09/30/2016 Date/Time Prepared: То 2/23/2017 9:31 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 2/23/2017 Time: 9:31 am use only 2. [] Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 F 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

AND SETTLEMENT SUMMARY

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 OF 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 (15-0064) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(C:	~	\mathbf{n}	2	
1.51	u	ne	(J)	

Officer or Administrator of Provider(s)

Peri od.

From 10/01/2015

In Lieu of Form CMS-2552-10

Worksheet S

Parts I-III

OMB NO. 0938-0050 EXPIRES 05-31-2019

Title

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	76, 812	-30, 382	0	-249, 280	1.00
2.00	Subprovider - IPF	0	22, 416	0		-51, 508	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						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	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	99, 228	-30, 382	0	-300, 788	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.

Date

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	FAYETTE REGIO		rovider CC	N: 15-0064	Period: From 10/01	/2015	Workshe Part I	et S-2	2552-10
							/2015	Date/Ti 2/23/20	me Pre	pared:
	1.00	2.00		3.00			4.00	2723720	717 7.3	
1.00	Hospital and Hospital Health Care Co Street: 1941 VIRGINIA AVE	PO Box:								1.00
2.00	City: CONNERSVILLE	State: IN	Zip	Code: 473	31 Cou	nty: FAYETTE				2.00
		Component Name		CN CBS nber Numb				ent Syst , 0, or		
							V	XVIII	XIX	-
	Hospital and Hospital-Based Componen	1.00 t Identification:	2.	00 3.0	0 4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	FAYETTE REGIONAL HE	ALTH 150	064 999	15 1	07/01/1966	5 N	Р	0	3.00
4.00	Subprovider - IPF	SYSTEM FAYETTE REGIONAL HEA	ALTH 155	5064 999	15 4	10/01/2013	3 N	Р	N	4.00
5.00	Subprovider - IRF	SYSTEM FAYETTE REGIONAL HEA	ALTH 151	064 999	15 5	10/01/2003	3 N	P	0	5.00
6.00	Subprovider - (Other)	SYSTEM								6.00
7.00	Swing Beds - SNF	FAYETTE REGIONAL HEA	ALTH 15L	1064 999	15	06/25/2009	P N	Р	P	7.00
8.00	Swing Beds - NF	STSTEM								8.00
9.00 10.00	Hospital-Based SNF Hospital-Based NF									9.00
11.00	Hospi tal -Based OLTC									11.00
12.00	Hospital-Based HHA	FAYETTE MEMORIAL HO HEALTH	ME 157	097 999	15	01/01/1984	I N	P	N	12.00
	Separately Certified ASC									13.00
14.00	Hospi tal -Based Hospi ce	FMH HOME HEALTHCARE HOSPICE	& 151	548 999	15	02/02/1996				14.00
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15.00
	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18. 00 19. 00	Renal Dialysis Other									18.00
		I	1	I		From		То		
20.00	Cost Reporting Period (mm/dd/yyyy)					1.00		2. (09/30/		20.00
21.00	Type of Control (see instructions)					2			2010	21.00
22.00	Inpatient PPS Information Does this facility qualify and is it	currently receiving	payment	s for disp	proporti onat	e Y		N		22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil	ance with 42 CFR §41	2.106?	In column [.]	1, enter "\	("				
	amendment hospital?) In column 2, en)(C)(Z)(PICK	le l				
22. 01	Did this hospital receive interim un) N		Ν		22.01
	period? Enter in column 1, "Y" for y reporting period occurring prior to									
	for no for the portion of the cost r									
22. 02	(see instructions) Is this a newly merged hospital that	requires final unco	mpensate	d care pay	ments to be	e N		Ν		22.02
	determined at cost report settlement	? (see instructions)	Enter i	n column 1	, "Y" for y	/es				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for									
22.02	or after October 1.				0.1					22.02
22.03	Did this hospital receive a geograph of the OMB standards for delineating							N		22.03
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column					ho				
	cost reporting period occurring on o	r after October 1. ((see inst	ructions)	Does this					
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,		•	nted in ac	cordance wi	th				
23.00	Which method is used to determine Me	dicaid days on lines	s 24 and/			n	3	N		23.00
	1, enter 1 if date of admission, 2 i method of identifying the days in th	J .			5	bd				
	used in the prior cost reporting per	iod? In column 2, e	enter "Y"	for yes o	o <mark>r "N" for r</mark>	10.				
			-State	In-State Medicaid	Out-of State		Medica HMO da		ther li cai d	
			id days	el i gi bl e	Medi cai d	Medi cai d			lays	
				unpai d days	paid days	el i gi bl e unpai d				
	1		1.00	2.00	3.00	4.00	5.00		. 00	
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum		60	422	0	0		376	C	24.00
	Medicaid eligible unpaid days in col	umn 2,								
								1		1
	out-of-state Medicaid paid days in c									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	d days in column t unpaid days in								

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX I			ALTH SYSTEM Provider CC		Peri od:		Workst	orm CMS- neet S-2	
						0/2016	2/23/2	Fime Pre 2017 9:3	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da		Other edi cai d days	
00 If this provider is on IDF onter the	in state	1.00	2.00	3.00	4.00	5.00	0	6.00	25
.00 If this provider is an IRF, enter the Medicaid paid days in column 1, the i Medicaid eligible unpaid days in colu out-of-state Medicaid days in column Medicaid eligible unpaid days in colu HMO paid and eligible but unpaid days	n-state mn 2, 3, out-of-state mn 4, Medicaid					unal C		f Cooge	25.
					Urban/R			00	
.00 Enter your standard geographic classi cost reporting period. Enter "1" for			s at the beg	ginning of t	he	2			26.
.00 Enter your standard geographic classi reporting period. Enter in column 1, enter the effective date of the geogr	fication (not wa "1" for urban o	age) status r "2" for r	rural. If ap		t	2			27.
.00 If this is a sole community hospital effect in the cost reporting period.				CH status in		0			35.
					Begi nı 1. (li ng: . 00	
.00 Enter applicable beginning and ending of periods in excess of one and enter			script line	36 for numb	er				36.
.00 If this is a Medicare dependent hospi is in effect in the cost reporting pe	tal (MDH), ente		er of period	ds MDH statu	s	0			37.
	1 Is this hospital a former MDH that is eligible for the MDH transitional payment in N accordance with FY 2016 0PPS final rule? Enter "Y" for yes or "N" for no. (see N							37.	
.00 If line 37 is 1, enter the beginning greater than 1, subscript this line f									38.
enter subsequent dates.					Y/		Y	/N	
.00 Does this facility qualify for the in	patient bospita	l payment a	adiustment f	for low volu	1.(me Y			. 00 Y	39.
hospitals in accordance with 42 CFR § or "N" for no. Does the facility meet CFR 412.101(b)(2)(ii)? Enter in colum .00 Is this hospital subject to the HAC p	412.101(b)(2)(i the mileage re n 2 "Y" for yes rogram reduction	i)? Enter i quirements or "N" for n adjustmer	n column 1 in accordar no. (see int? Enter "N	"Y" for yes nce with 42 nstructions (" for yes o) r N			N	40.
"N" for no in column 1, for discharge no in column 2, for discharges on or				es or "N" f	or	V	XVIII	_	
Prospective Payment System (PPS)-Capi	tal					1.00) 2.00	3.00	
.00 Does this facility qualify and receiv with 42 CFR Section §412.320? (see in	structions)		·			N	N	N	45.
.00 Is this facility eligible for additic pursuant to 42 CFR §412.348(f)? If ye Pt. III.						N	N	N	46.
.00 Is this a new hospital under 42 CFR § .00 Is the facility electing full federal Teaching Hospitals			2			N N	N N	N N	47. 48.
.00 Is this a hospital involved in traini or "N" for no.	ng residents in	approved G	GME programs	s? Enter "Y	" for yes	N			56.
.00 If line 56 is yes, is this the first GME programs trained at this facility is "Y" did residents start training i for yes or "N" for no in column 2. I "N", complete Wkst. D, Parts III & IV	? Enter "Y" fo n the first mon f column 2 is "	r yes or "N th of this Y", complet	V for no ir cost report ce Worksheet	n column 1. ting period?	If column 1 Enter "Y				57.
.00 If line 56 is yes, did this facility	elect cost reim	bursement f	°or physicia	ans' service	s as				58.
defined in CMS Pub. 15-1, chapter 21,	sheet A? If ye	s, complete	e Wkst. D-2,			N			59.
.00 Are costs claimed on line 100 of Work		for yes or			<u>ructions)</u>	IF N	Dire	ct GME	60.
		Y/N							
.00 Are you claiming nursing school and/c				0.00		20	-	00	-
 .00 Are costs claimed on line 100 of Work .00 Are you claiming nursing school and/o provider-operated criteria under §413 .00 Did your hospital receive FTE slots u section 5503? Enter "Y" for yes or "N 	nder ACA	Y/N 1.00	2.00	3.00	4. (00 0. 00		. 00	0 61.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Period: From 10/01/2015 To 09/30/2016		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00]
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.0	00		61.02
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.0	0C		61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.0	bo		61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.0	00		61.0
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.0	00		61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
		1.00	2.00	3.00	4.00	1
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 1, the program name, enter in column 2, the program code, enter in column 4, direct GME FTE unweighted count. 				0.00	0.00	61.2
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62.0
2.00 Enter the humber of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cent	ter (THC) into			62.0
<u>Teaching Hospitals that Claim Residents in Nonprovide</u> 3.00 Has your facility trained residents in nonprovider se			ot reporting	noriad2 Enton	N	42.0
"Y" for yes or "N" for no in column 1. If yes, comple					IN IN	63.0
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			This base year	r is your cost r	reporting	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair i-primar all nor l non-pr i columr	ned residents ry care nprovider rimary care n 3 the ratio	0. C	0 0.00	0. 000000	64.C
Program Name		ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3.00	4.00	5.00	1

OSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DAT	TA Provider (CCN: 15-0064 Pe Fr	eriod: com 10/01/2015	Worksheet S- Part I	
			To	09/30/2016	Date/Time Pr 2/23/2017 9:	epared:
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3	
	-		FTEs	FTEs in	(col. 3 + col	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	-
.00 Enter in column 1, if line 63	11.00	2100	0.00			0 65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3,						
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col 2))	•
			Si te	nosprear	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective fo	or cost reporti	ing periods	
5.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	Ratio (col. 3 (col. 3 + col 4))	
	1.00	2.00	3.00	4.00	5.00	-
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 00000	0 67.0
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility P	PPS			1.0	0 2.00 3.00	
.00 Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it cont	tain an IPF subp	rovi der? Y		70. (
Enter "Y" for yes or "N" for no .00 If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	yes or "N" for n s in a new teach yes or "N" for n	o. (see i ng o.	N O	71. (
Inpatient Rehabilitation Facilit 5.00 Is this facility an Inpatient Re		(IRF), or does it a	contain an IRF	Y		75.0
subprovi der? Enter "Y" for yes	and "N" for no.		program in the			76.0

