· '			•		

Heal th	Financial Systems FAYETTE REGIONAL HEA	ALTH SYSTEM	In Lie	u of Form CMS-2	2552-10		
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150064 Period: From 10/01/2013 To 09/30/2014 Period: From 10/01/2013 Period:						
	Title XVIII Hospital						
	1.00						
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst S						
1. 00	1, 164 1, 888						
2.00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12					2. 00 3. 00		
	3.00 Medicare HMO days from Wkst S-3, Part I, column 6. line 2						
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		3, 511	4. 00		
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			98, 393, 794			
6.00	Total hospital charity care charges from Wkst S-10, column 3 l			2, 313, 375			
7. 00	CAH only - The reasonable cost incurred for the purchase of ce Part I line 168	rtified HIT technology	Worksheet S-2,	0	7. 00		
8. 00	Calculation of the HIT incentive payment (see instructions)			605, 507	8. 00		
9. 00	Sequestration adjustment amount (see instructions)			12, 110			
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		593, 397	10.00		
10.00	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH	300 111311 4011 0113)		373, 371	10.00		
30.00	Initial/interim HIT payment adjustment (see instructions)			616, 432	30.00		
	Other Adjustment (specify)			0	31. 00		
22 00	20 Delanes due provider (line 0 (or line 10) minus line 20 and line 21) (occ instructions)						

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

616, 432 30. 00 0 31. 00 -23, 035 32. 00

Health Financial Systems	FAYETTE REGIONAL HEAL	_TH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 150064	Peri od: From 10/01/2013	Worksheet E-2
		Component CCN: 15U064		
		T' 11 \0.0111	C : D I CNE	

2.00			•		2/25/2015 10:	37 am
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient routine services - swing bed-SNF (see instructions) 79,984 0 1.00 2.00 Inpatient routine services - swing bed-SNF (see instructions) 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.2.00 2.			Title XVIII	Swing Beds - SNF	PPS	
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient routine services - Swing bed-NF (see instructions) 2.00 Inpatient routine services - Swing bed-NF (see instructions) 2.00 Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions) 3.00 Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions) 234 0.5.00 Part W, columns 6 and 7, line 202 for Part B) (For CAH, see instructions) 234 0.5.00 Program days 234 0.5.00 Instructions) 0.6.00 Interns and residents not in approved teaching program (see instructions) 0.6.00 Interns and residents not in approved teaching program (see instructions) 0.6.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00				Part A	Part B	
1.00 Inpatient routine services - swing bed-SNF (see instructions) 79,984 0 1.00				1. 00	2. 00	
2.00 Inpatient routine services - swing bed-NF (see instructions) 3.00 Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions) 4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Primary payer payments (see instructions) 9.00 Program days 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 9.12.00 Subtotal (line 8 minus line 9) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (lener the lesser of line 12 minus line 13, or line 14) 16.50 RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 19.00 Interim payments 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00 Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	1.00	Inpatient routine services - swing bed-SNF (see instructions)		79, 984	0	1.00
Part V, Columns 6 and 7, line 202 for Part B) (For CAH, see instructions) Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 5.00 Program days 6.00 Unterns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Primary payer payments (see instructions) 9.01 Deductible billed to program patients (exclude amounts applicable to physician professional services) 9.10 Deductible billed to program patients (exclude amounts applicable to physician professional services) 9.12 DO Subtotal (line 10 minus line 11) 9.13 DO Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 9.14 DO 80% of Part B costs (line 12 x 80%) 9.15 DO Subtotal (lenter the lesser of line 12 minus line 13, or line 14) 9.16 DO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.17 DO Allowable bad debts (see instructions) 9.18 DO Allowable bad debts (see instructions) 9.19 DO Total (see instructions) 9.10 Total (see instructions) 9.11 DO Total (see instructions) 9.12 DO Coll Interim payments 9.13 DO Coll Interim payments 9.14 DO Coll Interim payments 9.15 DO Coll Interim payments 9.17 DO Coll Interim payments 9.18 DO Allowable pad debts (see instructions) 9.19 DO Total (see instructions) 9.10 DO Total (see instructions) 9.11 DO Coll Interim payments 9.12 DO Coll Interim payments 9.13 DO Coll Interim payments 9.14 DO Coll Interim payments 9.15 DO Coll Interim payments 9.17 DO Coll Interim payments 9.18 DO Coll Interim payments 9.19 DO Coll Interim payments 9.19 DO Coll Interim payments 9.10 DO Coll Interim payments 9.10 DO Coll Interim payments 9.10 DO Coll Interim payments 9.10 DO Coll Interim payments 9.10 DO Coll Interim payments 9.11 DO Coll Interim payments 9.12 DO Coll Interim payments 9.13 DO Coll Interim payments 9.14 DO Coll In	2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Frogram days 234 0 5.00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 0 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00	3.00					3. 00
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5.00 Program days	4.00	1	g program (see		0.00	4. 00
6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 17.00 Allowable bad debts (see instructions) 18.00 Adjusted reimbursable bad debts (see instructions) 19.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.01 Total (see instructions) 20.00 Interim payments 21.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 22.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,						
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15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 74,664 0 15.00 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 16.00 16.50 RURAL DEMONSTRATION PROJECT 0 16.50 17.00 Allowable bad debts (see instructions) 0 0 17.00 18.00 Adjusted reimbursable bad debts (see instructions) 0 0 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 0 18.00 19.00 Total (see instructions) 74,664 0 19.00 19.01 Sequestration adjustment (see instructions) 1,493 0 19.01 20.00 Interim payments 73,171 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 21 0 22.00 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00						
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17. 01 Adjusted reimbursable bad debts (see instructions) 18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 10. 01 Interim payments 20. 00 Interim payments 21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program line 19 minus lines 19. 01, 20 and 21 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,				0		
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19.00 Total (see instructions) 74,664 0 19.00 19.01 Sequestration adjustment (see instructions) 1,493 0 19.01 20.00 Interim payments 73,171 0 20.00 21.00 Tentative settlement (for contractor use only) 0 0 21.00 22.00 Balance due provider/program line 19 minus lines 19.01, 20 and 21 0 0 22.00 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00		1 3		0	0	
19.01 Sequestration adjustment (see instructions) 1, 493 20.00 Interim payments 21.00 Tentative settlement (for contractor use only) 22.00 Balance due provider/program line 19 minus lines 19.01, 20 and 21 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 19.01 20.00 21.00 21.00 22.00 23.00		9 ,	ctions)	0	0	
20.00 Interim payments 73,171 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 21 0 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.00 2 20.0	19. 00	Total (see instructions)		74, 664	0	19. 00
21.00 Tentative settlement (for contractor use only) 22.00 Balance due provider/program line 19 minus lines 19.01, 20 and 21 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 21.00 0 22.00 23.00	19. 01	Sequestration adjustment (see instructions)		1, 493	0	19. 01
22.00 Balance due provider/program line 19 minus lines 19.01, 20 and 21 0 22.00 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00	20.00	Interim payments		73, 171	0	20. 00
23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00	21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
	22. 00	Balance due provider/program line 19 minus lines 19.01, 20 and 2	21	0	0	22. 00
section 115.2	23. 00		e with CMS Pub. 15-2,	0	0	23. 00
		section 115.2				

Health Financial Systems	FAYETTE REGIONAL HEAL	LTH SYSTEM	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 150064 Component CCN: 15U064	From 10/01/2013	Date/Time Pre	pared:
				2/25/2015 10: 3	37 am_
		Title XIX	Swing Beds - SNF	PPS	

		component con. 150004	10 077 307 2014	2/25/2015 10:	
		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, column 3, line 200 for Part A		0		3. 00
	Part V, columns 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	program (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instr		0		6. 00
7. 00	Utilization review - physician compensation - SNF optional method	l only	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
40.00	professional services)				1.0.00
	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13. 00
14.00	for physician professional services)				14.00
	80% of Part B costs (line 12 x 80%)		0		14. 00 15. 00
15. 00 16. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
16. 00	RURAL DEMONSTRATION PROJECT		0		16. 50
17. 00	Allowable bad debts (see instructions)		0		17. 00
17. 00	Adjusted reimbursable bad debts (see instructions)		0		17. 00
18. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	i one)	0		18. 00
19. 00	Total (see instructions)	.1 0115)	0		19. 00
			0		19.00
19. 01	Sequestration adjustment (see instructions)		0		20. 00
20.00	Interim payments Tentative contractor use only)				20.00
21. 00 22. 00	,				21.00
22. 00	1 1 9				22.00
23.00	section 115.2	WI LII CMS PUD. 15-2,	١		23.00
	360 ti 0ii 113. Z		1		1

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150064	From 10/01/2013	
	Component CCN: 15506	4 10 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
	Title XVIII	Subprovi der -	PPS

			I PF		
			•	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)		881, 022	1. 00
2.00	Net IPF PPS Outlier Payments	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10, 138	2. 00
3.00	Net IPF PPS ECT Payments			0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost r	eport filed on or be	efore November	0. 00	4. 00
	15, 2004. (see instructions)	•			
4. 01	Cap increases for the unweighted intern and resident FTE count for program or hospital closure, that would not be counted without a t $\$412.424(d)(1)(iii)(F)(1)$ or (2) (see instructions)			0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)			0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the n	new program growth po	eriod of a "new	0. 00	6. 00
7 00	teaching program". (see inst.)			0.00	7.00
7. 00	Current year's unweighted I&R FTE count for residents within the n	iew program growth po	eriod of a new	0. 00	7. 00
8. 00	teaching program". (see inst.) Intern and resident count for IPF PPS medical education adjustment	(coo instructions)		0. 00	8. 00
9.00	Average Daily Census (see instructions)	(see mstructions)		3. 613699	9. 00
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the p	nower of 5150 -1\		0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	Jowel 01 . 3130 -13.		0.000000	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			891, 160	12. 00
13. 00	Nursing and Allied Health Managed Care payment (see instruction)			071, 100	13. 00
14. 00	Organ acquisition (DO NOT USE THIS LINE)			O	14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	15. 00
16. 00	Subtotal (see instructions)	3113)		891, 160	
17. 00	Pri mary payer payments			0	17. 00
18. 00	Subtotal (line 16 less line 17).			891, 160	
19. 00	Deducti bl es			62, 880	19. 00
20. 00	Subtotal (line 18 minus line 19)			828, 280	20. 00
21. 00	Coinsurance			24, 624	21. 00
22.00	Subtotal (line 20 minus line 21)			803, 656	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		0	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)			0	24. 00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		0	25. 00
26.00	Subtotal (sum of lines 22 and 24)			803, 656	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, li	ne 49)		0	27. 00
28. 00	Other pass through costs (see instructions)			0	28. 00
29. 00	Outlier payments reconciliation			0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30. 00
30. 99	Recovery of Accelerated Depreciation			0	30. 99
31. 00	Total amount payable to the provider (see instructions)			803, 656	31. 00
31. 01	Sequestration adjustment (see instructions)			16, 073	31. 01
32. 00	Interim payments			787, 580	32. 00
33. 00	Tentative settlement (for contractor use only)			0	33. 00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33			3	34.00
35. 00	Protested amounts (nonallowable cost report items) in accordance w	/ITN CMS Pub. 15-2, (cnapter 1,	0	35. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
50 00	Original outlier amount from Worksheet E-3, Part II, line 2			10, 138	50. 00
	Outlier reconciliation adjustment amount (see instructions)			10, 136	51. 00
52. 00	The rate used to calculate the Time Value of Money				52. 00
	Time Value of Money (see instructions)				53. 00
55. 00	1 Talias of money (acc filetiactions)		ı	١	00.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15006	From 10/01/2013	
	Component CCN: 1510	04 10 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
	Title XVIII	Subprovi der -	PPS