Heal th Financial Systems FAYETTE REGIONAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HEALTH SYSTEM Provider C	CN: 15-0064	<u>In Lie</u> Period: From 10/01/2015	u of Form CMS Worksheet S- Part I	
			To 09/30/2016		
		I		272372017 4.	
Long Term Care Hospital PPS				1.00	_
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	s and "N" for	no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part of			period? Enter	N	81.00
"Y" for yes and "N" for no. TEFRA Provi ders					_
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)				N	85.00
86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Sectio	'n		86.00
87.00 Is this hospital a "subclause (II)" LTCH classified under se	ection 1886(d)	(1) (B) (i v) (I I)	? Enter "Y"	N	87.00
for yes or "N" for no.			V	XI X	_
			1.00	2.00	_
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through t			N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du				N	92.00
instructions) Enter "Y" for yes or "N" for no in the applica		101): (366		1	72.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V an	d XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	alicable colum	n	0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N 0.00	N 0.00	96.00
applicable column.		_	0.00	0.00	07.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	DITCADLE COLUM	n.	0.00	0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive met	hod of payment	N		106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost			N		107.00
training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.					
reimbursed. If yes complete Wkst. D-2, Pt. II.		-			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	/
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y"	N IN		N.		10 9. 00
for yes or "N" for no for each therapy.					
				1.00	_
110.00 Did this hospital participate in the Rural Community Hospita		on project (41	OA Demo)for	N	110.00
the current cost reporting period? Enter "Y" for yes or "N"	TOP NO.				
			1.00	2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no i	n column 1 If	column 1 N	0	115.00
is yes, enter the method used (A, B, or E only) in column 2.	lf column 2	is "E", enter	in column		
3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider					
Pub. 15-1, chapter 22, §2208. 1.					
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			"N" for Y		116.00 117.00
no.	ance: Enter	r ioi yes oi			117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol	icy? Enter 1	if the policy	is 1		118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		386, 05	9 0	1	0 118.01

	m CMS-2552-10
	et S-2
From 10/01/2015 Part I To 09/30/2016 Date/Ti	me Prepared:
	17 9:30 am
1.00 2.0 118.02 Are mal practice premiums and paid losses reported in a cost center other than the N	118.02
Administrative and General? If yes, submit supporting schedule listing cost centers	110.02
and amounts contained therein.	
119.00 DO NOT USE THIS LINE	119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N Y §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or	120.00
"N" for no. Is this a rural hospital with < 100 beds that gualifies for the Outpatient	
Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	
Enter in column 2, "Y" for yes or "N" for no.	121 00
121.00 Did this facility incur and report costs for high cost implantable devices charged to Y patients? Enter "Y" for yes or "N" for no.	121.00
122.00 Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" N	122.00
for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number	
where these taxes are included.	
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N	125.00
yes, enter certification date(s) (mm/dd/yyyy) below.	120.00
126.00 If this is a Medicare certified kidney transplant center, enter the certification date	126.00
in column 1 and termination date, if applicable, in column 2.	107.00
127.00 If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	127.00
128.00 If this is a Medicare certified liver transplant center, enter the certification date	128.00
in column 1 and termination date, if applicable, in column 2.	
129.00 If this is a Medicare certified lung transplant center, enter the certification date in	129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification	130.00
date in column 1 and termination date, if applicable, in column 2.	130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the certification	131.00
date in column 1 and termination date, if applicable, in column 2.	122.00
132.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	132.00
133.00 If this is a Medicare certified other transplant center, enter the certification date	133.00
in column 1 and termination date, if applicable, in column 2.	
134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1	134.00
and termination date, if applicable, in column 2. All Providers	
140.00Åre there any related organization or home office costs as defined in CMS Pub. 15-1, N	140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs	
are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 1.00 2.00 3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the	
home office and enter the home office contractor name and contractor number.	
141.00Name: Contractor's Name: Contractor's Number:	141.00
142.00 Street: P0 Box: 143.00 City: State: Zip Code:	142.00 143.00
	143.00
1.0	00
144.00 Are provider based physicians' costs included in Worksheet A?	
	144.00
1.00 2.1	00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for renal services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting Y	00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y	145.00
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145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N	00 145.00 146.00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y 146.00 Has the cost allocation methodol ogy changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N	00 145.00 146.00 00 147.00
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145.00 1f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. M 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. M 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. M 149.00 Enter "Y" for yes or "N" for no of no of the lower of cost or that qualifies for an exemption from the application of the lower of cos or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)	00 145.00 146.00 146.00 147.00 148.00 148.00 149.00 XI X 00 5ts
145.00 1f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y 146.00 Has the cost allocation methodol ogy changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 Loos this facility contain a provider that qualifies for an exemption from the application of the lower of cost 0.00	00 145.00 145.00 146.00 146.00 147.00 148.00 148.00 149.00 XI X 00 Sts 155.00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. Y 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 155.00 Hospital N N N 155.00 Hospital N N N N N 156.00 Subprovider - IPF N N N N N N	00 145.00 145.00 146.00 146.00 147.00 148.00 149.00 XI X 00 149.00 149.00 145.00 155.00 155.00 156.00 157.00
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Health Financial Systems	FAYETTE REGI	ONAL HEALTH SYSTEM			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN:	15-006			Worksheet S-2	2
					0/01/2015	Part I Date/Time Pre	anarod
				10 0	7/ 30/ 2010	2/23/2017 9:3	
							4
						1.00	-
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	s one or more campuse	es in di	fferent CE	3SAs?	N	165.00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	7
166.00 If line 165 is yes, for each						0.00	0 166. 00
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI	T) incentive in the Am	nerican Recovery and	Rei nves	tment Act		•	
167.00 Is this provider a meaningful user	r under §1886(n)? Ent	er "Y" for yes or "N	" for no).		Y	167.00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a me	aningful user (line '	167 is "	Y"), enter	the		d168. 00
reasonable cost incurred for the I	H∣T assetś (see instru	ictions)					
168.01 If this provider is a CAH and is i	not a meaningful user,	does this provider of	gualify	for a hard	lshi p		168. 01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful (user (line 167 is "Y")	and is not a CAH (li	ine 105	is ⁽ "N"), e	enter the	9.9	9169.00
transition factor. (see instruction	ons)						
				Be	gi nni ng	Endi ng	
					1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR I	peginning date and end	ling date for the repo	orting	10/	/01/2015	09/30/2016	170.00
period respectively (mm/dd/yyyy)							
					1.00	2.00	-
$171 \text{ OOUF Line } 1(7 \text{ is } \ V\ does this prov$	dan have any days fo		ad in				0 171. 00
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans i					Ν		0171.00
"Y" for yes and "N" for no in colu							
		yes, enter the number	or sec				
1876 Medicare days in column 2. (s	see instructions)			I		1	1

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet S- Part II Date/Time Pr 2/23/2017 9:	epared:
				Y/N	Date	_
		<u> </u>		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	Tor all NU re	sponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the	begi nni ng of	the cost	Ν		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	1 (
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare Pr	rogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports	flad Dubli	N N	•		
00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4. C
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6. C
00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions		Ν		7.0
00	Were nursing school and/or allied health programs approved a		l during the	N		8.0
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	araduate medic	al education	Ν		9.0
	program in the current cost report? If yes, see instructions	S.				
0. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.	r renewed in t	he current	N		10.0
I. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
				·	Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12.0
1.00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	yes, see ins	structions.	N	14. (
5.00	Did total beds available change from the prior cost reportin				N	15. (
	_		t A	Par	-	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	-
	PS&R Data	1.00	2.00	5.00	4.00	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	02/14/2017	Y	02/14/2017	16.0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		N		17. (
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

Health Financial Systems

FAYETTE	REGI ONAL	HEALTH	SYSTEM	

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provi der CCN: 15-0064 Peri od:			Worksheet S-	2		
			F	From 10/01/2015 To 09/30/2016	Date/Time Pr		
		Descri	ntion	Y/N	<u>2/23/2017 9:</u> Y/N	<u>30 ani</u>	
)	1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	······································	Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		Ν		21.00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)				
	Capital Related Cost				N	22.00	
	23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost						
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost repo	orting period?	Ν	24.00	
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period? I	f yes, see	Ν	25. 00	
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost reporti	ng period?lf	yes, see	Ν	26.00	
27.00	Has the provider's capitalization policy changed during th copy.	yes, submit	Ν	27.00			
28.00	Interest Expense Were new loans, mortgage agreements or letters of credit e	reporting	N	28.00			
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	serve Fund)	Ν	29.00			
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	Ν	30. 00	
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00	
22.00	instructions. Purchased Services	rui eco furni cho	d through cont	traatual	N	22.00	
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	uctions.	0		N	32.00 33.00	
33.00	no, see instructions. Provider-Based Physicians					- 33.00	
34.00	Are services furnished at the provider facility under an a	rrangement with	nrovi der-base	ed physicians?	Y	34.00	
	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	0				35. 00	
	physicians during the cost reporting period? If yes, see i			Y/N	Date		
				1.00	2.00	-	
	Home Office Costs						
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	N N		36.00 37.00	
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of			N		38.00	
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			Ν		39.00	
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfyes, see	Ν		40. 00	
	instructions.						
		1.	00	2.	00		
	Cost Report Preparer Contact Information	hou =					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH		41.00	
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7957		KCSMI TH@BLUEAN	DCO. COM	43.00	

Heal th	Financial Systems	FAYETTE REGIONAL	HEALTH SYSTE	М	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provider (Period:	Worksheet S-2	
					From 10/01/2015 To 09/30/2016		pared: 0 am
			3	. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti	tle/position	SENI OR MANAGE	R			41.00
	held by the cost report preparer in column	is 1, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cos	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respec						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part I Date/Time Prep 2/23/2017 9:30	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	38	13, 9(0.00	0	1. 00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00 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		38	13, 90	0.00	0	7.00
8.00	beds) (see instructions)	31.00	12	4 20	0.00	0	0.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00	12	4, 39	0.00	0	8.00 9.00
9.00 10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		50	18, 30	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4, 39	92	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.00
18.00	SUBPROVI DER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00	0		0		23.00
24.00 24.10	HOSPICE	116.00 30.00	0		0		24.00 24.10
24.10	HOSPICE (non-distinct part) CMHC - CMHC	30.00 99.00				0	24.10
25.00	CMHC - CORF	99.00 99.10				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		62				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
22.00	outpatient days (see instructions)						33.00
33.00	LTCH non-covered days						33

OSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC		Period: From 10/01/2015 To 09/30/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	1, 012	42	1, 81	5		1.00
. 00	HMO and other (see instructions)	28	777				2.00
. 00	HMO I PF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 012	42	1, 81	5		7.00
. 00	INTENSIVE CARE UNIT	230	0	49	8		8.00
. 00	CORONARY CARE UNI T						9.00
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		16	30	6		13.00
4.00	Total (see instructions)	1, 242	58	2, 61		390.63	
5.00	CAH visits	1, 242	0	2,01	0.00	370.03	15.0
6.00	SUBPROVIDER - IPF	1, 320	62	2, 09	8 0.00	14.09	
7.00	SUBPROVIDER - IRF	1, 520	02	2,07	0 0.00		
8.00	SUBPROVI DER	0	0		0 0.00		
9.00	SKILLED NURSING FACILITY		0		0.00	0.00	19.0
9.00 0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE	2,410	1 100	0.05	0.00	15 00	21.0
2.00	HOME HEALTH AGENCY	2, 410	1, 183	9, 05	2 0.00	15.33	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE	0	0		0 0.00	0.68	
4.10	HOSPICE (non-distinct part)	0	0		0		24.1
5.00	CMHC - CMHC	0	0		0 0.00		
5. 10	CMHC - CORF	0	0		0 0.00		
6. 00	RURAL HEALTH CLINIC	0	0		0 0.00		
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	420.73	
8.00	Observation Bed Days		0	50	6		28.0
9.00	Ambul ance Trips	92					29.0
0. 00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	23	2	8		32.0
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0		32. 0
3 00	LTCH non-covered days	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part I Date/Time Prep 2/23/2017 9:30	pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d	Title V	Title XVII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Patients	
1 00	Hachital Adults & Dods (columns E 6 7 and	11.00	12.00	13.00	14.00	15.00	1.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 16. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0	3	74 17 11 212 0 0 0 74 17 12 7 0 0 0 0	796	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00
24.10 25.00	HOSPICE (non-distinct part) CMHC - CMHC	0. 00					24.10 25.00
25.10	CMHC - CORF	0.00					25.0
26.00	RURAL HEALTH CLINIC	0.00					26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32. 0 32. 0
33.00	outpatient days (see instructions) LTCH non-covered days						33. (

РГГ	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 10/01/2015 To 09/30/2016		pare
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							-
0	Total salaries (see	200, 00	20, 262, 923	3 0	20, 262, 923	3 792, 207. 00	25.58	3 1.
	instructions)							
0	Non-physician anesthetist Part		C		C	0.00	0.00	2.
0	Non-physician anesthetist Part		C		C	0.00	0.00	3.
_	B			_				
0	Physician-Part A - Administrative		303, 628	3 C	303, 628	2, 177. 00	139. 47	4
1	Physicians - Part A - Teaching		C	o o	C	0.00	0.00	4
0	Physician and Non		3, 594, 869		3, 594, 869	32, 551. 00	110. 44	5
0	Physician-Part B Non-physician-Part B for		C		0	0.00	0.00	6
0	hospital -based RHC and FQHC		C			0.00	0.00	
	servi ces							
0	Interns & residents (in an	21.00	(C	0.00	0.00	7
1	approved program) Contracted interns and		C		C	0.00	0.00	7
	residents (in an approved			-				
0	programs) Home office and/or related		C			0.00	0.00	8 10
0	organization personnel		C			0.00	0.00	″ °
0	SNF	44.00	C		c	0.00		
00	Excluded area salaries (see		3, 613, 696	54, 646	3, 668, 342	2 164, 983. 00	22. 23	8 10
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		465, 656	b C	465, 656	5, 234. 00	88. 97	11
	Care							
00	Contract labor: Top level management and other management and administrative		C	D C	C	0.00	0.00	12
00	services Contract Labor: Physician-Part		732, 312		732, 312	6, 413. 00	114. 19	13
	A - Administrative		, 02, 012		,02,012	0, 110, 00		
00	Home office and/or related		C	0	C	0.00	0.00	14
	orgainzation salaries and wage-related costs							
01	Home office salaries		C	o c	C	0. 00	0.00	14
02	Related organization salaries		(C	0.00		
00	Home office: Physician Part A - Administrative		(C	0.00	0.00	15
00	Home office and Contract		C	0 0	C	0.00	0.00	16
	Physicians Part A - Teaching							
00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 707, 935	5 0	2, 707, 935	5		17
00	instructions)		2,707,730		2,707,730			
00	Wage-related costs (other)		C		C)		18
00	(see instructions) Excluded areas		789, 389		789, 389			19
	Non-physician anesthetist Part		(0,00)		C			20
	A		-		-			~-
00	Non-physician anesthetist Part B		C	ן נ				21
00	Physician Part A -		27, 235	5 C	27, 235	5		22
01	Administrative				-			0
	Physician Part A - Teaching Physician Part B		(343, 942	1 ×	343, 942			22
	Wage-related costs (RHC/FQHC)		(0)		24
00	Interns & residents (in an		C		C)		25
50	approved program) Home office wage-related		ſ		,			25
	Related orgainzation		(25
	wage-related Home office: Physician Part A - Administrative -		C	c c	c			25
	wage-rel ated							
53	Home office & Contract		C		C)		25
	Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIE	S		I	l	<u> </u>	I	1
	Employee Benefits Department	4.00	141, 432	85, 544	226, 976	5, 521. 00	41.11	1 26

^{27.00} Administrative & General 5. 00 1, 979, 265

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of									
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Peri od:	Worksheet S-3		
						From 10/01/2015			
						o 09/30/2016	Date/Time Pre 2/23/2017 9:30		
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly		
		Line Number		on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)		col. 4	,		
		1.00	2.00	3.00	4.00	5.00	6.00		
28.00	Administrative & General under		1, 119, 182	0	1, 119, 182	2 10, 482. 00	106. 77	28.00	
	contract (see inst.)								
29.00	Maintenance & Repairs	6.00	C	0	(0.00			
30.00	Operation of Plant	7.00	253, 305	7, 052	260, 357	13, 301. 00	19.57		
31.00	Laundry & Linen Service	8.00	C	0	(0.00	0.00	31.00	
32.00	Housekeepi ng	9.00	514, 447	15, 577	530, 024	49, 220. 00	10. 77	32.00	
33.00	Housekeeping under contract		C	0	(0.00	0.00	33.00	
	(see instructions)								
34.00	Dietary	10.00	509, 314	-297, 479	211, 835	5 104, 768. 00	2.02	34.00	
35.00	Dietary under contract (see		C	0	(0.00	0.00	35.00	
	instructions)								
36.00	Cafeteri a	11.00	C	312, 698	312, 698	3 22, 845. 00	13.69	36.00	
37.00	Maintenance of Personnel	12.00	C	0	(0.00	0.00	37.00	
38.00	Nursing Administration	13.00	743, 044	14, 010	757, 054	19, 197. 00	39.44	38.00	
39.00	Central Services and Supply	14.00	69, 895	2, 100	71, 995	4, 156. 00	17.32	39.00	
40.00	Pharmacy	15.00	200, 770	3, 318	204, 088	8, 177. 00	24.96	40.00	
41.00	Medical Records & Medical	16.00	641, 318	65, 190	706, 508	3 33, 440. 00	21. 13	41.00	
	Records Library								
42.00	Soci al Servi ce	17.00	C	0	(0.00	0.00	42.00	
43.00	Other General Service	18.00	C	0	(0.00	0.00	43.00	

Heal th	Financial Systems	FA	YETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 10/01/2015 To 09/30/2016		
						_	2/23/2017 9:3	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		17, 787, 236	0	17, 787, 23	6 770, 138. 00	23. 10	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 613, 696	54, 646	3, 668, 34	2 164, 983. 00	22. 23	2.00
	instructions)							
3.00	Subtotal salaries (line 1		14, 173, 540	-54, 646	14, 118, 89	4 605, 155. 00	23. 33	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 197, 968	0	1, 197, 96	8 11, 647. 00	102.86	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		2, 735, 170	0	2, 735, 17	0.00	19.37	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		18, 106, 678	-54, 646	18, 052, 03	2 616, 802. 00	29.27	6.00
7.00	Total overhead cost (see		6, 171, 972	-274, 318	5, 897, 65	4 350, 335. 00	16. 83	7.00
	instructions)							
		I I		•	1	1		1

Heal th	Financial Systems FAYETTE REGIONAL H	IEALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part IV Date/Time Pre 2/23/2017 9:30	pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS		· · · · · · · · · · · · · · · · · · ·		
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			8, 987	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2, 692, 679	
8.01	Health Insurance (Self Funded without a Third Party Administr			0	
8.02	Health Insurance (Self Funded with a Third Party Administrate	or)		0	
8.03	Heal th Insurance (Purchased)			0	
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			-82, 295	
11.00	Life Insurance (If employee is owner or beneficiary)			-73, 488	
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			-109, 129	
	Long-Term Care Insurance (If employee is owner or beneficiary	()		-	14.00
15.00	'Workers' Compensation Insurance		L L FACD 10/	83, 736	
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accruai require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			1, 321, 250	17 00
18.00	Medicare Taxes - Employers Portion Only			1, 321, 230	
19.00	Unemployment Insurance			26, 761	
	State or Federal Unemployment Taxes			20, 701	
20.00	OTHER			0	20.00
21.00	Executive Deferred Compensation (Other Than Retirement Cost F	Reported on lines 1 throu	ugh 4 above. (see	0	21.00
	instructions))		-		
22.00	Day Care Cost and Allowances			0	
23.00				0	
24.00	Total Wage Related cost (Sum of lines 1 -23)			3, 868, 501	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER			51, 931	25.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-:	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0064	Peri od:	Worksheet S-3	
		From 10/01/2015 To 09/30/2016	Part V Date/Time Pre	pared:
			2/23/2017 9:3	
Cost Center Description		Contract Labor		
		1.00	2.00	
PART V - Contract Labor and Benefit Co				-
Hospital and Hospital -Based Component				1 00
1.00 Total facility's contract labor and be 2.00 Hospital	nerit cost	0	0	1.00
2.00 Hospital 3.00 Subprovider - IPF		0	0	2.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital -Based SNF			-	8.00
9.00 Hospital-Based NF				9.00
10.00 Hospi tal -Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 Separately Certified ASC				12.00
13.00 Hospi tal -Based Hospi ce		0	0	13.00
14.00 Hospital-Based Health Clinic RHC		0	0	
15.00 Hospital-Based Health Clinic FQHC		0	0	
16.00 Hospi tal -Based-CMHC		0	0	
16.10 Hospital-Based-CMHC 10		0	0	
17.00 Renal Dialysis		0	0	
18.00 0ther		0	0	18.00