Not Federal PPS Payment (see instructions)		IRF		
PART III - MEDICARE PART A SERVICES - IRF PPS			4.00	
Net Federal PPS Payment (see Instructions)		DADT LLL MEDICADE DADT A CEDVICEC LDE DDC	1.00	
Medicare SSI ratio (IRF PPS only) (see instructions) 19,061 3.00 19,061 and 19.00 10.00 19,061 3.00 19,061 and 19.00 19,061 3.00 19,061 and 19,061 and 19.00 19,061 3.00 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 and 19,061 an	1 00		966 /13	1 00
Inpatient Rehabilitation LIP Payments (see Instructions) 19, 061 3.00				
2,731 4.00		, , , , , , , , , , , , , , , , , , , ,		
Unweighted Intern and resident FTE count in the most recent cost reporting period ending on or prior to to November 15, 20d (see instructions)		'		
to November 15, 2004 (see Instructions) 5.01 Cap increases for the unwel phted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under \$412.44(d)(1)(III)(FC)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unwelighted FTE count of 164 excluding FTEs in the new program growth period of a "new teaching program". (see inst.) 8.00 Current year's unwelighted FTE count of 164 excluding FTEs in the new program growth period of a "new teaching program". (see inst.) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Dail y Census (see instructions) 10.00 Average Dail y Census (see instructions) 10.00 Teaching Adjustment Factor (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment feactor (see instructions) 10.00 Teaching Adjustment feactor (see instructions) 10.00 Teaching Adjustment feactor (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00 Teaching Adjustment feactor (see instructions) 10.00 Deductiol (see instructions) 10.00 Teaching Adjustment (see inst				
5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under \$412.424(d)(1)(11)(F)(1) or (2) (see instructions)	0.00		0.00	0.00
Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payments Primary payer payme	5. 01		0.00	5. 01
6.00 New Teaching program adjustment. (see instructions) 0.00 6.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.				
2.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see inst.) See Inst.)		§412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
8.00 Larching program" (see inst.) 0.00 8.00 9.00 Incrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program". (see inst.) 0.00 9.00 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 11.00 Average Daily Gensus (see instructions) 2.331507 10.00 11.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00 Teaching Adjustment (see instructions) 888.205 13.00 13.00 Total PPS Payment (see instructions) 888.205 13.00 15.00 Total PPS Payment (see instructions) 0.14.00 15.00 16.00 Cost of physicians' services in a teaching hospital (see instructions) 0.0 15.00 17.00 Subtotal (see instructions) 18.00 18.00 19.00 Subtotal (see instructions) 888.205 17.00 19.00 Subtotal (line 17 less line 18). 888.205 19.00 20.00 Deductibles 13.312 20.00 20.00 Subtotal (6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
8.00 Current year's unwelghted IAR FTE count for residents within the new program growth period of a "new teaching program" (see inst.)	7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7.00
teaching program*. (see inst.) 0.00 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.				
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 10.00 Oxerage Daily Census (see instructions) 2.331507 1.00 10.00 12.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00 Teaching Adjustment (see instructions) 888,205 13.00 14.00 Nursing and Allied Heal th Managed Care payments (see instructions) 0 14.00 14.00 Oxor of physicians' services in a teaching hospital (see instructions) 0 16.00 15.00 Organ acquisit in (DO NOT USE THIS LINE) 15.00 16.00 16.00 Oxot of physicians' services in a teaching hospital (see instructions) 0 16.00 18.00 Primary payer payments 0 18.00 19.00 Subtotal (sine instructions) 888,205 17.00 19.00 Deductibles 13.312 20.00 21.00 Coinsurance 874,893 21.00 22.00 Coinsurance 9 22.00 23.00 Subtotal (line 21 minus line 22) 874,893 23.00 25.00 Adjusted relimbursable bad debts (see instructions) 9 <td>8. 00</td> <td></td> <td>0.00</td> <td>8. 00</td>	8. 00		0.00	8. 00
10. 00				
11.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00 Teaching Adjustment (see instructions) 0.000000 12.00 13.00 10.00 10.00 12.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00		, , , , , , , , , , , , , , , , , , ,	1	
12. 00 Teaching Adjustment (see instructions) 0 12. 00 Total PPS Payment (see instructions) 888, 205 13. 00 14. 00 15. 00 00 00 00 00 00 00 00		, , ,	1	
13. 00 Total PPS Payment (see instructions) 888, 205 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 0		, ,	1	
14. 00 Nursing and Ållied Health Managed Čare payments (see instruction) 0 14. 00 15. 00 Organ acquisition (D0 NOT USE THIS LINE) 15. 00 16. 00 Cost of physicians' services in a teaching hospital (see instructions) 888, 205 17. 00 17. 00 Subtotal (see instructions) 888, 205 17. 00 18. 00 Pimary payer payments 0 18. 00 19. 00 Subtotal (line 17 less line 18). 888, 205 19. 00 21. 00 Subtotal (line 19 minus line 20) 874, 893 21. 00 22. 00 Coinsurance 0 22. 00 23. 00 Subtotal (line 21 minus line 22) 874, 893 23. 00 24. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 25. 00 25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 25. 00 27. 00 Subtotal (sum of lines 23 and 25) 874, 893 27. 00 28. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 28. 00 29. 00 Other pass through costs (see instructions) 0 29. 00 31. 09		,	-	
15.00			1	
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Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150064	From 10/01/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2015 10:37 am

			lo 09/30/2014	2/25/2015 10:	
		Title XIX	Hospi tal	Cost	07 dill
		I II II AI A	Inpatient	Outpati ent	
			1. 00	2. 00	
P	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOES TON TITLES V ON XIT	COLINTOLO		
	Inpatient hospital/SNF/NF services		597, 692		1.00
	Medical and other services		377, 072	0	2. 00
1	Organ acquisition (certified transplant centers only)		0	O	3. 00
	Subtotal (sum of lines 1, 2 and 3)		597, 692	0	4. 00
1	Inpatient primary payer payments		377, 072	U	5. 00
	Outpatient primary payer payments		٩	0	6.00
	Subtotal (line 4 less sum of lines 5 and 6)		597, 692	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		397, 092	U	7.00
	Reasonable Charges				
	Routi ne servi ce charges		220 750		8. 00
1	•		338, 750	0	9. 00
	Ancillary service charges		613, 055	0	
	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		- Y	0	11.00
	Total reasonable charges (sum of lines 8 through 11)		951, 805	0	12. 00
_	CUSTOMARY CHARGES	<u>.</u>			40.00
	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	oasis			0	14 00
	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		0	0	14. 00
	Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
	Total customary charges (see instructions)		951, 805	0.000000	16. 00
	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	354, 113	0	17. 00
	line 4) (see instructions)	II Title to exceeds	334, 113	U	17.00
	Excess of reasonable cost over customary charges (complete only	if line 1 exceeds line	0	0	18. 00
	16) (see instructions)	II IIIle 4 exceeds IIIle	٩	Ü	16.00
	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
	Cost of covered services (enter the lesser of line 4 or line 16		597, 692	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			0	21.00
	Other than outlier payments	bilipreted for 113 provide	0	0	22. 00
	Outlier payments		0	0	23. 00
	Program capital payments		0	O	24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs			0	26. 00
	Subtotal (sum of lines 22 through 26)			0	27. 00
	Customary charges (title V or XIX PPS covered services only)			0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		597, 692	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		371, 072		27.00
_	Excess of reasonable cost (from line 18)		O	0	30. 00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		597, 692	0	31. 00
	Deductibles		377, 072	0	32.00
	Coi nsurance			0	33. 00
	Allowable bad debts (see instructions)			0	34. 00
	Utilization review		0	Ü	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	22)	597, 692	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	377, 072	0	37. 00
	Subtotal (line 36 ± line 37)		597, 692	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		377, 072	U	39. 00
			597, 692	0	40.00
	Total amount payable to the provider (sum of lines 38 and 39)			0	40.00
	Interim payments		1, 079, 357	0	
	Balance due provider/program (line 40 minus line 41)	o with CMS Dub 15 2	-481, 665	-	42.00
	Protested amounts (nonallowable cost report items) in accordanc chapter 1, §115.2	e with two Pub 15-2,	0	0	43. 00
Ic	Shaptor 1, 3110.2		1		ı

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 10/01/2013	Worksheet E-3
	Component CCN: 15SO64		
	Title XIX	Subprovi der -	

		THE MA	IPF		
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		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)		o	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		·		
	Reasonable Charges				
8.00	Routine service charges		75, 457		8.00
9. 00	Ancillary service charges		136, 559	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		212, 016	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
	basis	3			
14.00	Amounts that would have been realized from patients liable for p	ayment for services on	o	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	15. 00
16.00	Total customary charges (see instructions)		212, 016	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	212, 016	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	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	20. 00
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 co	mpleted for PPS provide			
	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review	0)	0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	0	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	,		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00	Interim payments		231, 168	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)	with CMC Dub 1E 2	-231, 168	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	WITH CMS PUB 15-2,	0	0	43. 00
	Jonaphier 1, 3110.2		ı		I

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 10/01/2013	Worksheet E-3 Part VII
	Component CCN: 15T064		
	Title XIX	Subprovi der -	Cost

		litle XIX	Subprovi der -	Cost	
			IRF	Outpotiont	
			I npati ent 1.00	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES EOD TITLES V OD VI		2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES TOR TITLES V OR ATA	N SERVICES		
1. 00	Inpatient hospital/SNF/NF services		45, 491		1. 00
2. 00	Medical and other services		43, 471	0	2. 00
3. 00	Organ acquisition (certified transplant centers only)			O	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		45, 491	0	4. 00
5. 00	Inpatient primary payer payments		10, 171	Ö	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		45, 491	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		127 111	-	
	Reasonable Charges				
8. 00	Routine service charges		75, 185		8. 00
9. 00	Ancillary service charges		0	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)		75, 185	0	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for p		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 42	CFR §413. 13(e)	0. 000000	0.000000	15. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0. 000000	
16. 00 17. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 14 eyeseds	75, 185 29, 694	0	16. 00 17. 00
17.00	line 4) (see instructions)	II Time to exceeds	29, 694	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
10.00	16) (see instructions)	TT TITLE T EXCECUS TITLE		o .	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		45, 491	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 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	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		45, 491	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		ol	0	30. 00
30. 00 31. 00	Excess of reasonable cost (from line 18)		45, 491	0	30.00
32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		45, 491	0	32.00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review			U	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	45, 491	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,3)	43, 471	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		45, 491	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		10, 171		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		45, 491	0	40. 00
41. 00	Interim payments		67, 978	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		-22, 487	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				

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

Provi der CCN: 150064 | Peri od: From 10/01/201:

| Period: | Worksheet G | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: 2/25/2015 10: 37 am

Ceneral Fund Specific Endowment Fund Plant Fit Purpose Fund 1.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00		37 am
CURRENT ASSETS	und	
CURRENT ASSETS		
1.00)	
2.00 Temporary investments	0	1.00
Notes receivable	0	
A. O. Accounts receivable 9, 176, 342 0 0 0 0 0 0 0 0 0	0	
Section State St	0	
All Owences for uncollectible notes and accounts receivable	0	
Prepaid expenses	0	
9.00 Other current assets 0 0 0 0 0 11.00 Other current assets (sum of lines 1-10) 11,002,396 0 0 0 11.00 Other mother funds 1,244,594 0 0 0 12.245,594 0 0 0 12.245,594 0 0 0 0 12.245,594 0 0 0 0 12.245,594 0 0 0 0 0 0 0 0 0	0	7. 00
10.00 Due from other funds	0	8. 00
11.00 Total current assets (sum of lines 1-10)	0	
FIXED ASSETS	0	1
12.00 Land	0	11. 00
13.00 Land improvements		
14.00 Accumulated depreciation 0 0 0 0 15.00 Buildings 55,418,067 0 0 0 0 16.00 Accumulated depreciation -54,202,007 0 0 0 0 0 0 0 0 0	0	1
15. 00 Buildings	0	
10. 0 Accumul atted depreciation -54, 202, 007 0 0 0 0 0 0 0 0 0	0	1
17.00 Leasehold improvements 0 0 0 0 0 18.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0	0	
18.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0	0	1
19.00 Fi xed equipment	0	
20.00 Accumul ated depreciation 0 0 0 0 0 0 0 0 0	0	
21.00 Automobiles and trucks 0 0 0 0 0 0 0 0 0	0	1
22. 00 Accumulated depreciation 0 0 0 0 0 0 0 0 0	0	1
23. 00 Maj or movable equi pment	0	
24. 00 Accumulated depreciation 0 0 0 0 0 0 0 0 0	0	
25. 00 Minor equipment depreciable 0 0 0 0 0 0 0 0 0	0	1
26. 00 Accumul ated depreciation	0	
27.00 HIT designated Assets 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	
29,00	0	27. 00
Total resets (sum of lines 12-29) 27, 839,716 0 0	0	28. 00
OTHER ASSETS 20, 462, 917 0 0 0 2 2 2 2 2 2 2	0	29. 00
31.00 Investments 20,462,917 0 0 0 0 0 0 0 0 0	0	30.00
32. 00 Deposits on leases		
33.00 Due from owners/officers 34.00 Other assets 1,291,899 0 0 35.00 Total other assets (sum of lines 31-34) 1754,816 0 0 10tal assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES 37.00 Accounts payable 38.00 Salaries, wages, and fees payable 1,450,661 39.00 Payroll taxes payable 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1
34.00 Other assets 1, 291, 899 0 0 0 0 0 0 0 0 0	0	
35.00 Total other assets (sum of lines 31-34) 21,754,816 0 0 0 0 0 0 0 0 0	0	33. 00
Total assets (sum of lines 11, 30, and 35)	0	
CURRENT LIABILITIES	0	1
37.00 Accounts payable 2,121,259 0 0 0 38.00 Sal aries, wages, and fees payable 1,450,661 0 0 0 0 0 0 0 0 0	0	36. 00
38.00 Salaries, wages, and fees payable 1,450,661 0 0 39.00 Payroll taxes payable 0 0 0 40.00 Notes and loans payable (short term) 0 0 0 41.00 Deferred income 0 0 0 42.00 Accelerated payments 0 0 0 43.00 Due to other funds 0 0 0 44.00 Other current liabilities 9 9,688,617 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 13,260,537 0 0 46.00 Mortgage payable 0 0 0 0 47.00 Notes payable 0 0 0 0 48.00 Unsecured loans 0 0 0 0 48.00 Unsecured loans 0 0 0 0 49.00 Other long term liabilities (sum of lines 46 thru 49 25,051,714 0 0 50.00 Total liabilites (sum of lines 45 and 50) 38,312,251 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 25,285,677 53.00 Specific purpose fund		
39.00 Payroll taxes payable 40.00 Notes and loans payable (short term) 0 0 0 41.00 Deferred income 42.00 Accelerated payments 43.00 Due to other funds 0 0 0 44.00 Other current liabilities 46.00 Total current liabilities 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 0 0 0 48.00 Unsecured loans 0 0 0 48.00 Total long term liabilities 25,051,714 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49 50.00 Total liabilites (sum of lines 45 and 50) 52.00 General fund balance 53.00 Specific purpose fund	0	1
40.00 Notes and Loans payable (short term) 41.00 Deferred income 42.00 Accelerated payments 43.00 Due to other funds Other current Liabilities 45.00 Notes and Loans payable (short term) 45.00 Other current Liabilities 46.00 Notes payable 46.00 Notes payable 46.00 Unsecured Loans 47.00 Notes payable 46.00 Unsecured Loans 47.00 Other long term Liabilities 48.00 Unsecured Loans 49.00 Other long term Liabilities 40.00 Oth	0	
41.00 Deferred income 42.00 Accelerated payments 43.00 Due to other funds 0 0 0 0 44.00 Other current liabilities 45.00 Deferred income 46.00 Other current liabilities (sum of lines 37 thru 44) 46.00 Deferred income 47.00 Notes payable 46.00 Unsecured loans 48.00 Unsecured loans 48.00 Unsecured loans 49.00 Other long term liabilities 40.00 Other long term liabilities (sum of lines 46 thru 49 other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50) 40.00 Other long term liabilities (sum of lines 45 and 50)	0	1
42.00 Accelerated payments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	
43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities 46.00 Total long term liabilities 47.00 Other long term liabilities 48.00 Unsecured loans 49.00 Other long term liabilities 49.00 Other long term liabilities 49.00 Total long term liabilities (sum of lines 46 thru 49 49.00 Other long term liabilities (sum of lines 46 thru 49 49.00 Other long term liabilities (sum of lines 46 thru 49 40.00 Total long term liabilities (sum of lines 45 and 50) 40.00 Total liabilites (sum of lines 45 and 50) 40.00 Specific purpose fund	U	42.00
44. 00 Other current liabilities 9, 688, 617 0 0 45. 00 Total current liabilities (sum of lines 37 thru 44) 13, 260, 537 0 0 LONG TERM LIABILITIES Value 0 0 0 46. 00 Mortgage payable 0 0 0 47. 00 Notes payable 0 0 0 48. 00 Unsecured loans 0 0 0 49. 00 Other long term liabilities 25, 051, 714 0 0 50. 00 Total long term liabilities (sum of lines 46 thru 49 25, 051, 714 0 0 51. 00 Total liabilities (sum of lines 45 and 50) 38, 312, 251 0 0 CAPITAL ACCOUNTS Ceneral fund balance 25, 285, 677 0 53. 00 Specific purpose fund 0 0	0	1
45.00 Total current liabilities (sum of lines 37 thru 44) 13, 260, 537 0 0 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 47.00 Notes payable 0 0 0 0 48.00 Unsecured loans 0 0 0 49.00 Other long term liabilities (sum of lines 46 thru 49 25, 051, 714 0 0 Total liabilities (sum of lines 45 and 50) 38, 312, 251 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 25, 285, 677 53.00 Specific purpose fund 0	0	1
LONG TERM LIABILITIES 46. 00 Mortgage payable 0 0 0 0 47. 00 Notes payable 0 0 0 0 48. 00 Unsecured Loans 0 0 0 49. 00 Other Long term Liabilities 25, 051, 714 0 0 50. 00 Total Long term Liabilities (sum of Lines 46 thru 49 25, 051, 714 0 0 51. 00 Total Liabilities (sum of Lines 45 and 50) 38, 312, 251 0 0 CAPITAL ACCOUNTS 52. 00 General fund balance 25, 285, 677 53. 00 Specific purpose fund 0	0	
46. 00 Mortgage payable 0 0 0 0 0 47. 00 Notes payable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<u>J</u>	1 .5. 55
47. 00 Notes payable 0 0 0 0 0 48. 00 Unsecured Loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	46. 00
48. 00 Unsecured Loans 0 0 0 0 49. 00 Other Long term Liabilities 25, 051, 714 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	
50.00 Total long term liabilities (sum of lines 46 thru 49 25,051,714 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	48. 00
51.00 Total Liabilites (sum of Lines 45 and 50) 38,312,251 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 25,285,677 53.00 Specific purpose fund 0	0	49. 00
CAPI TAL ACCOUNTS 52. 00 General fund balance 25, 285, 677 53. 00 Specific purpose fund 0	0	50.00
52. 00 General fund balance 25, 285, 677 53. 00 Speci fi c purpose fund 0	0	51.00
53.00 Specific purpose fund 0		
		52. 00
		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,	0	58. 00
replacement, and expansion	^	F0 00
59.00 Total fund balances (sum of lines 52 thru 58) 25,285,677 0 0 100 Total Liabilities and fund balances (sum of lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lines 51 and lin	0	1
60.00 Total liabilities and fund balances (sum of lines 51 and 63,597,928 0 0 59)	U	60.00
		1

STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 150064 Pe

0

0

0

Peri od: Worksheet G-1 From 10/01/2013

15.00

16.00

17.00

18.00

19.00

09/30/2014 Date/Time Prepared: 2/25/2015 10:37 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 29, 846, 878 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -4, 548, 260 2.00 3.00 Total (sum of line 1 and line 2) 25, 298, 618 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 00000 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 25, 298, 618 0 11.00 11.00 12.00 MI SC 12, 941 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 12, 941 18.00 Fund balance at end of period per balance 25, 285, 677 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 MI SC 12.00 13.00 13.00 14.00 0 14.00

0

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

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

			'	0 09/30/2014	2/25/2015 10:3	
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		5, 458, 322		5, 458, 322	1.00
2.00	SUBPROVI DER - I PF		2, 256, 477		2, 256, 477	2.00
3.00	SUBPROVI DER - I RF		1, 059, 924		1, 059, 924	3.00
4.00	SUBPROVI DER		C		0	4. 00
5.00	Swing bed - SNF		C		0	5. 00
6.00	Swing bed - NF		C		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSI NG FACILITY					8. 00
9.00	OTHER LONG TERM CARE		0 774 700		0 774 700	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		8, 774, 723		8, 774, 723	10. 00
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		2, 354, 889	I	2, 354, 889	11. 00
12. 00	CORONARY CARE UNIT		2, 334, 667		2, 334, 007	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	2, 354, 889		2, 354, 889	16. 00
	11-15)		2,001,007		2,00.,00,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		11, 129, 612		11, 129, 612	17.00
18.00	Ancillary services		12, 559, 147	55, 369, 310	67, 928, 457	18.00
19.00	Outpatient services		1, 626, 639	25, 098, 970	26, 725, 609	19.00
20.00	RURAL HEALTH CLINIC		C	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21.00
22. 00	HOME HEALTH AGENCY			846, 466	846, 466	
23. 00	AMBULANCE SERVICES		C	1, 121, 670	1, 121, 670	
24. 00	CMHC					24. 00
24. 10	CORF		C	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)			4/0 555	440 555	25. 00
26.00	HOSPI CE		4 7/7 00/	462, 555	462, 555	
27. 00	NON REIMBURSEABLE	Wkat	4, 767, 806 30, 083, 204		8, 503, 585	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to G-3, line 1)	WKSL.	30, 083, 204	86, 634, 750	116, 717, 954	28. 00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			59, 184, 471		29. 00
30.00	ADD (SPECIFY)		C			30. 00
31. 00	(6. 26)		C			31. 00
32. 00			C			32. 00
33.00			C			33.00
34.00			C			34.00
35. 00			C			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		C			37.00
38. 00			C			38. 00
39. 00			C			39. 00
40.00			C			40.00
41. 00	Total deductions (com of lines 27 42)		C			41.00
42.00	Total deductions (sum of lines 37-41)	+		0 104 471		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(to Wkst. G-3, line 4)	transfer		59, 184, 471		43. 00
	10 WKSt. U-3, TINE 4)			ı I	l	

Heal th	Financial Systems FAYETTE REGIONAL HEA	LTH SYSTEM	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150064	Peri od:	Worksheet G-3	
			From 10/01/2013	5	
			To 09/30/2014	Date/Time Pre 2/25/2015 10:	
				2/23/2013 10.	37 alli
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		116, 717, 954	1. 00
2. 00	Less contractual allowances and discounts on patients' accounts			66, 002, 203	
3.00	Net patient revenues (line 1 minus line 2)			50, 715, 751	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		59, 184, 471	1
5.00	Net income from service to patients (line 3 minus line 4)	-8, 468, 720			
	OTHER I NCOME			.,,	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other that	an patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			4, 506, 164	24. 00
24. 01	UNREALI ZED GAI N			83, 003	24. 01
24. 02	MI SC			7, 315	24. 02
05 00	T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			4 507 400	1 05 00

7, 315 24, 02 4, 596, 482 25, 00 -3, 872, 238 26, 00 676, 022 27, 00 676, 022 28, 00 -4, 548, 260 29, 00

24.02 MISC
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 UNREALIZED LOSS
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)

14.00 0 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 15.00 16.00 0 0 Ω 0 16 00 Respiratory Therapy 0 0 0 17.00 Private Duty Nursing C 17.00 18.00 0 0 18.00 0 19.00 Health Promotion Activities 0 0 0 19.00 0 0 20.00 Day Care Program Ω 20.00 0 21.00 Home Delivered Meals Program 0 0 21.00 Homemaker Service 0 0 0 22.00 All Others (specify) 23.00 0 23.00 0 0 0 24.00 | Total (sum of lines 1-23) -50.011 873.597 873.597 24.00

0

14.00

0

DMF

	Financial Systems		YETTE REGIONAL				u of Form CMS-	
COST A	ILLOCATION - HHA GENERAL SERVICE	E COST		Provi der HHA CCN:	CCN: 150064 157097	Peri od: From 10/01/2013 To 09/30/2014	Worksheet H-1 Part I Date/Time Pre 2/25/2015 10:	pared:
						Home Health	PPS	
			Canital Dal	atad Caata		Agency I		
			Capital Rel	ated Costs				
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equi pment	PI ant Operation & Mai ntenance		Subtotal (cols. 0-4)	
	Jackson acres acres acres	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	1 0	ol		T		0	1.00
1.00	Fixtures		J				O	1.00
2. 00	Capital Related - Movable Equipment	0		O			0	2. 00
3.00	Plant Operation & Maintenance	0	0	0		0	0	
4.00	Transportation Administrative and General	0	0	0	1	0 0	220 227	4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	320, 326	0	0	1	0 0	320, 326	5.00
6. 00	Skilled Nursing Care	293, 402	0	C		0 0	293, 402	6. 00
7.00	Physi cal Therapy	78, 819	o	0	1	0 0	78, 819	
8.00	Occupational Therapy	62, 704	0	0		0 0	62, 704	
9.00	Speech Pathology	12	0	0	1	0 0	12	
10. 00 11. 00	Medical Social Services Home Health Aide	31, 837 86, 497	0	0	1	0 0	31, 837 86, 497	
12. 00	Supplies (see instructions)	00, 497	o	0	1		00, 497	
13. 00	Drugs		- 1	0	1		0	
14.00	DME	0		0		0 0	0	1
	HHA NONREIMBURSABLE SERVICES							
	Home Dialysis Aide Services	0		0	•	0 0	0	
16.00	Respiratory Therapy Private Duty Nursing	0	0	0	I .	0 0	0	16. 00 17. 00
17.00	Clinic	0	0	0	•		0	18.00
	Health Promotion Activities	0	0	0	1		0	19. 00
20. 00	Day Care Program	0	Ö	0		0 0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21. 00
22. 00	Homemaker Service	0	0	0	1	0 0	0	22. 00
23. 00	All Others (specify)	0	0	0	1	0 0	072 507	20.00
24. 00	Total (sum of lines 1-23)	873, 597 Admi ni strati ve	Total (cols.	0	1	0 0	873, 597	24. 00
		& General	4A + 5)					
		5. 00	6.00					
	GENERAL SERVICE COST CENTERS	1						
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable Equipment							2. 00
3. 00	Plant Operation & Maintenance							3.00
4. 00	Transportation							4. 00
5.00	Administrative and General	320, 326						5. 00
	HHA REIMBURSABLE SERVICES	4/0.6/5	4/0 074					, ,,
6. 00 7. 00	Skilled Nursing Care Physical Therapy	169, 869 45, 634	463, 271 124, 453					6. 00 7. 00
7. 00 8. 00	Occupational Therapy	36, 304	124, 453 99, 008					8.00
9. 00	Speech Pathology	7	19					9. 00
10.00	Medical Social Services	18, 433						10.00