	2	AYETTE REGIONAL				u of Form CMS-2	2552-10
HOME	IEALTH AGENCY STATI STI CAL DATA		Provider C Component		eriod: rom 10/01/2015 o 09/30/2016		
					Home Health Agency I	2/23/2017 9:3 PPS	<u>0 am</u>
					1.	00	
0.00	County						0.00
		<u>Title V</u> 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	C	0	0		1.00
2.00	Unduplicated Census Count (see instructions)	0.00	164.00		0.00 oyees (Full Ti		2.00
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C)	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		0.00	0.00			3.00 4.00
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00 7.00	Direct Nursing Service Nursing Supervisor			0.00		0.00 0.00	6.00 7.00
8.00 9.00	Physical Therapy Service			0.00			8.00 9.00
9.00 10.00	Physical Therapy Supervisor Occupational Therapy Service			0.00 0.00		0.00 0.00	
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.00		0.00 0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.00		0.00 0.00	14.00 15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.00 0.00			
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			5			19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			17140			20. 00
20. 01	contains the first code).			50031			20. 01
20. 02				50035			20. 02
20. 03 20. 04				50042 99915			20. 03 20. 04
		Full Ep Without		LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	<u>1-4)</u> 5. 00	
21.00	PPS ACTIVITY DATA	1					21.00
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 184 149, 336	149 18, 923			1, 429 180, 415	
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	298 40, 916	0	16 2, 195		319 43, 801	
25.00	Occupational Therapy Visits	220	C	1	5	226	25.00
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	30, 165 16	0	138	690 0	30, 993 20	
28.00	Speech Pathology Visit Charges	2, 384	0	596	0	2, 980	28.00
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	15 2, 952	0	198	0	16 3, 150	
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	394 29, 769	C	2 152	4 304	400 30, 225	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 127	149			2, 410	
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 255, 522	0 18, 923		-	0 291, 564	34.00 35.00
36.00	30, 32, and 34) Total Number of Episodes (standard/non	169	10, 723	36		271, 304	
37.00	outlier) Total Number of Outlier Episodes		3		0		37.00
	Total Non-Routine Medical Supply Charges	9, 169	479	916			38.00

	Financial Systems		YETTE REGIONAL	HEALTH SYSTEM			u of Form CMS-2	2552-10
HOSPII	AL-BASED HOSPICE IDENTIFICATION	IDATA		Provider CC Hospice CCN	N: 15-0064 N: 15-1548	Period: From 10/01/2015 To 09/30/2016	Worksheet S-9 PARTS I THROU Date/Time Pre 2/23/2017 9:30	pared:
						Hospi ce I	2/23/2017 9:30	U ani
		Unduplicated				nospi ce i		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	-			
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR C	OST REPORTING P	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
. 00	Hospice Inpatient Respite Care							3.00
. 00	Hospice General Inpatient Care							4.00
. 00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015			
. 00	Number of patients receiving							6.00
	hospi ce care							
. 00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
. 00	Average Length of Stay (line 5							8.00
	/line 6)							
9.00	Unduplicated census count							9.00
OTE:	Parts I and II, columns 1 and 2	also include t	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	F PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1	, 2015		
0.00	Hospice Continuous Home Care			0		0 0	0	
1.00	Hospice Routine Home Care			551		0 0	551	11.00
2.00	Hospice Inpatient Respite Care			0		0 0	0	
3.00	Hospice General Inpatient Care			0		0 0	0	
4.00	Total Hospice Days			551		0 0		14.00
	PART IV - CONTRACTED STATISTIC		T REPORTING PE	RIODS BEGINNIN	G ON OR AFTE	R OCTOBER 1, 2015		
	Hospice Inpatient Respite Care			0		0 0	0	15.00
5.00	Inospice inpatient kespite care					0	0	

Heal th	Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	N: 15-0064	Peri od:	Worksheet S-1	
					From 10/01/2015		
					To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
				I		2,20,201, 10	
						1.00	
	Uncompensated and indigent care cost comp						
1.00	Cost to charge ratio (Worksheet C, Part I		vided by li	ne 202 column	8)	0. 354199	1.00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					2, 078, 153	2.00
3.00 4.00	Did you receive DSH or supplemental payme If line 3 is "yes", does line 2 include a		al paymonto :	From Modicaid	2	Y	3.00 4.00
4.00 5.00	If line 4 is "no", then enter DSH or supp				1	4, 005, 795	4.00 5.00
6.00	Medi cai d charges	prementar payments into				10, 793, 252	6.00
7.00	Medicaid cost (line 1 times line 6)					3, 822, 959	7.00
8.00	Difference between net revenue and costs	for Medicaid program	(line 7 minu	us sum of lin	es 2 and 5: if	0,022,707	8.00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP	?) (see instructions f	°or each lin∉	e)			
9.00	Net revenue from stand-alone CHIP					319, 190	9.00
10.00	Stand-alone CHIP charges					0	10.00
	Stand-alone CHIP cost (line 1 times line					0	11.00
12.00	Difference between net revenue and costs	for stand-alone CHIP	(line 11 mi)	nus line 9; i	f < zero then	0	12.00
	enter zero) Other state or local government indigent	caro program (soo ins	structions fo	or each line)			
13.00	Net revenue from state or local indigent					0	13.00
	Charges for patients covered under state					0	14.00
	10)	en recar ritargent ca	o program (i			Ū	
15.00	State or local indigent care program cost	: (line 1 times line [·]	14)			0	15.00
16.00	Difference between net revenue and costs	for state or local in	ndigent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)						
47.00	Uncompensated care (see instructions for		<u> </u>			0	47.00
	Private grants, donations, or endowment i Government grants, appropriations or trar					0	17.00 18.00
	Total unreimbursed cost for Medicaid , CH				(sum of lines	0	18.00
19.00	8, 12 and 16)		ar margent (0	19.00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
	1			1.00	2.00	3.00	
	Charity care charges for the entire facil			1, 088, 57			
	Cost of patients approved for charity car		20)	385, 57			
	Partial payment by patients approved for			205 53	0 0		22.00
23.00	Cost of charity care (line 21 minus line	22)		385, 57	0	385, 573	23.00
						1.00	
24.00	Does the amount in line 20 column 2 inclu	ude charges for patier	nt days beyo	nd a length c	f stay limit		24.00
	imposed on patients covered by Medicaid of	or other indigent care	e program?	0	5		
	If line 24 is "yes," charges for patient			ogram's lengt	h of stay limit	0	25.00
	Total bad debt expense for the entire hos					3, 444, 459	
27.00	Medicare bad debts for the entire hospita					167, 994	27.00
	Cost of non-Medicare and non-reimbursable		kpense (line	i times line	28)	1, 160, 521	
	Cost of uncompensated care (line 23 colum Total unreimbursed and uncompensated care		ino 20)			1, 546, 094 1, 546, 094	
31.00	Liorar annermonisen and ancomhensared care	- cost (inne ia hinz i	116 30)			1, 340, 094	J 31.00