50, 270 136, 576 10.00 Medical Social Services 18, 433 50, 079 11.00 Home Health Aide 11.00 12.00 Supplies (see instructions) 0 0 0 12.00 0 Drugs 13.00 13.00 14.00 DME 14.00 HHA NONREIMBURSABLE SERVICES
Home Dialysis Aide Services
Respiratory Therapy 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 15.00 16.00 16.00 17.00 Private Duty Nursing 17.00 18.00 Clinic 18.00 19.00 19.00 Health Promotion Activities 20.00 20.00 Day Care Program 21.00 Home Delivered Meals Program 21.00 22.00 Homemaker Service 23.00 All Others (specify) 22.00 23.00 24.00 Total (sum of lines 1-23) 873, 597 24.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der CCN: 150064	Peri od: From 10/01/2013	Worksheet H-1 Part II
	HHA CCN: 157097	To 09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
		Home Health	PPS

							2/25/2015 10:	3/ am_
						Home Health Agency I	PPS	
		Capital Rel	ated Costs			/ rigeriey i		
		dapi tai ito	00010					
		BI dgs &	Movabl e	PI ant	Transportatio	nReconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
			(DOLLAR VALUE)	Mai ntenance	(22,102)		(ACCUM. COST)	
		(SQUINE FEET)	(BOLLAN WILDE)	(SQUARE FEET)			(71000111111111111111111111111111111111	
		1.00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	(0		3. 00
4.00	Transportation (see	0	0	(0		4.00
	instructions)							
5.00	Administrative and General	0	0	(0 -320, 326	553, 271	5. 00
	HHA REIMBURSABLE SERVICES							1
6.00	Skilled Nursing Care	0	0	(0 0	293, 402	6.00
7.00	Physical Therapy	0	0	(0 0	78, 819	7. 00
8.00	Occupational Therapy	0	0	(0 0	62, 704	8. 00
9.00	Speech Pathology	0	0	(0 0	12	9. 00
10.00	Medical Social Services	0	0	(0 0	31, 837	10.00
11.00	Home Health Aide	0	0	(0 0	86, 497	11. 00
12.00	Supplies (see instructions)	0	0	(0 0	0	12. 00
13.00	Drugs	0	0	(0	0	13.00
14.00	DME	0	0	(0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES				•			Ī
15.00	Home Dialysis Aide Services	0	0	(0 0	0	15. 00
16.00	Respiratory Therapy	0	0	(0 0	0	16. 00
17.00	Private Duty Nursing	0	0	(0 0	0	17. 00
18.00	Clinic	l 0	0	(0 0	0	18. 00
19.00	Health Promotion Activities	l 0	0	(0 0	0	19. 00
20.00	Day Care Program	l o	0	(0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0	Ċ		0 0	0	21. 00
22. 00	Homemaker Service	0	0	(0	0	22. 00
23. 00	All Others (specify)	1 0	o o	Ò		0	l ő	23. 00
24. 00	Total (sum of lines 1-23)	1 0	o o	Ò		0 -320, 326	553, 271	24. 00
25. 00	Cost To Be Allocated (per	1 0	l ő			0	320, 326	
20.00	Worksheet H-1, Part I)	Ĭ					525, 525	=0.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	0	0. 578968	26, 00
	1				1 2.23000	- I		

Peri od: Worksheet H-2
From 10/01/2013 Part I
To 09/30/2014 Date/Time Prepared: 2/25/2015 10: 37 am Provi der CCN: 150064 HHA CCN: 157097 Home Health PPS

						Agency I	PPS	
			CAPI TAL			/igency 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		190, 935	201, 393		42, 250	1. 00
2.00	Skilled Nursing Care	463, 271	0	0	463, 271	89, 128	0	
3.00	Physi cal Therapy	124, 453		0	124, 453		0	3. 00
4.00	Occupati onal Therapy	99, 008	0	0	99, 008		0	4. 00
5. 00	Speech Pathology	19		0	19		0	5. 00
6.00	Medical Social Services	50, 270	0	0	50, 270		0	6. 00
7. 00	Home Health Aide	136, 576	0	0	136, 576	26, 276	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12. 00
13.00	Private Duty Nursing	0	0	U	0	0	0	13.00
14.00	Clinic	0	0	U	0	0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	873, 597	10, 458	190, 935	1, 074, 990	206, 816	42, 250	
21. 00	Unit Cost Multiplier: column	0,0,0,,	107 100	.,0,,00	0. 000000		12, 200	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	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	6 decimal places.	PLANT	LINEN SERVICE				ADMI NI STRATI ON	
1 00	6 decimal places. Cost Center Description	PLANT 7. 01	LINEN SERVICE 8.00	9. 00	10. 00	11.00	ADMI NI STRATI ON 13. 00	1 00
1.00	6 decimal places. Cost Center Description Administrative and General	PLANT	LINEN SERVICE 8.00 5,798	9. 00 17, 498		11.00	ADMI NI STRATI ON 13. 00 48, 492	1.00
2.00	6 decimal places. Cost Center Description Administrative and General Skilled Nursing Care	PLANT 7. 01	8.00 5,798 0	9. 00	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 0	2. 00
2. 00 3. 00	6 decimal places. Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	PLANT 7. 01	LINEN SERVICE 8.00 5,798	9. 00 17, 498	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 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 5,798 0	9. 00 17, 498	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 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 5,798 0	9. 00 17, 498	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 0 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	8.00 5,798 0 0 0	9. 00 17, 498	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2.00 3.00 4.00 5.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	PLANT 7. 01	8. 00 5, 798 0 0 0 0 0	9. 00 17, 498	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	PLANT 7. 01	8. 00 5, 798 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0	10. 00	11.00	ADMI NI STRATI ON 13. 00 48, 492 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	8. 00 5, 798 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0	10. 00	11. 00 26, 488 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 5, 798 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0	10.00 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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
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 Home Dialysis Aide Services Respiratory Therapy	PLANT 7. 01	8. 00 5, 798 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 12.00 13.00	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	8.00 5,798 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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
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	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	PLANT 7. 01	8.00 5,798 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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
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 5, 798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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
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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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	8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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 All Others (specify)	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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	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	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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 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 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	EINEN SERVICE 8.00 5,798 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 17,498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 26, 488 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 48, 492 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.

From 10/01/2013 Part I 157097 09/30/2014 Date/Time Prepared: HHA CCN: 2/25/2015 10:37 am Home Health PPS Agency I Cost Center Description CENTRAL **PHARMACY** MEDI CAL Subtotal Intern & Subtotal Residents Cost SERVICES & RECORDS & LIBRARY **SUPPLY** & Post Stepdown Adjustments 14. 00 15. 00 16.00 24.00 25. 00 26.00 1.00 Administrative and General 0 12, 832 393, 497 393, 497 1.00 0 0 o 552, 399 552, 399 2 00 2 00 Skilled Nursing Care 3.00 Physical Therapy 0 0 0 148, 396 0 148, 396 3.00 4.00 Occupational Therapy 0 0000000000000000 0 118,056 0 0 0 0 0 0 0 0 0 0 0 0 0 118,056 4.00 Speech Pathology 0 5 00 Ω 5 00 23 23 59, 941 59, 941 6.00 Medical Social Services C 6.00 0 7.00 Home Heal th Aide 162, 852 162, 852 7.00 0 8.00 Supplies (see instructions) 0 8.00 0 0 9.00 0 0 9 00 Drugs 0 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 Respiratory Therapy 0 0 12.00 12.00 0 0 0 0 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 14.00 Health Promotion Activities 15.00 15.00 Day Care Program 0 0 0 16.00 16, 00 17.00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 18.00 19.00 All Others (specify) 0 0 O 0 19.00 20.00 Total (sum of lines 1-19) (2) 12, 832 1, 435, 164 1, 435, 164 20.00 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. Allocated HHA Cost Center Description Total HHA A&G (see Part Costs 27. 00 28. 00 1.00 Administrative and General 1.00 2.00 Skilled Nursing Care 208, 673 761, 072 2.00 3.00 Physical Therapy 56, 058 204, 454 3.00 Occupational Therapy 162, 652 4.00 44, 596 4.00 Speech Pathology 5 00 32 5 00 6.00 Medical Social Services 22,643 82, 584 6.00 7.00 Home Heal th Aide 61, 518 224, 370 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 0 9 00 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 Respiratory Therapy 0 0 0 12.00 12.00 0 Private Duty Nursing 13.00 13.00 0 14.00 Clinic 14.00 Health Promotion Activities 0 15.00 15.00 0 0 16.00 16.00 Day Care Program Home Delivered Meals Program 0 17.00 17 00 Homemaker Service 0 18.00 All Others (specify) 19.00 0 19.00 Total (sum of lines 1-19) (2) 393, 497 20.00 20.00 1, 435, 164 Unit Cost Multiplier: column 0. 377757 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⁾ 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	TH SYSTEM	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA BASIS		Provi der CCN: 150064 HHA CCN: 157097		Worksheet H-2 Part II Date/Time Prepared: 2/25/2015 10:37 am

Home Health Agency I CAPI TAL RELATED COSTS Reconciliation ADMINISTRATIVE **EMPLOYEE** OPERATION OF OPERATION OF Cost Center Description NEW BLDG & PI ANT FIXT **BENEFITS** & GENERAL PI ANT (SQUARE DEPARTMENT (ACCUM. (SQUARE (SQUARE FEET) (GROSS COST) FEET) FEET) SALARI ES) 1.00 5A 5.00 7. 00 7. 01 4.00 3, 913 751, 392 201, 393 3, 913 1.00 Administrative and General C 1.00 2.00 Skilled Nursing Care 0 463, 271 2.00 3.00 Physical Therapy 0 0 124, 453 3.00 000000000000000 0 Occupational Therapy 0 4.00 0 99,008 4.00 0 0 5.00 Speech Pathology 19 5.00 6.00 Medical Social Services 0 0 50, 270 0 0 0 0 0 0 6.00 7.00 Home Health Aide 0 0 0 136, 576 7.00 8.00 0 8.00 Supplies (see instructions) 0 0 9.00 Drugs 0 0 9.00 10.00 DMF 10.00 0 0 0 11.00 Home Dialysis Aide Services 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 13.00 0 0 14.00 Clinic 0 0 0 0 0 14.00 0 Health Promotion Activities 15.00 0 15.00 0 16.00 Day Care Program 16.00 0 0 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 18.00 18.00 All Others (specify) 0 0 0 19.00 19.00 20.00 Total (sum of lines 1-19) 3, 913 751, 392 1,074,990 3, 913 20.00 Total cost to be allocated 10, 458 190, 935 206, 816 42, 250 21.00 21.00 22.00 Unit cost multiplier 2 672630 0. 254108 0.192389 10.797342 0. 000000 22.00 LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG CENTRAL Cost Center Description CAFETERI A ADMINISTRATION LINEN SERVICE (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 3, 913 Administrative and General 33, 796 1,625 1.00 2.00 Skilled Nursing Care 0 C 2.00 3.00 Physical Therapy 0 000000000000000 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 0 7.00 Home Health Aide 7.00 0 8 00 0 0 O 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 0 11.00 0 0 Respiratory Therapy 0 12 00 12 00 13.00 Private Duty Nursing 0 13.00 0 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 15 00 0 0 15 00 0 0 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 ol 18.00 Homemaker Service 0 0 0 18.00 0 19 00 All Others (specify) 0 Ω O 0 19 00 20.00 Total (sum of lines 1-19) 1,924 3, 913 C 33, 796 1,625 20.00 26, 488 Total cost to be allocated 5, 798 17, 498 48, 492 21.00 22.00 Unit cost multiplier 3. 013514 4. 471761 0.000000 0. 783761 29. 841231 0.000000 22.00

ALLOCATION OF GENERAL SERVI	CE COSTS TO	HHA COST CENT	TERS STATISTICAL	Provi der	CCN: 150064		Worksheet H-2	2
BASIS				HHA CCN:	15709	7 From 10/01/2013 7 To 09/30/2014		
						Home Health Agency I	PPS	
Cost Center Des	scription	PHARMACY (100%)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00					
1.00 Administrative and G	oporal	15.00	846, 466					1, 00
2.00 Skilled Nursing Care		0	040, 400					2.00
3.00 Physical Therapy		0	0					3.00
4.00 Occupational Therapy		Ö	o					4.00
5.00 Speech Pathology		O	O					5. 00
6.00 Medical Social Servi	ces	0	O					6.00
7.00 Home Health Aide		0	O					7. 00
8.00 Supplies (see instru	ctions)	0	0					8. 00
9. 00 Drugs		0	0					9. 00
10. 00 DME		0	0					10.00
11.00 Home Dialysis Aide S	ervi ces	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 Act	ivities	0	0					15.00
16.00 Day Care Program	Drogrom	0	0					16.00
17.00 Home Delivered Meals 18.00 Homemaker Service	Program	0	0					17. 00 18. 00
19.00 All Others (specify)		0	0					19.00
20.00 Total (sum of lines	1_10)	0	846, 466					20.00
21.00 Total cost to be all		0	12, 832					21.00
22.00 Unit cost multiplier		0. 000000	0. 015159					22. 00

Heal th	Financial Systems	F.A	AYETTE REGIONAL	HEALTH SYSTE	M	In Lie	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150064	Peri od:	Worksheet H-3	
				HHA CCN:	157097	From 10/01/2013 To 09/30/2014		
				Ti t	le XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 + col.	
		0	1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00	4.00	5. 00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F	RUGRAW CUST, A	GGREGATE OF T	HE PROGRAM LIN	IIIAIION COSI, OF	X	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2. 00	761, 072		761, 0	72 4, 608	165. 16	1. 00
2.00	Physi cal Therapy	3.00	204, 454		0 204, 45	630	324. 53	2. 00
3.00	Occupational Therapy	4. 00			0 162, 65		338. 15	
4.00	Speech Pathology	5. 00				32 6		
5.00	Medical Social Services	6. 00			82, 58		,	
6.00	Home Health Aide	7. 00			224, 3			
7. 00	Total (sum of lines 1-6)		1, 435, 164		0 1, 435, 10			7. 00
			I		Program Vi si			
	Coot Contan Decemention	Coot limits	CDCA No. (1)	Downt A	Not Subject	art B to Subject to		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Deducti bl es			
					Coi nsurance			
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	•			·	_		
8.00	Skilled Nursing Care		17140	1	0 18	31		8. 00
8. 01	Skilled Nursing Care		99915	14	0 2, 48	39		8. 01
9.00	Physi cal Therapy		17140		•	10		9. 00
9. 01	Physi cal Therapy		99915	1	•			9. 01
10. 00	Occupational Therapy		17140		-	17		10. 00
10. 01	Occupational Therapy		99915	1	1			10. 01
11. 00	Speech Pathology		17140		0	0		11.00
11. 01	1 33		99915		0	5		11. 01
12.00	Medical Social Services Medical Social Services		17140 99915		0 2	2 21		12. 00 12. 01
12. 01 13. 00	Home Heal th Aide		17140		0 10			13. 00
13. 00			99915	2	-			13. 00
	Total (sum of lines 8-13)		77713	20	1			14. 00
11.00		From Wkst. H-2	Facility Costs		Total HHA		Ratio (col. 3	11.00
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)	,	
				Part II)				
	In	0	1. 00	2. 00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Computation Cost of Medical Supplies				ما		0.000000	15 00
	Cost of Medical Supplies	8. 00 9. 00			0	0 0		
10.00	Cost of brugs		Program Visits		Cost of	0 0	0.000000	16.00
			11 Ogram VI 31 t3		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	·		Deductibles &		k	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	DART COMPUTE STATE	6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PRUGRAM COST, A	GGREGATE OF T	HE PROGRAM LIN	TITATION COST, OF	К	
1 00	Cost Per Visit Computation	150	2 470		24.7	7.4 4.40 077		1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	150 17			24, 77 5, 5			1. 00 2. 00
3.00	Occupati onal Therapy	13						3. 00
3. 00 4. 00	Speech Pathology	0			4, 39	0 27		4.00
5.00	Medical Social Services	0				0 51, 336		5. 00
6. 00	Home Heal th Aide	20			7	· ·	1	6. 00
7. 00	Total (sum of lines 1-6)	200			35, 46		1	7. 00
			.,	•	/		. '	

near tr	ı Financial Systems	F.A	YETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-	2552-10
APPOR	FIONMENT OF PATIENT SERVICE COST	S		Provi der HHA CCN:	CCN: 150064 157097	Peri od: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Pre 2/25/2015 10:	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	37 aiii
	Cost Center Description	4.00	7.00	0.00	0.00		11 00	
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00
14.00	Total (suil of Titles 6-13)	Progi	ram Covered Cha	l arges	Cost of			14.00
		J		3	Servi ces			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8.00	9. 00	10.00	11. 00	
15 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations I						15. 00
	Cost of Drugs		12			0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OR	!	
1.00	Skilled Nursing Care	465, 751						1.00
2. 00 3. 00 4. 00 5. 00 6. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	110, 989 105, 503 27 51, 336 30, 405						2. 00 3. 00 4. 00 5. 00 6. 00
7.00	Total (sum of lines 1-6)	764, 011						7. 00
	Cost Center Description	12. 00						_
	Limitation Cost Computation	12.00						
8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-1							2552-10			
APPORT	APPORTIONMENT OF PATIENT SERVICE COSTS				Provi der	CCN: 150064	Peri od: From 10/01/20		Worksheet H-3	
					HHA CCN:	157097	To 09/30/20	014	Part II Date/Time Prep 2/25/2015 10:3	
					Ti tl	e XVIII	Home Health	า	PPS	
							Agency I			
	Cost Center Description	From Wkst. C,	Cost to Charge	Tot	tal HHA	HHA Shared	Transfer t	0		
		Part I, col.	Ratio	Char	ge (from	Ancillary	Part I as	;		
		9, line		pr	ovi der	Costs (col.	1 Indicated			
				re	cords)	x col. 2)				
		0	1. 00		2. 00	3.00	4. 00			
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	CES FURNI SHED B	SHA	RED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physi cal Therapy	66. 00	0. 551990		0		Ocol. 2, line	e 2.0	00	1.00
2.00	Occupational Therapy									2.00
3.00	Speech Pathology									3.00
4.00	Cost of Medical Supplies	71. 00	0. 500946		0		Ocol. 2, line	e 15.	. 00	4.00
5.00	Cost of Drugs	73. 00	0. 357525		0		Ocol. 2, line	e 16.	. 00	5.00

	Financial Systems FAYETTE REGIONAL HEAD				eu of Form CMS-	
LCULA	ITION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150064	Peri od: From 10/01/201	Worksheet H-4 3 Part I-II	
		HHA CCN:	157097	To 09/30/201	4 Date/Time Pre	
		Ti +I	e XVIII	Home Health	2/25/2015 10: PPS	37 an
		11 (1		Agency I		
					nrt B	
			Part A	Not Subject t Deductibles 8		
				Coi nsurance	Coinsurance	
			1.00	2. 00	3. 00	
+	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE	S			
	Reasonable Cost of Part A & Part B Services		Г	_T		١.
1	Reasonable cost of services (see instructions)				0	
00	Total charges Customary Charges			0	0 0	2.
00	Amount actually collected from patients liable for payment for	servi ces		0	ol o	3.
	on a charge basis (from your records)	JJ1 V1 003			اً ا	3.
00	Amount that would have been realized from patients liable for p	ayment		0	0 0	4.
	for services on a charge basis had such payment been made in ac					
.	with 42 CFR 413.13(b)			0.0000	0.000000	_
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	1 2		1
00 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (c	omnl ete		0	0 0	1
	only if line 6 exceeds line 1)	ompi e te			٥	'
00	Excess of reasonable cost over customary charges (complete only	ifline		0	0 0	8.
20	1 exceeds line 6)			0		
00	Primary payer amounts			Part A	0 0 Part B	9.
				Servi ces	Servi ces	
				1. 00	2.00	
					2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					1.0
. 00	Total reasonable cost (see instructions)				0 0	
. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0 0 2 525, 774	11
.00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				0 0 2 525, 774 0 5, 233	11 12
.00 .00 .00 .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0 0 2 525, 774 0 5, 233 0 21, 181	11 12 13
00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				0 0 2 525, 774 0 5, 233	11 12 13 14
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796	11 12 13 14 15
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0	11 12 13 14 15 16
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18
00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments				0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments	ance)			0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur	ance)		31, 17	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21
00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments	ance)			0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21 22
00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21)	ance)		31, 17	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 2, 719 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21 22 23
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	ance)		31, 17	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
00 0 00 0 00 0 00 0 00 0 00 0 00 0 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	ance)		31, 17	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Quitlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	ŕ		31, 17 31, 17 31, 17	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 26 27
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Quitlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	tructions)		31, 17 31, 17 31, 17	0 0 0 2 525, 774 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28.
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Dwgen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	tructions)		31, 17 31, 17 31, 17	0 0 0 2 525, 774 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29.
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions)		31, 17 31, 17 31, 17 31, 17	0 0 0 2 525, 774 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 30
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Dwgen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	tructions)		31, 17 31, 17 31, 17	0 0 0 2 525, 774 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30)	tructions)		31, 17 31, 17 31, 17 31, 17 31, 17	0 0 0 2 525, 774 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 31
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	tructi ons) 27)		31, 17 31, 17 31, 17 31, 17 31, 17 62	0 0 0 2 525, 774 0 5, 233 0 21, 181 0 4, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111, 122, 133, 144, 155, 166, 177, 188, 199, 200, 211, 222, 233, 244, 255, 266, 277, 288, 299, 300, 311, 311, 322, 324, 324, 324, 324, 324, 324, 324
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions) Interim payments (see instructions)	tructi ons) 27) 33		31, 17 31, 17 31, 17 31, 17 31, 17 62	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111. 122. 133. 144. 156. 177. 18. 199. 200. 211. 222. 233. 244. 255. 266. 277. 288. 299. 300. 311. 311. 323. 333. 344.

PROGRAM BENEFICIARIES

HHA CCN: 157097

ome Health	PPS
Agonov I	

				Agency I		
		I npati en	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		30, 548		548, 520	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
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			0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3.05
	Provider to Program	1				
3.50			0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0 0	3. 53 3. 54
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 54
3. 77	3. 50-3. 98)		U		ا	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		30, 548		548, 520	4. 00
00	(transfer to Wkst. H-4, Part II, column as appropriate,		00,0.0		0.107.020	00
	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)					
F 01	Program to Provider		0		0	F 01
5. 01			0			5. 01 5. 02
5. 02 5. 03			0			5. 02
5.03	Provider to Program		<u> </u>		0	5. 03
5. 50	1 ovi dei to 11 ogi dili		0		0	5. 50
5. 51			o o		l ol	5. 51
5.52			0		o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		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		1		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		11	6. 02
7. 00	Total Medicare program liability (see instructions)		30, 549	Contractor	548, 509	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
00		1	ļ		ı J	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	Period: Worksheet K		

Hospi ce CCN: 151548 To 09/30/2014 Date/Time Prepared: 2/25/2015 10:37 am 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 3.00 4.00 5. 00 2.00 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 0 4.00 0 0 0 5.00 Volunteer Service Coordination 0 0 5.00 79<u>,</u> 696 0 Administrative and General 0 6.00 0 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 46, 529 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 0 12.00 Physical Therapy 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 6, 187 0 16.00 Spiritual Counseling 0 0 0 16.00 Dietary Counseling 0 0 0 17.00 17.00 0 0 0 Counseling - Other 0 18.00 18.00 0 0 19.00 Home Health Aide and Homemaker 13, 316 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 0 22.00 23.00 Anal gesi cs 0 0 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 0 35.00 0 0 Bereavement Program Costs 0 35.00 0 36.00 Volunteer Program Costs 0 0 0 36.00 0 37.00 Fundrai si ng 0 0 0 0 37.00 0 0

0

66, 032

0

38.00

0

79, 696 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-2552-1			
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS					
		From 10/01/2013			