Cost Center Description Sal aries Other Total (col. 1 ecl ass) ficat I Reclass) field ons (See A-b) Total Col. 1 ecl ass) field ons (See A-b) Reclass field ons (See A-b) Total Col. 1 ecl ass) field ons (See A-b) Total Col. 1 ecl ass) field ons (See A-b) Reclass field ons (See A-b) Total Col. 1 ecl ass) field ons (See A-b) Reclass field ons (See A-b) 0 Othor (Cal CAP REL COST - BLDC & FIXT 00 0400 CMP/OFE ERNET IS DEPARTIENT 1 14, 422 1, 00 2, 940, 851 2, 941, 851 <th></th> <th>IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C</th> <th></th> <th></th> <th></th> <th>eriod: rom 10/01/2015 o 09/30/2016</th> <th>Worksheet A Date/Time Pre</th> <th>nared</th>		IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C				eriod: rom 10/01/2015 o 09/30/2016	Worksheet A Date/Time Pre	nared
ENERGY Control Prod 20 75 (56 (56 (17) (17) 0				0.11			2/23/2017 9:3	
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03 04952 CI C 0 0 0 0 0 0 93. 04 04953 RI C 0 0 0 0 0 93. 05 04954 POILATRY 2,981 130 3,111 0 3,111 93. 00 09500 AMBULANCE SERVICES 53,171 7,168 60,339 664 61,003 95. 00 09900 CORF 0 0 0 0 0 99. 10 01010 HEALTH AGENCY 706,464 105,468 811,932 -16,609 795,323 101. SPECIAL PURPOSE COST CENTERS			0	0	0	0		
0.05 D4954 PODI ATRY 2,981 130 3,111 0 3,111 93 0 THER REIMBURSABLE COST CENTERS	. 03 0	D4952 CI C	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS 00 09500 AMBULANCE SERVICES 53, 171 7, 168 60, 339 664 61, 003 95. 00 09500 CMHC 0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 99.0 0 0 0 0 99.0 0 0 0 0 0 0 99.0 0			0	0	0	0	0	
00 09500 AMBULANCE SERVICES 53, 171 7, 168 60, 339 664 61, 003 95. 00 09900 CMHC 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 09910 CORF 706, 464 105, 468 811, 932 -16, 609 795, 323 101. SPECI AL PURPOSE COST CENTERS 706, 464 105, 468 811, 932 -16, 609 795, 323 101. SPECI AL PURPOSE COST CENTERS 9.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 1100. 0.01000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 0.011000 ISLET ACQUI SI TI ON 0 0 0 0 0 110. 0.011600 HOSPI CE 0 63, 488 63, 488 23, 167 86, 655 116. 8.00 SUBTOTALS (SUM OF LINES 1-117) 18, 048, 520	-		2, 981	130	3, 111	0	3, 111	93.
00 09900 CMHC 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 1.00 10100 HOME HEALTH AGENCY 706, 464 105, 468 811, 932 -16, 609 795, 323 101. SPECIAL PURPOSE COST CENTERS			53 171	7 168	60 339	664	61.003	05
110 09910 CORF 0 0 0 0 0 99. 1.00 10100 HOME HEALTH AGENCY 706, 464 105, 468 811, 932 -16, 609 795, 323 101. SPECIAL PURPOSE COST CENTERS 5 5 0 0 0 0 0 109. 9.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109. 0.01 10001 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 1.00 INTECT AL PURPOSE COST CENTERS 0 63, 488 63, 488 23, 167 86, 655 116. 5.00 11600 HOSPI CE 0 63, 488 63, 488 23, 167 86, 655 116. 8.00 SUBTOTALS (SUM OF LINES 1-117) 18, 048, 520 30, 782, 619 48, 831, 139 -11, 278 48, 819, 861 118. 1.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 1.01 19101 FMH DI AGNOSTI C CENTER 191, 291 18, 494 209, 785			0	7,108	00, 339			
SPECIAL PURPOSE COST CENTERS 9. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 1090 0. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 1100 1. 00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 1110 1500 1510 0			0	0	0	0	-	
9. 00 10900 PANCREAS ACQUI SI TI ON 0	1.00	10100 HOME HEALTH AGENCY	706, 464	105, 468	811, 932	-16, 609	795, 323	101.
D. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110. 1. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 111. 6. 00 1100 HOSPICE 0 63,488 63,488 23,167 86,655 116. 8. 00 SUBTOTALS (SUM OF LINES 1-117) 18,048,520 30,782,619 48,831,139 -11,278 48,819,861 118. NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 1. 01 19100 RESEARCH 0 0 0 0 0 191. 11.04 191.291 18,494 209,785 4,461 214,246 191. 191.201 RELLNESS 3,085 13,495 16,580 1,091 17,671 192. 192.02 192.02 MARKETING 64,263 228,590 292,853 </td <td></td> <td></td> <td>1 1</td> <td></td> <td></td> <td></td> <td></td> <td></td>			1 1					
1. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 1111. 6. 00 11600 HOSPI CE 0 63, 488 63, 488 23, 167 86, 655 116. 8. 00 SUBTOTALS (SUM OF LINES 1-117) 18, 048, 520 30, 782, 619 48, 831, 139 -11, 278 48, 819, 861 118. NONREL MBURSABLE COST CENTERS 0 0 0 0 0 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 0 0 0 190. 0 0 0 0 190. 0 0 0 0 190. 0 0 0 0 190. 0 0 0 0 190. 0 0 0 0 190. 0 0 0 190. 0 0 0 0 0 0 0 190. 0 0 0 0 191. 191. 191.291 18, 494 209, 785 4, 461 214, 246 191. 191.291 18, 494 209, 785 4, 461 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></t<>			0	0	0	0		
5.00 11600 HOSPI CE 0 63, 488 63, 488 23, 167 86, 655 116. 3.00 SUBTOTALS (SUM OF LINES 1-117) 18, 048, 520 30, 782, 619 48, 831, 139 11, 278 48, 819, 861 118. NONRET MBURSABLE COST CENTERS 0 0 0 0 1900. 0 0 0 190. 1900. GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 191.00 RESEARCH 0 0 0 191.01 FMH DI AGNOSTI C CENTER 191, 291 18, 494 209, 785 4, 461 214, 246 191. 1.00 19102 WELLNESS 85, 658 107, 222 192, 880 1, 463 194, 343 191. 2.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 085 13, 495 16, 580 1, 091 17, 671 192. 2.01 19202 MARKETI NG 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2.03 19204			0	0	0	0		
B. 00 SUBTOTALS (SUM OF LINES 1-117) 18,048,520 30,782,619 48,831,139 -11,278 48,819,861 118,778 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 1900 0 0 0 1900 19107 18,048,520 30,782,619 48,831,139 -11,278 48,819,861 118,77 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 1900 0 0 0 1900 0 0 0 1900 18,494 209,785 4,461 214,246 191 191 18,494 209,785 4,461 214,246 191 191 19102 WELLNESS 85,658 107,222 192,880 1,463 194,343 191 192 2.01 19201 RFE 0 14 14 0 14 192 2.02 19204 RARKETI NG 64,263 228,590 292,853 -29,393 263,460 192 2.04 19204 BROOKVI LLE CLINI C			0	0 63 488	0 63 488	23 167		
NONREI MBURSABLE COST CENTERS 0.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 1900 1.00 19100 RESEARCH 0 0 0 0 0 0 0 1910 1.01 19101 FMH DI AGNOSTI C CENTER 191, 291 18, 494 209, 785 4, 461 214, 246 191. 1.02 19102 WELLNESS 85, 658 107, 222 192, 880 1, 463 194, 343 191. 2.00 19200 PHYSI CI ANS' PRI VATE OFFICES 3, 085 13, 495 16, 580 1, 091 17, 671 192. 2.01 19202 MARKETI NG 0 14 14 0 14 12. 12.03 19203 FOUNDATI ON 0 <td></td> <td></td> <td>18, 048, 520</td> <td></td> <td></td> <td></td> <td></td> <td></td>			18, 048, 520					
1. 00 19100 RESEARCH 0 0 0 0 1911 1. 01 19101 FMH DI AGNOSTI C CENTER 191, 291 18, 494 209, 785 4, 461 214, 246 191. 1. 02 19102 WELLNESS 85, 658 107, 222 192, 880 1, 463 194, 343 191. 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 3, 085 13, 495 16, 580 1, 091 17, 671 192. 2. 01 19201 RFE 0 14 14 0 14 192. 2. 02 19203 MARKETI NG 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2. 03 F0203 FOUNDATI ON 0 0 0 0 192. 2. 04 19203 BROKVI LLE CLINIC 0 0 0 0 192. 2. 05 19205 ATOD 0 0 0 0 0 192.	-						1	
1. 01 19101 FMH DI AGNOSTI C CENTER 191, 291 18, 494 209, 785 4, 461 214, 246 191. 1. 02 19102 WELLNESS 85, 658 107, 222 192, 880 1, 463 194, 343 191. 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 3, 085 13, 495 16, 580 1, 091 17, 671 192. 2. 01 19202 MARKETI NG 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2. 03 19204 BROKVI LLE CLINIC 0 0 0 0 192. 2. 04 19204 BROKVI LLE CLINIC 0 0 0 0 192.			1	-				
I. 02 19102 WELLNESS 85, 658 107, 222 192, 880 1, 463 194, 343 191. 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 3, 085 13, 495 16, 580 1, 091 17, 671 192. 2. 01 19201 RFE 0 14 14 0 14 142 2. 02 19202 MARKETI NG 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2. 03 19203 FOUNDATI ON 0 0 0 0 192. 2. 04 19204 BROKVI LLE CLINIC 0 0 0 0 192. 2. 05 19205 ATOD 0 0 0 0 192.			-	0	0	•		
2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 3,085 13,495 16,580 1,091 17,671 192 2. 01 19201 RFE 0 14 14 0 14 192 2. 02 19202 MARKETI NG 64,263 228,590 292,853 -29,393 263,460 192 2. 03 19203 FOUNDATI ON 0 0 0 192 2. 04 19204 BROOKVI LLE CLINIC 0 0 0 192 2. 05 19205 ATOD 0 0 0 0 192								
2. 01 19201 RFE 0 14 14 0 14 192. 2. 02 19202 MARKETI NG 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2. 03 19203 FOUNDATI ON 0 0 0 0 192. 2. 04 19204 BROOKVI LLE CLINIC 0 0 0 0 192. 2. 05 19205 ATOD 0 0 0 0 192.								
2. 02 19202 MARKETING 64, 263 228, 590 292, 853 -29, 393 263, 460 192. 2. 03 19203 FOUNDATION 0 0 0 0 192. 2. 04 19204 BROOKVILLE CLINIC 0 0 0 0 192. 2. 05 19205 ATOD 0 0 0 0 192.			3,085					
2. 03 19203 FOUNDATION 0 0 0 1922. 2. 04 19204 BROOKVILLE CLINIC 0 0 0 0 1922. 2. 05 19205 ATOD 0 0 0 0 0 0 1922.			64.263			•		
2. 05 19205 ATOD 0 0 0 0 192.			0	0	0	0		
	2.04	19204 BROOKVILLE CLINIC	0	0	0	0		
			0	0	0	0		

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC		eriod: rom 10/01/2015	Worksheet A	
				o 09/30/2016		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
192. 07 19207 WVCP	1, 589, 924	591, 325	2, 181, 249	28, 736	2, 209, 985	192.07
192.08 19208 OCCUPATIONAL MED	7, 333	1, 028	8, 361	149	8, 510	192.08
192. 09 19209 HOME MEDI CAL EQUI PMENT	0	0	0	0	0	192.09
192. 10 19210 HOSPI TALI ST	272, 849	925, 292	1, 198, 141	4, 771	1, 202, 912	192.10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 TOTAL (SUM OF LINES 118-199)	20, 262, 923	32, 668, 079	52, 931, 002	0	52, 931, 002	200. 00

	Financial Systems F SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (AYETTE REGIONAL	HEALTH SYSTEM Provider CC	N: 15-0064	Period:	u of Form CMS Worksheet A	-2552-10
					From 10/01/2015 To 09/30/2016		epared:
	Cost Conton Description	Adiustmente	Not Experses			2/23/2017 9:	
	Cost Center Description		Net Expenses For Allocation				
	GENERAL SERVICE COST CENTERS	6.00	7.00				-
1.00	00100 CAP REL COSTS-BLDG & FIXT	-38, 452					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 254, 004				4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-1, 082, 988					5.00
7.00	00701 OPERATION OF PLANT	-2, 522	1, 755, 142 880, 108				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	125, 985				8.00
9.00	00900 HOUSEKEEPI NG	0	631, 514				9.00
10.00	01000 DI ETARY	0	355, 473				10.00
11.00		-214,007					11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-398	768, 315 820, 011				13.00 14.00
15.00	01500 PHARMACY	-2, 270, 824					14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	-9, 420					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30.00	03000 ADULTS & PEDIATRICS	0					30.00
31.00	03100 I NTENSI VE CARE UNI T	0					31.00
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	1, 413, 635 2, 080				40.00
42.00	04200 SUBPROVI DER	0	2,000				41.00
43.00	04300 NURSERY	0	368, 886				43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	-648, 643	818, 866				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	-83, 065	2, 663, 204				54.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	1, 728, 207				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
65.00		0	424, 567				65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	-42, 304	444, 521 0				66.00 69.00
69.00	06901 CARDI AC REHAB	0	154, 644				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	66, 678				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00	07400 RENAL DI ALYSI S	0	0				74.00
88. 00	OUTPATIENT SERVICE COST CENTERS	0	0				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
91.00	09100 EMERGENCY	-705, 791	1, 259, 951				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050 CLINIC	-4, 023, 376					93.00
	04950 BI C 04951 UCI C	-163, 781	909, 594				93.01
	04952 CI C	0	o				93.02
	04953 RI C	0	0				93.04
93.05	04954 PODI ATRY	0	3, 111				93.05
05 00		24.750	24, 252				05.00
95.00 99.00	09500 AMBULANCE SERVICES 09900 CMHC	-24, 650					95.00 99.00
	09910 CORF	0	0				99.10
	10100 HOME HEALTH AGENCY	0	795, 323				101.00
	SPECIAL PURPOSE COST CENTERS	1					
	10900 PANCREAS ACQUISITION	0					109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0				110.00
	11600 HOSPI CE	0	86, 655				116.00
118.00		-9, 310, 221	39, 509, 640				118.00
	NONRE MBURSABLE COST CENTERS	· · ·					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	19100 RESEARCH	0	0				191.00
	19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS	0	214, 246 194, 343				191.01 191.02
	19102 WELLNESS 19200 PHYSICIANS' PRIVATE OFFICES		17, 671				191.02
	19201 RFE	0	14				192.00
192.02	19202 MARKETI NG	0	263, 460				192. 02
	19203 FOUNDATION	0	0				192.03
	19204 BROOKVILLE CLINIC	0	0				192.04
	19205 ATOD	0	0				192.05
	10206 HEADT CENTED	∩					
192.06	19206 HEART CENTER 19207 WVCP	0	0 2, 209, 985				192.06

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CC	N: 15-0064	Peri od:	Worksheet A
				From 10/01/2015	
				To 09/30/2016	Date/Time Prepared: 2/23/2017 9:30 am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7.00			
192. 09 19209 HOME MEDI CAL EQUI PMENT	0	0			192.09
192. 10 19210 HOSPI TALI ST	0	1, 202, 912			192.10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0			194.00
200.00 TOTAL (SUM OF LINES 118-199)	-9, 310, 221	43, 620, 781			200.00