			Hospi ce		To 09/30/2014		pared: 37 am
					Hospi ce I		
		Total (cols.	Recl assi fi cati	Subtotal (col.	Adjustments	Total (col. 8	
		1-5)	on	6 ± col . 7)		± col. 9)	
	T	6. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS		1		T	1	1
1. 00	Capital Related Costs-Bldg and Fixt.	0	C		0	0	
2. 00	Capital Related Costs-Movable Equip.	0	C)	0	0	
3. 00	Plant Operation and Maintenance	0)	0	0	
4.00	Transportation - Staff	0) (0	0	1
5. 00	Volunteer Service Coordination	0	C		0	0	
6.00	Administrative and General	79, 696	C	79, 696	6 0	79, 696	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0					
8.00	Inpatient - Respite Care	0) () 0	0	8. 00
0.00	VI SI TI NG SERVI CES			\			0.00
9.00	Physician Services	44 530	_		1	_	
10.00	Nursing Care	46, 529		1	9	46, 529	1
11.00	Nursing Care-Continuous Home Care		0		0	0	
12. 00 13. 00	Physical Therapy				0	0	
14. 00	Occupational Therapy				0	0	14.00
	Speech/ Language Pathology Medical Social Services	6, 187		6, 18	7	6, 187	
16. 00	Spiritual Counseling	0, 107		0, 10,		0, 187	1
17. 00	Dietary Counseling					0	17.00
18. 00	Counseling - Other						18.00
19. 00	Home Health Aide and Homemaker	13, 316		13, 316		13, 316	1
20. 00	HH Ai de & Homemaker - Cont. Home Care	13,310		13, 310		13,310	20.00
21. 00	Other					0	1
21.00	OTHER HOSPICE SERVICE COSTS			/	<u> </u>	0	21.00
22. 00	Drugs, Biological and Infusion Therapy				0	0	22. 00
23. 00	Anal gesi cs				-	j o	23. 00
24. 00			1			,	24. 00
25. 00	Other - Specify		1			o o	25. 00
26. 00	Durable Medical Equipment/Oxygen		1			o o	26. 00
27. 00	Pati ent Transportation	0	1		o o	Ō	27. 00
	Imaging Services	0	1		o o	Ō	28. 00
29. 00	Labs and Diagnostics	0			0	o	29. 00
	Medical Supplies	0			0	o	30.00
31. 00	Outpatient Services (including E/R Dept.)	0			0	0	31.00
32.00	Radiation Therapy	0	1		ol o	0	32. 00
33. 00	Chemotherapy	0			0	0	1
34. 00	Other	0			0	0	1
	HOSPICE NONREIMBURSABLE SERVICE		<u> </u>	1	<u>'</u>		1
35.00	Bereavement Program Costs	0	C) (0	0	35. 00
36.00	Volunteer Program Costs	0	C		o	0	36. 00
37.00		0	() (0	0	1
38. 00	Other Program Costs	0	C) (0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	145, 728	(145, 728	0	145, 728	39. 00

			nospi ce (JON. 151546	0 09/ 30/ 2014	2/25/2015 10:	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces			
		1.00	2. 00	3. 00	4. 00	5. 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	0	0	1		0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6. 00	Administrative and General	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	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0			0	9. 00
10. 00	Nursing Care	0	0		0	46, 529	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12. 00	Physi cal Therapy	0	0	1	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	6, 187	1	0	15. 00
16. 00	Spiritual Counseling	0	0	(1	0	16. 00
17. 00		0	0	(-	0	17. 00
18. 00	Counseling - Other	0	0		0	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	0	20. 00
21. 00	Other	0	0	(0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	T		Т	T		
22. 00	Drugs, Biological and Infusion Therapy						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	Pati ent Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0			0	28. 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	(7	0	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	1 (0	0	34. 00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE		^	,	J	^	25.00
35. 00	Bereavement Program Costs	0	0		0	0	35. 00
36. 00 37. 00	Volunteer Program Costs		0]	0	0	36. 00 37. 00
37.00	Fundrai si ng		0			0	37.00
	Other Program Costs Total (sum of lines 1 thru 38)		0	6, 18	7 0	46, 529	
39.00	Total (Sum Of Titles I till 0 30)	١	U	J 0, 18	'I 이	40, 529	1 39.00

Health Financial Systems	FAYETTE REGIONAL HEAL	TH SYSTEM		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der CCN:	150064	Peri od: From 10/01/2013	Worksheet K-1
		Hospice CCN:	151548		Date/Time Prepared

			Hospi ce CCN	: 151548 To	09/30/2014	Date/Time Prepared: 2/25/2015 10:37 am
					Hospi ce I	2/23/2013 10:3/ dill
		Total	Ai des	All-Other	Total (1)	
		Therapi sts			` ′	
		6. 00	7. 00	8. 00	9. 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		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	6. 00
	I NPATI ENT CARE SERVI CE					
7. 00	Inpatient - General Care		0	0	0	7. 00
8.00	Inpatient - Respite Care		0	0	0	8. 00
	VI SI TI NG SERVI CES					
9.00	Physi ci an Servi ces		0	0	0	9. 00
10. 00	Nursing Care		0	0	46, 529	10.00
11. 00	Nursing Care-Continuous Home Care		0	0	0	11.00
12. 00	Physical Therapy	0	0	0	0	12. 00
13. 00	Occupational Therapy	0	0	0	0	13. 00
	Speech/ Language Pathol ogy	0	0	0	0	14. 00
	Medical Social Services		0	0	6, 187	15. 00
	Spiritual Counseling		0	0	0	16.00
	Di etary Counseling		0	0	0	17. 00
	Counseling - Other		10 01	0	10.01	18. 00
19. 00	Home Health Aide and Homemaker		13, 316	0	13, 316	19. 00
	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21. 00	OTHER HOSPICE SERVICE COSTS		U	0	U	21. 00
22. 00	Drugs, Biological and Infusion Therapy		<u> </u>		T	22. 00
	Anal gesics				ł	23. 00
24. 00	Sedatives / Hypnotics					24. 00
	Other - Specify					25. 00
26. 00	Durable Medical Equipment/Oxygen					26. 00
	Patient Transportation			0	0	27. 00
	Imaging Services			0	0	28. 00
	Labs and Diagnostics		0	0	0	29. 00
30. 00	Medical Supplies		0	0	0	30.00
	Outpatient Services (including E/R Dept.)		o o	0	0	31.00
32. 00	Radi ati on Therapy		0	0	0	32.00
33. 00	Chemotherapy		o	0	0	33. 00
34. 00	Other		o	0	0	34.00
51.50	HOSPI CE NONREI MBURSABLE SERVI CE		<u> </u>	0	<u> </u>	34.00
35. 00	Bereavement Program Costs		0	0	0	35. 00
	Volunteer Program Costs		o	Ö	n	36.00
	Fundrai si ng		ő	Ö	0	37. 00
38. 00	Other Program Costs		ol	Ö	o	38. 00
	Total (sum of lines 1 thru 38)	0	13, 316	O	66, 032	39. 00
	1	-1		-1		1

| Provider CCN: 150064 | Period: From 10/01/2013 | Part | Part |
| Hospice CCN: 151548 | To 09/30/2014 | Date/Time Prepared: | Health Financial Systems

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

NET EXPENSES FOR COST SUIL DINGS & FIXTURES CAPITAL RELATED COST				nospi ce c	CN. 131346	10 09/30/2014	2/25/2015 10:	
CENTERAL SERVICE COST CENTERS						Hospi ce I	2, 20, 2010 101	<u> </u>
NET EXPENSES FOR COST FIXTURES COUPMENT OPERATION & PLANT OPERATION & PLAN				CAPLTAL RE	LATED COST	110001.00		
FOR COST ALLOCATION OPERATION & MAINT.				ON TIME RE	LITTED COOT			
FOR COST ALLOCATION OPERATION & MAINT.			NET EXPENSES	BIILLDINGS &	MOVARIE	DI ΔΝΤ	TRANSPORTATION	
ALLOCATION ANAINT. ALLOCATION BANKIT. ALLOCATION ALLOCATIO					-		THANSI OKTATION	
CEMERAL SERVICE COST CENTERS				TIXTURES	LQUITWLINI			
CEMERAL SERVICE COST CENTERS				1 00	2.00		4 00	
1.00		CENEDAL CEDVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
2.00	1 00				I			1 00
1.00			0	U				
4.00			0					
5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0			0	ū		-	l .	1
Administrative and General 79,696 0 0 0 0 0 0 0 0 0			0	O		-	1	
INPATIENT CARE SERVICE			0	-				
Inpatient - General Care	6. 00		79, 696	0		0 0) 0	6. 00
Inpatient - Respite Care								
VISITING SERVICES	7.00	Inpatient - General Care	0	0				7. 00
9,00 Physician Services	8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
10. 00 Nursing Care		VISITING SERVICES						
11. 00 Nursing Care-Continuous Home Care	9.00	Physi ci an Servi ces	0	0		0 0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 19.00 Other 0 0 0 0 0 19.00 Other Other 0 0 0 0 0 19.00 Other	10.00	Nursi ng Care	46, 529	0		0 0	0	10. 00
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 15.00 Medical Social Services 6,187 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 19.00 Other 0 0 0 0 0 19.00 Other Other 0 0 0 0 0 19.00 Other	11. 00	Nursing Care-Continuous Home Care	o	0		0 0	ol o	11.00
13.00			0	0		0		1
14. 00 Speech Language Pathology 0 0 0 0 0 14. 00			0	0		0		
15.00 Medical Social Services 6, 187 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling 0 0 0 0 0 18.00 Counseling 0 0 0 0 0 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 19.00 Hill Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21.00 Other 0 0 0 0 0 22.00 Other 0 0 0 0 0 22.00 Other 0 0 0 0 0 23.00 Anal gesics 0 0 0 0 0 24.00 Seadtives / Hypnotics 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 27.00 Patient Transportation 0 0 0 0 28.00 Labs and Diagnostics 0 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 0 31.00 Other Services (including E/R Dept.) 0 0 0 0 32.00 Other Services (including E/R Dept.) 0 0 0 0 33.00 Other Services (Including E/R Dept.) 0 0 0 0 34.00 Other Services (Including E/R Dept.) 0 0 0 0 35.00 Bereavement Program Costs 0 0 0 0 36.00 Volunteer Program Costs 0 0 0 0 37.00 Other Program Costs 0 0 0 0 38.00 Other Program Costs 0 0 0 0 38.0				-				1
16.00 Spiritual Counseling 0 0 0 0 0 0 16.00 17.00 Diletary Counseling 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 18.00 19.00 Home Health Aide and Homemaker 13,316 0 0 0 0 0 19.00 Hill Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 22.00 Other Service Costs 20.00 Other Specify 0 0 0 0 0 23.00 Other - Specify 0 0 0 0 0 24.00 Other - Specify 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 26.00 Unrable Medical Equipment/Oxygen 0 0 0 0 0 27.00 Patient Transportation 0 0 0 0 0 28.00 Imaging Services 0 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 0 30.00 Medical Supplies 0 0 0 0 0 31.00 Other Services (including E/R Dept.) 0 0 0 0 32.00 Other Services 0 0 0 0 0 33.00 Other Borner MBURSABLE SERVICE Bereavement Program Costs 0 0 0 0 0 36.00 Other Program Costs 0 0 0 0 37.00 Other Program Costs 0 0 0 0 38.00 Other Program Costs 0 0 0			6 197	O				
17.00 Di etary Counseling 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 18.00 19.00 Home Healt h Aide and Homemaker 13,316 0 0 0 0 0 20.00 HI Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 21.00 Other Other Other Other Other Other Other Other 22.00 DTHER HOSPICE SERVICE COSTS Other Ot		· ·	0, 107	-		-	1	
18.00			0	-				1
19.00 Home Heal th Ai de and Homemaker 13,316 0 0 0 0 0 0 0 0 0			0	0				
20.00			12 214	0		-	ή	
21.00 Other O O O O O O O O O		1	13, 310	· ·				
DTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy O O O O O O O O O		4	0					
22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesics 0 0 0 0 0 0 23. 00 24. 00 Sedati ves / Hypnotics 0 0 0 0 0 0 24. 00 25. 00 Other - Speci fy 0 0 0 0 0 0 25. 00 26. 00 Durable Medi cal Equi pment/0xygen 0 0 0 0 0 0 0 25. 00 26. 00 Pati ent Transportation 0 0 0 0 0 0 0 0 0 0 26. 00 27. 00 Pati ent Transportation 0 0 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 30. 00 Medi cal Suppli es 0 0 0 0 0 0 0 0 0 0 0 0 <td>21.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>) 0</td> <td>21.00</td>	21.00		0	0		0 0) 0	21.00
23.00 Anal gesics					1			
24.00 Sedatives / Hypnotics 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26.00 27.00 Patient Transportation 0 0 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 0 28.00 0 0 0 0 0 28.00 0 0 0 0 0 28.00 0 0 0 0 0 0 28.00 0 0 0 0 0 28.00 0 0 0 0 0 28.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	-		-	1	
25.00 Other - Specify 0 0 0 0 0 0 25.00			0	0				
26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 26.00 27.00 Patient Transportation 0 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 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
27.00 Patient Transportation 0 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 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td>25. 00</td> <td>' '</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>) 0</td> <td>25. 00</td>	25. 00	' '	0	0		0 0) 0	25. 00
28.00 Imaging Services 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 0 32.00 34.00 Other 0 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 0 34.00 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 0 0 0 0 0 0 37.00 0 0 0 0 <td< td=""><td>26.00</td><td>Durable Medical Equipment/Oxygen</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>26. 00</td></td<>	26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26. 00
29.00 Labs and Diagnostics 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other HOSPICE NONREIMBURSABLE SERVICE 8 8 0 0 0 0 0 0 35.00 35.00 Bereavement Program Costs 0 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 0 0 0 0 0	27. 00	Patient Transportation	0	0		0 0	0	27. 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 Radiation Therapy 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE	28.00	I maging Services	0	0		0 0	0	28. 00
31.00 Outpati ent Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radi ati on Therapy 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 0 0 0 38.00	29.00	Labs and Diagnostics	0	0		0 0	0	29. 00
31.00 Outpati ent Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radi ati on Therapy 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 0 0 0 0 38.00	30.00	Medical Supplies	o	0		0 0	0	30. 00
Radiation Therapy 0 0 0 0 0 32.00	31.00		o	0		0 0	0	31.00
33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs 0 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 0 38. 00		, , , , , , , , , , , , , , , , , , , ,	0	0		0	ol o	32, 00
34. 00 Other O O O O O O O O O O O O O O O O O O O			0	0		0		33 00
HOSPICE NONREIMBURSABLE SERVICE		1	0	0				
35.00 Bereavement Program Costs 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 0 38.00	01.00		<u> </u>				,ı	0 00
36.00 Volunteer Program Costs 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00	35 00		ام	0		0		35 00
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00								1
38.00 Other Program Costs 0 0 0 0 38.00				-	•			
				-	ł			
			145 700	0				
39.00 Total (sum of lines 1 thru 38) 145,728 0 0 0 39.00	37.00	Tiotai (Suiii Oi Titlies T till u So)	140, 728	U	I	o _l	'I U	J 37. UU

| Provider CCN: 150064 | Period: From 10/01/2013 | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part |

			Hospi ce (CN: 151548 1	0 09/30/2014	2/25/2015 10:37 am
					Hospi ce I	272372013 10.37 4111
		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	79, 696	79, 696		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
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0		1	0	9. 00
10. 00	Nursi ng Care	0	46, 529	56, 158	102, 687	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 3	0	C	0	0	14.00
	Medical Social Services	0	6, 187	7, 467	13, 654	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	18. 00
19. 00	Home Health Aide and Homemaker	0	13, 316	16, 071	29, 387	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	20.00
21. 00	Other	0) 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	1			0	22.00
22. 00	Drugs, Biological and Infusion Therapy	0			0	22. 00
23. 00	Anal gesi cs		C	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			1	0	32.00
33. 00	Chemotherapy		_	-	0	33.00
34. 00	Other		_	-	0	34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE			,	O _I	34.00
35. 00	Bereavement Program Costs	1 0		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)		145, 728		145, 728	
57.50	1.111. (11 0. 1 0. 1 0.)	1	1, , 20	T	, , 20	1 07.00

CAPITAL RELAYED COST							2/25/2015 10:	37 am_
BUILDINGS & FIXTRES (SO. VALUE) COUPLENT (SO. MAINT (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATOR (MILEAGE) COORDINATO						Hospi ce I		
FIXTURES (SQ) FOUNDAMENT (SQ) FOUNDAMENT (SQ) FOUNDAMENT (SQ) FOUNDAMENT (FOUNDAMENT)			CAPITAL RE	LATED COST				
FIXTURES (SQ) FOUNDAMENT (SQ) FOUNDAMENT (SQ) FOUNDAMENT (SQ) FOUNDAMENT (FOUNDAMENT)								
FT. VALUE			BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
CONTRIBUTION CONTRIBUTION CONTRIBUTION CHOICE			FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
CENERAL SERVICE COST CENTERS					MAINT. (SO.	, ,		
CENERAL SERVICE COST CENTERS			,					
CEMERAL SERVICE COST CENTERS			1 00	2 00		4 00		
1.00		GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	00	0.00	
2.00	1 00							1 00
Plant Operation and Maintenance								
4.00								
S. 00			0					
Administrative and General 0 0 0 0 0 0 0 0 0			0				0	
INPATIENT CARE SERVICE			0		1			1
Inpatient - General Care	6.00		0		1	0 0	0	6.00
Inpatient - Respite Care			1		1			
VISITING SERVICES			1	1	1			
9,00 Physician Services	8. 00		0	0		0 0	0	8.00
10.00 Nursing Care								
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 12.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 17.00 18.00 Counseling 0 0 0 0 0 0 0 17.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 19.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 0 19.00 Other	9. 00	Physi ci an Servi ces	0	0)	0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 13.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 17.00 Dietary Counseling 0 0 0 0 0 0 15.00 17.00 Dietary Counseling 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 18.00 19.00 Home Health Aide and Homemaker 0 0 0 0 0 0 19.00 19.00 Hid Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 21.00 19.00 Other 0 0 0 0 0 0 0 21.00 19.00 Other Ot	10.00		0	0	l .		0	10. 00
13.00	11.00	Nursing Care-Continuous Home Care	0	0)	0	0	11. 00
14.00 Speech/ Language Pathology 0 0 0 0 0 0 14.00	12.00	Physi cal Therapy	0	0)	0	0	12. 00
15.00 Medical Social Services 0 0 0 0 0 15.00	13.00	Occupational Therapy	0	0	1	0	0	13. 00
15.00 Medical Social Services 0 0 0 0 0 0 15.00	14.00		0	l)	0	0	14. 00
16.00 Spiritual Counseling 0			0	0	,	0	0	15. 00
17. 00 Di etary Counsel ing 0			0	1				
18. 00 Counseling - Other 0 0 0 0 0 18. 00 19. 00 Home Heal th Aid de and Homemaker 0 0 0 0 0 0 20. 00 HH Aid de & Homemaker - Cont. Home Care 0 0 0 0 0 21. 00 Other 0 0 0 0 0 21. 00 Other 0 0 0 0 0 22. 00 Other 0 0 0 0 23. 00 Orther Orther Orther Orther Orther 22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 0 25. 00 Other - Specify 0 0 0 0 0 26. 00 Ourable Medical Equipment/Oxygen 0 0 0 0 27. 00 Patient Transportation 0 0 0 0 28. 00 Imaging Services 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 30. 00 Medical Supplies Orther Orther Orther 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 32. 00 Radi ation Therapy 0 0 0 0 33. 00 Other Orther Orther Orther Orther HOSPICE NONEI MBURSABLE SERVICE Orther Orther Orther Orther Orther HOSPICE NONEI MBURSABLE SERVICE Orther Orth			1 0	l o				
19. 00 Home Heal th Ai de and Homemaker			0	٥				
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0					1			
21.00 Other			0	l ~		-	-	
OTHER HOSPICE SERVICE COSTS			0		1			
22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesics 0 0 0 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 0 0 0 22. 00 25. 00 Other - Specify 0 0 0 0 0 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 26. 00 28. 00 Imaging Services 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>21.00</td> <td></td> <td>0</td> <td></td> <td>1</td> <td>0</td> <td>0</td> <td>21.00</td>	21.00		0		1	0	0	21.00
23. 00	22.00				ı		0	22 00
24. 00			0	1	1			
25. 00 Other - Specify 0 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 25. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 27. 00 28. 00 Labs and Diagnostics 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 29. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1			
26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1	1			
27.00			0	0	1			
28.00 Imaging Services 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 30.00 Medical Supplies 0 0 0 0 0 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 32.00 Radiation Therapy 0 0 0 0 33.00 Chemotherapy 0 0 0 0 34.00 Other 0 0 0 0 HOSPICE NONREI MBURSABLE SERVICE 0 0 0 0 35.00 Sereavement Program Costs 0 0 0 0 36.00 Volunteer Program Costs 0 0 0 0 37.00 Fundraising 0 0 0 0 38.00 Other Program Costs 0 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 O			0	0	1	-		
29.00 Labs and Diagnostics 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 34.00 400 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 0 0 0 0 35.00 35.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundrai sing 0 0 0 0 0 0 0 0 0 0 37.00 0 0 0 0			0	1				
30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 0 0 33.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00	I maging Services	0	0)	0	0	28. 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 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00	Labs and Diagnostics	0	0)	0	0	29. 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 0 HOSPICE NONREIMBURSABLE SERVICE	30.00	Medical Supplies	0	0	1	0	0	30. 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 0 HOSPICE NONREIMBURSABLE SERVICE	31.00	Outpatient Services (including E/R Dept.)	0)	0	0	31.00
33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 0 39.00	32.00		0	l 0)	0	0	32. 00
34.00 Other O O O O O O O O O O O O O O O O O O O		1 3	0	0	,	0	0	33.00
HOSPICE NONREIMBURSABLE SERVICE		1	0	1				
35.00 Bereavement Program Costs 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 39.00	01.00				1	<u> </u>		01.00
36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 39.00	35 00		0	0		0	n	35 00
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 39.00				1	1			
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					1	-	-	
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 39.00					1			
						ا ا	-	
40.00 junit cost martipiter 0.000000 40.00 0.000000 0.0000000 0.000000 0.000000 40.00			0.000000	0 000000		ا ا		
	40.00	Joint Cost Multipitel	1 0.000000	J 0. 000000	J 0.00000	U _I U. UUUUUU	0. 000000	I 40.00

Hospi ce CCN:

				Hooni oo I	2/25/2015 1	U: 37 alli
		DECONCLL LATION	ADMI NI CTDATI VE	Hospi ce I		
		RECONCI LI ATI ON				
			& GENERAL			
		/ A	(ACC. COST)			
	CENEDAL CEDALCE COCT CENTERS	6A	6. 00			
1 00	GENERAL SERVICE COST CENTERS		1			1.00
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	-79, 696	66, 032			6. 00
	I NPATI ENT CARE SERVI CE					
7. 00	Inpatient - General Care	0	0			7. 00
8.00	Inpatient - Respite Care	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	46, 529			10.00
11. 00	Nursing Care-Continuous Home Care	0	0			11. 00
12.00	Physi cal Therapy	0	0			12.00
13.00	Occupational Therapy	0	0			13. 00
14.00	Speech/ Language Pathology	O	o			14. 00
15.00	Medical Social Services	o	6, 187			15. 00
16.00	Spiritual Counseling	o	ol			16. 00
17. 00		o	ol			17. 00
18. 00	Counseling - Other	o	ol			18. 00
19. 00	Home Health Aide and Homemaker	o	13, 316			19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0			20.00
21. 00	Other	0	o			21. 00
	OTHER HOSPICE SERVICE COSTS		-1			
22. 00	Drugs, Biological and Infusion Therapy	0	0			22. 00
23. 00	Anal gesi cs	0	o			23. 00
24. 00	Sedatives / Hypnotics	0	0			24. 00
25. 00	Other - Specify	0	o			25. 00
26. 00	Durable Medical Equipment/Oxygen		Ö			26. 00
27. 00	Patient Transportation		0			27. 00
28. 00	Imaging Services		0			28. 00
29. 00	Labs and Diagnostics		0			29. 00
30. 00	Medical Supplies		0			30.00
31. 00	Outpatient Services (including E/R Dept.)		0			31.00
32. 00	Radi ati on Therapy	0	0			32.00
		0	0			33.00
33.00	Chemotherapy	0				
34. 00	Other	ı oj	0	 		34. 00
25.00	HOSPI CE NONREI MBURSABLE SERVI CE		2			25.00
35. 00	Bereavement Program Costs	0	0			35. 00
36.00	3	0	0			36. 00
37. 00		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)		79, 696			39. 00
40. 00	Unit Cost Multiplier	1	1. 206930			40. 00

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

						2/25/2015 10:	37 am
					Hospi ce I		
			CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Hospice Trial	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		Bal ance (1)	FLXT	BENEFITS		& GENERAL	
				DEPARTMENT			
		0	1.00	4. 00	4A	5. 00	
1.00	Administrative and General		0	16, 77	9 16, 779	3, 228	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	Nursing Care	102, 687	0		102, 687	19, 756	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	0	0		0	0	9. 00
10.00	Medical Social Services	13, 654	0		13, 654	2, 627	10.00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counseling	0	0		0	0	12.00
13.00	Counseling - Other	0	0		0	0	13.00
14.00	Home Health Aide and Homemaker	29, 387	0		29, 387	5, 654	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	26. 00
27.00	Radi ati on 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	0	0		0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	145, 728	0	16, 77	9 162, 507	31, 265	34.00
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 150064 | Peri od: From 10/01/2013 | Part I | Part I | Prepared: 2/25/2015 | 10: 37 am Provi der CCN: 150064 Hospi ce CCN:

						2/23/2013 10.	37 4111
					Hospi ce I		
	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	
1.00	Administrative and General	0) C) 0	0	0	
2.00	Inpatient - General Care	0) C) 0	0	0	
3.00	Inpatient - Respite Care	0) C	0	0	0	
4.00	Physi ci an Servi ces	0) C	0	0	0	4. 00
5.00	Nursing Care	0) C	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0) C	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0) C	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	C	0	0	0	9. 00
10.00	Medical Social Services	0	C	0	0	0	10.00
11.00	Spiritual Counseling	0	o	0	0	0	11. 00
12.00	Di etary Counseling	0	ol c	0	0	0	12.00
13.00	Counseling - Other	0	ol c	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	ol c	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0		ol o	0	0	15. 00
16.00	Other	0		ol o	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0) c	ol o	0	0	17. 00
18.00	Anal gesi cs	0		ol o	0	0	18. 00
19.00	Sedatives / Hypnotics	0		ol o	0	0	19. 00
20.00	Other - Specify	0) c	ol o	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0		ol o	0	0	21. 00
22. 00	Patient Transportation	0		ol o	0	0	22. 00
23.00	I maging Services	0		ol o	0	0	23. 00
24.00	Labs and Diagnostics	0	ol c	ol o	0	0	24.00
25.00	Medical Supplies	0		ol o	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0		ol o	0	0	26. 00
27. 00	Radiation Therapy	0	ol c	ol o	0	0	27. 00
28. 00	Chemotherapy	0	ol c	ol o	0	0	28. 00
29. 00	Other	0			0	0	
30. 00	Bereavement Program Costs	0			0	Ō	
31. 00	Volunteer Program Costs	0			0	Ō	
32. 00	Fundrai si ng	0			0	Ō	1
33. 00	Other Program Costs				n	0	
34. 00	Total (sum of lines 1 thru 33) (2)				n	o o	
35. 00	1 ' ' ' '			Ï			35. 00
55.00	Join Coost martipiter (see Histractions)	Ţ	Ţ	I	ļ	I	1 33.00

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

						2/25/2015 10:	37 am
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	2, 256	0	0	0	7, 012	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	Physi ci an Servi ces	C	0	0	0	0	4. 00
5.00	Nursing Care	C	0	0	0	0	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	C	0	0	0	0	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	C	0	0	0	0	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	C	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	C	0	0	0	0	23. 00
24.00	Labs and Diagnostics	C	0	0	0	0	24. 00
25.00	Medical Supplies	C	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C	0	0	0	0	26. 00
27.00	Radi ati on Therapy	C	0	0	0	0	27. 00
28.00	Chemotherapy	C	0	0	0	0	28. 00
29.00	Other	C	0	0	0	0	29. 00
30.00	Bereavement Program Costs	C	0	0	0	0	30. 00
31.00	Volunteer Program Costs	C	0	0	0	0	31.00
32.00	Fundrai si ng	C	0	0	0	0	32. 00
33.00	Other Program Costs	C	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	2, 256	0	0	0	7, 012	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00
					•		

| In Lieu of Form CMS-2552-10 | Provider CCN: 150064 | Period: | Worksheet K-5 | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: | 2/25/2015 10: 37 am Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider (

						2/25/2015 10:	37 am
					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	29, 275					1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4.00
5.00	Nursi ng Care	122, 443	0	122, 443	20, 628	143, 071	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal 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	0	9. 00
10.00	Medical Social Services	16, 281	0	16, 281	2, 743	19, 024	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	35, 041	0	35, 041	5, 904	40, 945	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22.00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging 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	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	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	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	Fundrai si ng	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)	203, 040	0	203, 040		203, 040	
35.00	Unit Cost Multiplier (see instructions)				0. 168475		35. 00

STATISTICAL BASIS

						2/25/2015 10:	<u>3/ am </u>
					Hospi ce I		
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	(SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
1.00	Administrative and General	0	66, 032	C	16, 779	0	1. 00
2.00	Inpatient - General Care	0	0	C	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	C	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	C	0	0	4. 00
5.00	Nursing Care	0	0	C	102, 687	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	C	0	0	6. 00
7.00	Physi cal Therapy	0	0	C	0	0	7. 00
8.00	Occupational Therapy	0	0	·	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	·	0	0	9. 00
10. 00	Medical Social Services	0	0	1	13, 654	0	10. 00
11. 00	Spiritual Counseling	0	0	1	0	0	11. 00
12. 00	Di etary Counsel i ng	0	0	·	0	0	12. 00
13. 00	Counseling - Other	0	0	1	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	1	29, 387	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	1	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	1	0	0	18. 00 19. 00
20. 00	Sedatives / Hypnotics Other - Specify		0	1	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	·	0	0	20.00
21.00	Pati ent Transportati on		0	1	0	0	22.00
23. 00	Imaging Services		0	·	0	0	23. 00
24. 00	Labs and Diagnostics		0	1	0	0	24. 00
25. 00	· ·		0	1	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)		0	·	0	0	26. 00
27. 00	Radi ati on Therapy		0	·	0	0	27. 00
28. 00	Chemotherapy		0	·	0	0	28. 00
29. 00	Other		0		0	0	29. 00
30. 00	Bereavement Program Costs	l ol	0	l c	0	0	30.00
31. 00	Volunteer Program Costs	o	0		0	0	31. 00
32. 00	Fundrai si ng	O	0	C	0	0	32. 00
33. 00	Other Program Costs	0	0	C	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	66, 032		162, 507	0	34. 00
35.00	Total cost to be allocated	o	16, 779		31, 265	0	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 254104		0. 192392	0.000000	36. 00

STATISTICAL BASIS

							2/25/2015 10:	37 am_
						Hospi ce I		
	Cost Center Description	OPERATION OF	LA	UNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINE	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	2, 878	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	C		0	(0	0	9. 00
10.00	Medical Social Services	C		0	(0	0	10.00
11.00	Spiritual Counseling	C		0	(0	0	11. 00
12.00	Di etary Counsel i ng			0		o	0	12.00
13.00	Counseling - Other	C	ol .	0		o	0	13.00
14.00	Home Health Aide and Homemaker		ol .	0		o o	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	C	ol	0		o	0	15. 00
16.00	Other	C	ol .	0		o	0	16. 00
17.00	Drugs, Biological and Infusion Therapy		ol .	0		o o	0	17. 00
18.00	Anal gesi cs			0		o o	0	18. 00
19.00	Sedatives / Hypnotics			0		o o	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		ol o	0	22. 00
23. 00	Imaging Services			0		0	0	23. 00
24. 00	Labs and Diagnostics		ا	0		0	0	24. 00
25. 00	Medical Supplies		ا	0		0	0	25. 00
	Outpatient Services (including E/R Dept.)		ا	0		0	0	26. 00
27. 00	Radi ati on Therapy		ا	0		0	0	27. 00
28. 00	Chemotherapy		l l	0		0	0	28. 00
29. 00	Other		l l	0		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)			0			2, 878	1
35. 00	Total cost to be allocated			0			2, 256	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000		0. 000000	0. 000000	0. 000000		
30.00	John C 003 C Mul Cipitel (366 Thatructions)	0.000000	1	5. 000000	1 0.00000	0.00000	0.703070	1 30.00

						2/25/2015 10:37 am
					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	(O	0 462, 555	1. 00
2.00	Inpatient - General Care	0	(O	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	(o	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	(0	6. 00
7.00	Physi cal Therapy	0	(0	7. 00
8.00	Occupational Therapy	0	(0	8. 00
9.00	Speech/ Language Pathology	0	(0	9. 00
10.00	Medical Social Services	O	(0	10.00
11.00	Spiritual Counseling	O	(0	11. 00
12.00	Di etary Counseling	O	(o	0 0	12. 00
13.00	Counseling - Other	O	(o	0 0	13. 00
14.00	Home Health Aide and Homemaker	O	(o	0 0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	O	(ol	0 0	15. 00
16.00	Other	O	(0 0	16. 00
17.00	Drugs, Biological and Infusion Therapy	o	(0 0	17. 00
18.00	Anal gesi cs	o	(0 0	18. 00
19.00	Sedatives / Hypnotics	O	(ol	0 0	19. 00
20.00	Other - Specify	O	(ol	0 0	20.00
21.00	Durable Medical Equipment/Oxygen	O	(ol	0 0	21. 00
22. 00	Patient Transportation	O	(ol	0 0	22. 00
23.00	I maging Services	O	(ol	0 0	23. 00
24.00	Labs and Diagnostics	O	(ol	0 0	24. 00
25.00	Medical Supplies	O	(ol	0 0	25. 00
26.00	Outpatient Services (including E/R Dept.)	O	(ol	0 0	26. 00
27.00	Radi ati on Therapy	O	(ol	0 0	27. 00
28. 00	Chemotherapy	O	(ol	0 0	28. 00
29.00	Other	O	(ol	0 0	29. 00
30.00	Bereavement Program Costs	O	(ol	0 0	30.00
31.00	Volunteer Program Costs	0	(o	0 0	31. 00
32.00	Fundrai si ng	O	(o	0 0	32.00
33.00	Other Program Costs	0	(o	0 0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	o	(ol	0 462, 555	34.00
35.00	Total cost to be allocated	0	(O	0 7, 012	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 00000	0. 015159	36. 00

Heal th	Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
	FATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150064	Peri od:	Worksheet K-5	
					From 10/01/2013		
			Hospi ce (CCN: 151548	To 09/30/2014	Date/Time Pre	pared:
					Hospi ce I	2/25/2015 10:3	37 alli
	Cost Center Description		Wkst C Part	Cost to Char	ge Total Hospice	Hospice Shared	
	cost center bescription		I, col. 11	Ratio	Charges	Ancillary	
			line	l matro		Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	0. 5519	90 0	0	1. 00
2.00	OCCUPATI ONAL THERAPY		67.00				2. 00
3.00	SPEECH PATHOLOGY		68.00				3. 00
4.00	DRUGS CHARGED TO PATIENTS		73.00		25 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5. 00
6.00	LABORATORY		60.00	0. 1774!	55 0	0	6. 00
6. 01	BLOOD LABORATORY		60. 01			0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00			0	7. 00
8.00	CLINIC		93. 00			0	
8. 01	BIC		93. 01			0	8. 01
8. 02	UCIC		93. 02			0	
8. 03	CIC		93. 03			0	8. 03
8. 04	RIC		93. 04			0	
8. 05	PODI ATRY		93. 05		38 0	0	8. 05
9.00	RADI OLOGY-THERAPEUTI C		55. 00	l .			9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76. 00				10.00
11. 00	Totals (sum of lines 1-10)			l		0	11. 00

CALCUL	ATION OF HOSPICE PER DIEM COST	P	rovi der	CCN: 150064	Pe	ri od:	Worksheet K-6	
		Н	lospi ce C	CN: 151548		om 10/01/2013 09/30/2014	Date/Time Pre 2/25/2015 10:	
						Hospi ce I	2/23/2013 10.	37 aiii
		Title	XVIII	Title XIX		Other	Total	
		1.	. 00	2. 00		3. 00	4. 00	
1. 00	Total cost (see instructions)						203, 040	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)						2, 405	2. 00
3.00	Average cost per diem (line 1 divided by line 2)						84. 42	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		2, 405					4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)		203, 030					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)		İ		0			7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		0					8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		0					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)					O		12. 00
13.00	Aggregate cost for other days (line 3 times line 12)					ol		13.00

JALCIJI	Peri od:	eu of Form CMS-255 Worksheet L			
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150064	From 10/01/2013 To 09/30/2014	Parts I-III Date/Time Prep 2/25/2015 10:3	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier	245, 589	1. 0		
. 01	Model 4 BPCI Capital DRG other than outlier	0	1.0		
2. 00	Capital DRG outlier payments	71	2.0		
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2.0		
3. 00	Total inpatient days divided by number of days in the cost	9. 62	3.0		
1.00	Number of interns & residents (see instructions)	0.00	4.0		
5. 00	Indirect medical education percentage (see instructions)	0.00	5. C		
. 00	Indirect medical education adjustment (multiply line 5 by t	0	6. 0		
. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	, part A line	0.00	7. (
. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8. (
. 00	Sum of lines 7 and 8		0. 00	9. (
0. 00	Allowable disproportionate share percentage (see instruction	0. 00			
1. 00	Disproportionate share adjustment (line 10 times the sum of			0	11.
2. 00	Total prospective capital payments (sum of lines 1, 1.01, 2	, 2.01, 6 and 11)		245, 660	12.
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instructions)			0	1. (
. 00	Program inpatient ancillary capital cost (see instructions)				2. (
. 00					3.
. 00	Capital cost payment factor (see instructions)				4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1 00	
	DART III - COMPUTATION OF FYCEDTION DAYMENTS			1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)				1
	Program inpatient capital costs (see instructions)	nces (see instructions)		0	1.
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2.
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2)	nces (see instructions)		0	2. 3.
00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2. 3. 4.
00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0 0 0.00	2. 3. 4. 5.
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	instructions)	line 6)	0 0 0 0.00	2. 3. 4. 5. 6.
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)	line 6)	0 0 0 0.00 0 0.00	2. 3. 4. 5. 6. 7.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina	instructions) ry circumstances (line 2 x	line 6)	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	instructions) ry circumstances (line 2 x licable)	ŕ	0 0 0 0.00 0.00 0.00	1. 2. 3. 4. 5. 6. 7. 8. 9.
00 00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app	instructions) ry circumstances (line 2 x licable) capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0 0 0.00 0 0.00 0	2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	instructions) ry circumstances (line 2 x licable) capital payments (line 8 capital payment (from pri payments (line 10 plus lin	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
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