	Financial Systems SIFICATIONS		YETTE REGIONAL	Provi der CCN: 15-0064	Peri od:	u of Form CMS-2552- Worksheet A-6
					From 10/01/2015	
					To 09/30/2016	Date/Time Prepared 2/23/2017 9:30 am
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
h	A – CAFETERIA CAFETERIA	11 00	212 409	228 440		1.0
C	TOTALS	<u>11.00</u>	<u>312, 698</u> 312, 698	<u>228, 440</u> 28, 440		1.1
	B - NURSERY		512, 090	228, 440		
0	NURSERY	43.00	280, 947	87, 939		1.0
0	TOTALS		280, 947	87,939		
	C - COACH RECLASS	I	2007717	0,,,,0,		
)	EMPLOYEE BENEFITS DEPARTMENT	4.00	85, 544	0		1. (
C	ADMI NI STRATI VE & GENERAL	5.00	191, 556	0		2.0
0	OPERATION OF PLANT	7.00	7, 052	0		3.0
0	HOUSEKEEPI NG	9.00	15, 577	0		4. C
C	DI ETARY	10.00	15, 219	0		5.0
0	NURSING ADMINISTRATION	13.00	14, 010	0		6. 0
0	CENTRAL SERVICES & SUPPLY	14.00	2, 100	0		7.0
0	PHARMACY	15.00	3, 318	0		8.0
0	MEDICAL RECORDS & LIBRARY	16.00	65, 190	0		9. (
00	ADULTS & PEDIATRICS	30.00	18, 218	0		10. 0
00	I NTENSI VE CARE UNI T	31.00	11, 117	0		11. (
00	SUBPROVIDER - IPF	40.00	12, 024	0		12.0
00	OPERATING ROOM	50.00	12, 018	0		13. (
00	RADI OLOGY-DI AGNOSTI C	54.00	30, 100	0		14. (
00		60.00	19, 402	0		15. (
00		65.00	6, 708	0		16.0
00	PHYSICAL THERAPY	66.00	8, 900	0		17.0
00 00	CARDIAC REHAB	69.01	2, 426	0		18.0
00	EMERGENCY CLINIC	91.00 93.00	17, 494 86, 268	0		19.0 20.0
00	BIC	93.00 93.01	7, 021	0		20.0
00	AMBULANCE SERVICES	95.00	664	0		21.0
00	HOME HEALTH AGENCY	101.00	6, 558	0		23.0
00	FMH DIAGNOSTIC CENTER	191.00	4, 461	0		23.0
00	WELLNESS	191.02	1, 463	0		25.0
00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 091	0		26.0
00	MARKETING	192.02	1, 510	0		27.0
00	WVCP	192.07	28, 736	0		28.0
00	OCCUPATI ONAL MED	192.08	149	0		29.0
00	HOSPI TALI ST	192.10	4, 771	0		30.0
	TOTALS	<u> </u>	680, 665	ō		
	D - MARKETING	· · · · ·		· · · ·		
0	ADMI NI STRATI VE & GENERAL	5.00	6, 781	24, 122		1.0
	TOTALS		6, 781	24, 122		
	E - HOSPICE					
0		116.00	23, 167	0		1.0
	TOTALS		23, 167	ō		
_	F - HOSPITAL UTILITIES					
0	OPERATION OF PLANT			880, 108		1.0
	TOTALS		0	880, 108		
	G - IMPLANTABLE DEVICES		. 1			
0	IMPL. DEV. CHARGED TO	72.00	0	66, 678		1. (
	PATIENTS	+				
	TOTALS Grand Total: Increases		0	66, 678 1, 287, 287		500.0

th Financial Systems	F.F.	YETTE REGIONAL			In Lieu of Forr	
LASSI FI CATI ONS			Provi der	CCN: 15-0064	Period: Workshe From 10/01/2015	et A-6
					To 09/30/2016 Date/Ti	me Prepare
	Decreases				2723720	<u>17 9:30 an</u>
Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	<u>-</u> .	
6.00	7.00	8.00	9.00	10.00		
A – CAFETERIA						
0 <u>DIETARY</u>	10.00	31 <u>2, 6</u> 98	228, 440)	0	1
TOTALS		312, 698	228, 440)		
B - NURSERY	1					
0 ADULTS & PEDIATRICS	30.00	28 <u>0, 9</u> 47	8 <u>7, 9</u> 39		Q	1
TOTALS		280, 947	87, 939	9		
C - COACH RECLASS	5.00	(00.445				
0 ADMI NI STRATI VE & GENERAL	5.00	680, 665	0		0	1
0	0.00	0	((0	2
0	0.00	0	(0	3
0	0.00	0	(0	5
0	0.00	0	(0	6
0	0.00	0	(0	7
0	0.00	0	(0	6
0	0.00	0	(0	9
00	0.00	o	(0	10
00	0.00	o	(0	11
00	0.00	0	0		0	12
00	0.00	0	C		0	13
00	0.00	0	C		0	14
00	0.00	0	C		0	15
00	0.00	0	C	D	0	16
00	0.00	0	C	b	0	17
00	0.00	0	C	D	0	18
00	0.00	0	C	D	0	19
00	0.00	0	C	D	0	20
00	0.00	0	C		0	21
00	0.00	0	C		0	22
00	0.00	0	C		0	23
00	0.00	0	C		0	24
00	0.00	0	C		0	25
00	0.00	0	C		0	26
00	0.00	0	0		0	27
00	0.00	0	0		0	28
00	0.00	0	0		0	29
00		680, 665	(<u> </u>	30
D - MARKETING		000, 000				
0 MARKETING	192.02	6, 781	24, 122		0	1
TOTALS	172.02	6, 781	24, 122			'
E - HOSPICE	I	0,701	27,122	-1		
0 HOME HEALTH AGENCY	101.00	23, 167	(0	0	1
TOTALS		23, 167	0		7	'
F - HOSPITAL UTILITIES	<u> </u>	_0, .0.			1	
0 OPERATION OF PLANT	7.00	ol	880, 108	3	0	1
TOTALS	- $ +$		880, 108		7	
G - IMPLANTABLE DEVICES		5				
0 CENTRAL SERVICES & SUPPLY	14.00	0	66, 678	3	0	1
		<u>_</u>	66, 678		1	
. 00 Grand Total: Decreases		1, 304, 258	1, 287, 287		-	500

Health Financial Systems	FAYETTE REGIONAL H	EAL
RECONCILIATION OF CAPITAL COSTS CENTERS		Pr

 EALTH SYSTEM
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0064
 Period: From 10/01/2015
 Worksheet A-7

					From 10/01/2015 To 09/30/2016		
				Acqui si ti ons	6		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 244, 594	0		0 0	150, 192	1.00
2.00	Land Improvements	606, 043			0 3,063		2.00
3.00	Buildings and Fixtures	55, 308, 231	240, 370		0 240, 370	4, 799, 402	3.00
4.00	Building Improvements	138, 533	0		0 0	102, 820	4.00
5.00	Fixed Equipment	25, 052, 118	544, 073		0 544, 073	1, 064, 575	5.00
6.00	Movable Equipment	0	0		0 0	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	82, 349, 519	787, 506		0 787, 506	6, 205, 517	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	82, 349, 519	787, 506		0 787, 506	6, 205, 517	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 094, 402	0				1.00
2.00	Land Improvements	520, 578	0				2.00
3.00	Buildings and Fixtures	50, 749, 199	0				3.00
4.00	Building Improvements	35, 713	0				4.00
5.00	Fixed Equipment	24, 531, 616	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	76, 931, 508	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	76, 931, 508	0				10.00

Heal th	Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 10/01/2015	Worksheet A-7 Part II	
					To 09/30/2016		pared: <u>0 am</u>
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	865, 242	0	2, 075, 60	9 0	0	1.00
3.00	Total (sum of lines 1-2)	865, 242	0	2, 075, 60	9 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 940, 851				1.00
3.00	Total (sum of lines 1-2)	0	2, 940, 851				3.00

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 10/01/2015 Fo 09/30/2016		pared:
	COM	PUTATION OF RAT	ri os	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	50, 749, 199	0	50, 749, 19	9 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	50, 749, 199		50, 749, 19	9 1.000000	0	3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -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 C	0.00	7.00	0.00	7.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0		826, 790	0	1.00
3.00 Total (sum of lines 1-2)	0	-		826, 790	0	3.00
		SL	JMMARY OF CAPI		-	
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	2,075,609	0		0 0	2, 902, 399	1.00
3.00 Total (sum of lines 1-2)	2, 075, 609	0		0 0	2, 902, 399	3.00

Heal th	Fi nanci	al Systems	
AD IIIST	MENTS TO) EXPENSES	

	Financial Systems MENTS TO EXPENSES	FA	YETTE REGIONAL	Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	u of Form CMS-2 Worksheet A-8 Date/Time Pre 2/23/2017 9:30	pared:
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0,	*** Cost Center Deleted ***	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		О		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		О		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 918, 865		0.00	0 0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service		0		0.00 0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee		0		0.00	0	
16.00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients		О		0.00	0	17.00
18.00	Sale of medical records and abstracts	A	-9, 420	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		О		0.00	0	19.00
20.00	Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS MURIE FOULD		0	*** Cost Center Deleted ***	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0.00 67.00		29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0,	*** Cost Center Deleted ***	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest PFS BILLING SVC -OTHER REV	В		ADMI NI STRATI VE & GENERAL	5.00		
33. 01	VENDOR REBATE/REFUND-OTHER REV	В	-54, 340	ADMINISTRATIVE & GENERAL	5.00	0	33. 01

	Financial Systems	FA	YETTE REGIONAL	HEALTH SYSTEM		eu of Form CMS-	
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0064	Period: From 10/01/2015		
					To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
				Expense Classification (
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
3. 02	PURCHASE DI SC EARNED-OTHER REV			ADMINISTRATIVE & GENERAL	5.00		
3. 03		В		ADMINISTRATIVE & GENERAL	5.00		
3. 04	COLLEDTION FEES REV-OTHER REV	В		ADMINISTRATIVE & GENERAL	5.00		
3. 05	CAFETERIA SALES-OTHER REV	В		CAFETERI A	11.00		000
3.06	CAFÉ VEND MACHIN-OTHER REV	В		CAFETERI A	11.00		
3. 07	EDUCATION & TRAINING-OTHER REV			NURSING ADMINISTRATION	13.00		
3. 08	EMPLOYEE DRUG SALES-OTHER REV	В		PHARMACY	15.00		
3.09	PHARMACY REBATES - OTHER	В		PHARMACY	15.00		
3. 10	PHY TH SCHOOL REV-OTHER REV	В		PHYSICAL THERAPY	66.00		
3. 11	PHYSICAL NIGHT-OTHER REV	В		PHYSICAL THERAPY	66.00		
3. 12	AQUATIC THERAPY-OTHER REV	В		PHYSICAL THERAPY	66.00		
3. 13	HELPLINE -OTHER REV	В		AMBULANCE SERVICES	95.00		
3. 14	I HA DUES	A		ADMINISTRATIVE & GENERAL	5.00		
3. 15	TELEVI SI ON	A		ADMINISTRATIVE & GENERAL	5.00		
3. 16	TELEVISION ELECTRICITY	A		OPERATION OF PLANT	7.00		00.
3.17	24TH ST OLD DEPRECIATION	A		CAP REL COSTS-BLDG & FIXT	1.00		1 00.
3. 18	24TH ST NEW DEPRECIATION	A		CAP REL COSTS-BLDG & FIXT	1.00		00.
3.19	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00		00.
3.20	340B REVENUE	A	-2, 216, 039		15.00		
3.21	ER PURCHASED SERVICES	A		EMERGENCY	91.00		00.
3.22	HAF OFFSET	A	-910, 701	ADMINISTRATIVE & GENERAL	5.00		1 001
3.23			0 210 221		0.00	0	00.
50.00			-9, 310, 221				50.0
	(Transfer to Worksheet A, column 6. Line 200.)						
		1		1			1

 column 6, line 200.)
 |

 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	FAYETTE REGIONA	L HEALTH SYSTEM	Л	In Li	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT					Period: Worksheet A-8-2 From 10/01/2015 To 09/30/2016 Date/Time Prepared:			
	William A. I. S. a. a. //		Tatal	Desfersional	Dreaminateur		2/23/2017 9:3	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Domunososti on	Professi onal	Provi der	RCE Amount	Physician/Prov ider Component	
		rdentrirer	Remuneration	Component	Component		Hours	
	1.00	2.00	3.00	4,00	5.00	6, 00	7.00	
1 00								1 00
1.00		CLINIC	4, 104, 614	3, 928, 118	176, 496			1.00
2.00	93.01		220, 407	158, 524	61, 883			
3.00		OPERATING ROOM	648, 643	648, 643	(3.00
4.00		RADI OLOGY-DI AGNOSTI C	83, 065	83, 065	(4.00
5.00	0.00		0	0	(0 0	-	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			5, 056, 729	4, 818, 350	238, 379		1, 602	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1, 00	2.00	8,00	9,00	12.00	13.00	14.00	
1.00	93.00	CLINIC	81, 238	4, 062	(0	1.00
2.00	93.01		56, 626	2, 831	(2.00
3.00		OPERATING ROOM	00,020	2,001	(-	-	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	(0	4,00
5.00	0.00		0	0	(°	-	4.00 5.00
6.00	0.00		0	0	(0	6,00
7.00	0.00		0	0			0	7.00
			0	0	ĺ		-	
8.00	0.00		0	0	C		0	8.00
9.00	0.00		0	0	(0	0	9.00
10.00	0.00		0	0	(0	-	10.00
200.00			137, 864	6, 893	(0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		CLINIC	0	81, 238	95, 258			1.00
2.00	93. 01		0	56, 626	5, 257			2.00
3.00		OPERATING ROOM	0	0	(648, 643		3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(83, 065		4.00
5.00	0.00		0	0	(0		5.00
6.00	0.00		0	0	(0 0		6.00
7.00	0.00		0	0	(0 0		7.00
8.00	0.00		0	0	(8.00
9.00	0.00		0	0	(9,00
10.00	0.00		0	0	(10.00
200.00	5.00		0	0	100, 515	°		200.00
200.00		1		,	, 010	1, 7, 10, 000	1	

ealth Financial Systems OST ALLOCATION - GENERAL SERVICE COSTS		HEALTH SYSTEM		riod: om 10/01/2015	u of Form CMS-: Worksheet B Part I	2002-
			To		Date/Time Pre	pare
		,			2/23/2017 9:3	<u>0 am</u>
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost		BENEFITS		& GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS	0	1.00	4.00	47	5.00	
. 00 00100 CAP REL COSTS-BLDG & FIXT	2, 902, 399	2,902,399				1.
			4 9/5 999			
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 254, 004		4, 265, 280			4.
. 00 00500 ADMINISTRATIVE & GENERAL	5, 875, 778	180, 275	419, 557	6, 475, 610	6, 475, 610	5.
. 00 00700 OPERATION OF PLANT	1, 755, 142	1, 187, 420	53, 695	2, 996, 257	522, 343	7.
. 01 00701 OPERATION OF PLANT	880, 108	o	0	880, 108	153, 431	7.
. 00 00800 LAUNDRY & LINEN SERVICE	125, 985		0	129, 465	22, 570	
. 00 00900 HOUSEKEEPING	631, 514		109, 050	754, 888	131,601	9.
0. 00 01000 DI ETARY	355, 473		107, 962	482, 224	84, 067	
1. 00 01100 CAFETERIA	327, 131	30, 256	0	357, 387	62, 304	11.
3. 00 01300 NURSING ADMINISTRATION	768, 315	0	157, 507	925, 822	161, 400	13.
4.00 01400 CENTRAL SERVICES & SUPPLY	820, 011	19, 044	14, 816	853, 871	148, 857	14.
5. 00 01500 PHARMACY	3, 390, 062	18, 427	42, 558	3, 451, 047	601, 628	15.
6. 00 01600 MEDICAL RECORDS & LIBRARY	773, 809		135, 944	937, 373		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	, , 3, 007	27,020	155, 744	757, 575	105, 414	1 '0.
	1.045.721	450 / 05	045 70-	1 445 000	054 001	1 22
0. 00 03000 ADULTS & PEDIATRICS	1, 045, 691		245, 787	1, 445, 083	251, 924	
1.00 03100 INTENSIVE CARE UNIT	753, 714		137, 533	957, 096	166, 852	
0. 00 04000 SUBPROVIDER - IPF	1, 413, 635	55, 955	135, 569	1, 605, 159	279, 831	40.
1.00 04100 SUBPROVIDER - IRF	2,080		23	2, 103		41.
2. 00 04200 SUBPROVI DER	0	0	0	0	0	
3. 00 04300 NURSERY	368, 886	Ŭ	0	405, 074	70, 617	
	300,000	JU 30, 100	U	405, 074	70,017	43.
ANCI LLARY SERVI CE COST CENTERS	010.0(/	474 474	100.001	4 404 0/0	105 005	1 - 0
0.00 05000 OPERATING ROOM	818, 866	176, 476	128, 921	1, 124, 263		
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 663, 204	157, 255	214, 514	3, 034, 973	529, 093	54.
7.00 05700 CT SCAN	0	ol	0	0	0	57.
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	
			0	0	0	
	1 700 007		0	0	-	
0. 00 06000 LABORATORY	1, 728, 207	50, 604	134, 211	1, 913, 022	333, 501	
0.01 06001 BLOOD LABORATORY	0	0	0	0	0	
5. 00 06500 RESPI RATORY THERAPY	424, 567	23, 778	79, 328	527, 673	91, 990	65.
6. 00 06600 PHYSI CAL THERAPY	444, 521	52, 248	88, 928	585, 697	102, 106	66.
9. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.
9. 01 06901 CARDI AC REHAB	154, 644	21, 135	30, 344	206, 123		
	134,044	21,133	50, 544	200, 123		
		0	0	0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	66, 678	1	0	66, 678		
3.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.
4.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.
OUTPATIENT SERVICE COST CENTERS	•					1
8. 00 08800 RURAL HEALTH CLINIC	0		0	0	0	88.
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	1 250 051		210 071	1 504 774		
1.00 09100 EMERGENCY	1, 259, 951	58, 754	218, 071	1, 536, 776	267, 909	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.
3. 00 04050 CLINIC	3, 674, 229		1, 054, 525	4, 917, 966	857, 378	93.
3. 01 04950 BIC	909, 594	0	125, 382	1, 034, 976	180, 429	93.
3. 02 04951 UCI C	0	ol	0	0	0	93.
3. 03 04952 CIC			0	0	0	
3. 04 04953 RI C			0	0	0	
	2 111	0	(22)	0		
3. 05 04954 PODI ATRY	3, 111	0	632	3, 743	653	93.
OTHER REIMBURSABLE COST CENTERS		1 1				١.
5. 00 09500 AMBULANCE SERVICES	36, 353	0	11, 271	47, 624	8, 302	
9. 00 09900 CMHC	0	0	0	0	0	99.
9. 10 09910 CORF	0	l ol	0	0	0	99.
D1. 00 10100 HOME HEALTH AGENCY	795, 323	21, 624	149, 753	966, 700	168, 527	
SPECIAL PURPOSE COST CENTERS			,			1
09. 00 10900 PANCREAS ACQUISITION	0		~	0	0	109.
	-		0	0		
10. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.
11.00 11100 I SLET ACQUI SI TI ON	0	ן 0	0	0		111.
16. 00 11600 HOSPI CE	86, 655	0	0	86, 655	15, 107	116.
18.00 SUBTOTALS (SUM OF LINES 1-117)	39, 509, 640	2, 573, 594	3, 795, 881	38, 711, 436	5, 619, 754	118.
NONREI MBURSABLE COST CENTERS						1
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.
91. 00 19100 RESEARCH			0	0		191.
	214.244					
91. 01 19101 FMH DI AGNOSTI C CENTER	214, 246		40, 549	254, 795		
91. 02 19102 WELLNESS	194, 343		18, 157	212, 500	37, 046	
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	17, 671	40, 589	654	58, 914	10, 271	192.
92. 01 19201 RFE	14		0	14		192.
92. 02 19202 MARKETI NG	263, 460	1	13, 622	286, 331	49, 917	
	200,400		10,022			
92. 03 19203 FOUNDATI ON	0	9, 993	11	9, 993	1, 742	1100

Health Financial Systems F	AYETTE REGIONAL	GIONAL HEALTH SYSTEM In Lieu of Form CMS-				2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 10/01/2015	Worksheet B 5 Part I	
				To 09/30/2016		
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost		BENEFITS		& GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A col. 7)					
	0	1.00	4.00	4A	5.00	
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	6, 683		0 6, 683		192.06
192. 07 19207 WVCP	2, 209, 985					
192.08 19208 OCCUPATI ONAL MED	8, 510	0	1, 55	4 10, 064		192.08
192.09 19209 HOME MEDI CAL EQUI PMENT	0	0		0 0		192.09
192. 10 19210 HOSPI TALI ST	1, 202, 912		57, 83			
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	112, 860		0 112, 860		194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	42 (20 701	0	4 0/5 00			201.00
202.00 TOTAL (sum lines 118-201)	43, 620, 781	2, 902, 399	4, 265, 28	0 43, 620, 781	6, 475, 610	202.00

	Financial Systems F ALLOCATION - GENERAL SERVICE COSTS	AYETTE REGIONAL	HEALTH SYSTEM Provider C	CN: 15-0064 P F	In Lie eriod: rom 10/01/2015 o 09/30/2016		pared.
	Cost Center Description	OPERATION OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT 7.00	PLANT 7.01	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	7.00	7.01	0.00	7.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	3, 518, 600					5.00
7.00	00701 OPERATION OF PLANT	0	1, 033, 539				7.01
8.00	00800 LAUNDRY & LINEN SERVICE	7,022	3, 390				8.00
9.00	00900 HOUSEKEEPI NG	28, 904	13, 955		929, 348		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	37,914 61,054	18, 305 29, 477		10, 685 17, 206	650, 187 0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	01,034	29,477			0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	38, 429	18, 554		10, 830	0	1
15.00	01500 PHARMACY	37, 185	17, 953			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	55, 734	26, 909	C	15, 707	0	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	309, 962	149, 652	39, 996	87, 351	245, 124	30.00
31.00	03100 I NTENSI VE CARE UNI T	132, 877	64, 154			50, 605	
40.00	04000 SUBPROVI DER - I PF	112, 912	C	C	31, 820	67, 616	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	1
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 73, 025	0 35, 257		0 20, 579	0	1
43.00	ANCI LLARY SERVICE COST CENTERS	73,023	35,257		20, 379	0	43.00
50.00	05000 OPERATI NG ROOM	356, 113	171, 935	14, 290	100, 357	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	317, 327	153, 208	21, 182	89, 427	0	54.00 57.00
57.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0) C	0	0	
60.00	06000 LABORATORY	102, 114	49, 302	C	28, 777	0	
60.01	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0			12 522	0	
65.00 66.00	06600 PHYSI CAL THERAPY	47, 982 105, 432	23, 166 50, 904			0	
69.00	06900 ELECTROCARDI OLOGY	0	00, 701	C	0	0	1
69.01	06901 CARDI AC REHAB	42, 648	20, 591	1, 334	12, 019	0	69.01
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			0	0	
74.00	07400 RENAL DI ALYSI S	0	0		0	0	1
	OUTPATIENT SERVICE COST CENTERS						
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	1
89.00 91.00	09100 EMERGENCY	118, 561	57, 242	i i	-	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		077212		00,112		92.00
	04050 CLI NI C	392, 268	43, 715				93.00
	04950 BI C 04951 UCI C	303, 955	0		85, 658	0	1
93.02 93.03	04951 0CTC	0	0		0	0	1
	04953 RI C	0	0) C	0	0	1
93.05	04954 PODI ATRY	0	C	C	0	0	93.05
95 00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES		0			0	95.00
	09900 CMHC	0	0		0	0	1
	09910 CORF	0	C	C	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	43, 635	21, 067	4, 796	12, 297	0	101.00
100.00	SPECIAL PURPOSE COST CENTERS	0	C		0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0		0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11600 HOSPI CE	0	C	C	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2, 725, 053	968, 736	159, 396	748, 007	363, 345	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191.00	19100 RESEARCH	0	0) C	0	0	191.00
	19101 FMH DIAGNOSTIC CENTER	0	C	C	0		191. 01
		130, 046	20 545		36, 649		191.02
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 RFE	81,906	39, 545 0	2,540	23, 082 0		192.00 192.01
	19202 MARKETI NG	18, 664	9, 011		5, 260		192.02
	19203 FOUNDATI ON	20, 165	9, 736	C	5, 683		192.03
	19204 BROOKVILLE CLINIC	0	0		0		192.04
	19205 ATOD 19206 HEART CENTER	13, 487	6, 511		0 3, 801		192.05 192.06
	19207 WVCP	301, 538		1		286, 842	
192.08	19208 OCCUPATI ONAL MED	0	C) C	0	0	192.08

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
				From 10/01/2015 To 09/30/2016		oparod
				10 09/30/2010	2/23/2017 9:	
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	
192.09 19209 HOME MEDI CAL EQUI PMENT	0	0	(0 0		0 192. 09
192. 10 19210 HOSPI TALI ST	0	0	(0 0		0 192. 10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	227, 741	0	(23, 255		0 194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0		0 201.00
202.00 TOTAL (sum lines 118-201)	3, 518, 600	1, 033, 539	162, 44	7 929, 348	650, 18	7 202.00

		AYETTE REGIONAL	_ HEALTH SYSTEM			u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet B Part I Date/Time Pre 2/23/2017 9:3	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 1 00
1.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00 11.00 13.00 14.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	527, 428 16, 27(3, 757	1, 103, 492	1, 074, 24	78		1.00 4.00 5.00 7.01 8.00 9.00 10.00 11.00 13.00 14.00
15.00	01500 PHARMACY	9, 245		1107112	0 4, 163, 776		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	28, 134	0		0 0	1, 227, 271	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	00.70	100.00(44.404	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	33, 783			0 0	46, 191 16, 446	
40.00	04000 SUBPROVI DER – I PF	25, 963			0 0	44, 717	
41.00	04100 SUBPROVI DER – I RF	(0 0	43	1
42.00	04200 SUBPROVI DER	(0 0		0 0	0	42.00
43.00	04300 NURSERY	9, 202	36, 095		0 0	4, 097	43.00
	ANCI LLARY SERVICE COST CENTERS	27.02	148, 205			100 720	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	37, 824			0 0	100, 730 0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	39, 976	-		0 0	275, 920	
57.00	05700 CT SCAN	(0 0		0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	(0 0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	(° I		0 0	0	
60.00	06000 LABORATORY	28, 640	112, 255		0 0	194, 205	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	20, 612	80, 780		0 0	0 37, 471	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 081				20, 886	
69.00	06900 ELECTROCARDI OLOGY	13,00			0 0	20, 000	
69.01	06901 CARDI AC REHAB	5, 836	22, 884		0 0	4, 582	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	(0 0	1, 074, 29	98 0	30, 407	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 0		0 0	1, 736	
73.00	07300 DRUGS CHARGED TO PATIENTS	(0		0 4, 163, 776	130, 030	
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS		0 0		0 0	0	74.00
88.00	08800 RURAL HEALTH CLINIC	(0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	
91.00	09100 EMERGENCY	34, 837	0		0 0	154, 528	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	04050 CLINIC	71, 554	0		0 0	126, 078	
	04950 BI C 04951 UCI C				0 0	26, 726 0	
	04952 CI C				0 0	0	
93.04	04953 RI C	(0 0		0 0	0	
93.05	04954 PODI ATRY	235	0		0 0	142	93.05
95.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	3, 752	2 14, 727		0 0	1, 336	95.00
	09900 CMHC	3, / 52	14, 727		0 0	1, 330	
	09910 CORF				0 0	0	
	10100 HOME HEALTH AGENCY	28, 594	112, 038		0 0	8, 685	101.00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	(0 0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION				0		110.00
	11600 HOSPICE				0 0		111.00
118.00		436, 373	1, 103, 492	1, 074, 29	98 4, 163, 776	1, 227, 271	
	NONREI MBURSABLE COST CENTERS			=			1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0 0		0 0		190.00
	19100 RESEARCH				0 0		191.00
	19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS						191.01
	19102 WELLNESS 19200 PHYSICIANS' PRIVATE OFFICES						191.02
	19201 RFE		ol ol		0 0		192.01
	19202 MARKETI NG	1,659			0 0	0	192.02
	19203 FOUNDATI ON	1, 933	3 0		0 0		192.03
	19204 BROOKVILLE CLINIC	(0		0 0		192.04
	19205 ATOD				0 0		192.05 192.06
	19206 HEART CENTER 19207 WVCP	85, 615					192.06
172.07	17207 WV0F	00,015	ין 0		<u>v</u> 0	0	1172.0/

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 10/01/2015	Worksheet B Part I	
				To 09/30/2016	Date/Time Pre	pared:
					2/23/2017 9:3	<u>0 am</u>
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	
192.08 19208 OCCUPATI ONAL MED	0	0		0 0	0	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0 0	0	192.09
192. 10 19210 HOSPI TALI ST	1, 848	0		0 0	0	192.10
194.0007950 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)	527, 428	1, 103, 492	1, 074, 29	4, 163, 776	1, 227, 271	202.00

ST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	I: 15-0064	Period: From 10/01/2015	Worksheet B Part I
				To 09/30/2016	Date/Time Prepar 2/23/2017 9:30 a
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown	Total		
	24.00	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS	1	1 1			
00 00100 CAP REL COSTS-BLDG & FIXT 00 00400 EMPLOYEE BENEFITS DEPARTMENT					1
00 00500 ADMINI STRATI VE & GENERAL					E
00 00700 OPERATION OF PLANT					7
01 00701 OPERATION OF PLANT					7
00 00800 LAUNDRY & LINEN SERVICE					8
00 00900 HOUSEKEEPING . 00 01000 DI ETARY					9 10
. 00 01100 CAFETERIA					11
. 00 01300 NURSI NG ADMI NI STRATI ON					13
. 00 01400 CENTRAL SERVICES & SUPPLY					14
. 00 01500 PHARMACY					15
. 00 01600 MEDICAL RECORDS & LIBRARY					16
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 741, 462	0	2, 741, 4	62	30
. 00 03100 I NTENSI VE CARE UNI T	1, 563, 389	1	1, 563, 3		31
. 00 04000 SUBPROVI DER – I PF	2, 269, 733	1	2, 269, 7		40
. 00 04100 SUBPROVI DER – I RF	2, 513	1 1	2, 5		41
. 00 04200 SUBPROVI DER	C		(50.0	0	42
ANCI LLARY SERVI CE COST CENTERS	653, 946	0	653, 9	46	43
. 00 05000 OPERATING ROOM	2, 249, 712	0	2, 249, 7	12	50
. 00 05200 DELIVERY ROOM & LABOR ROOM	2,217,712	0	2,217,7	0	52
. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 617, 759	0	4, 617, 7	59	54
. 00 05700 CT SCAN	C	0		0	57
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	u u		0	58
00 05900 CARDI AC CATHETERI ZATI ON 00 06000 LABORATORY	2, 761, 816	0	2, 761, 8	0	59
. 01 06001 BLOOD LABORATORY	2,701,010	0	2,701,0	0	60
. 00 06500 RESPIRATORY THERAPY	843, 196	0	843, 1	96	65
. 00 06600 PHYSI CAL THERAPY	977, 246	0	977, 2	46	66
. 00 06900 ELECTROCARDI OLOGY	C	0		0	69
01 06901 CARDI AC REHAB	351,951	1	351,9		69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS . 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 104, 705		1, 104, 7 80, 0		71
. 00 07300 DRUGS CHARGED TO PATIENTS	4, 293, 806		4, 293, 8		73
. 00 07400 RENAL DIALYSIS	C	0		0	74
OUTPATIENT SERVICE COST CENTERS					
. 00 08800 RURAL HEALTH CLINIC				0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00 09100 EMERGENCY	2, 231, 214		2, 231, 2	0	89
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,231,214	0	2,231,2	14	92
00 04050 CLINIC	6, 509, 781	Ő	6, 509, 7	81	93
01 04950 BI C	1, 631, 744	0	1, 631, 7	44	93
. 02 04951 UCI C	C C	0		0	93
03 04952 CIC 04 04953 RIC				0	93
05 04954 PODI ATRY	4,773	0	4, 7	73	93
OTHER REIMBURSABLE COST CENTERS	.,,,,		.,,,		
. 00 09500 AMBULANCE SERVICES	75, 741	0	75, 7	41	95
00 09900 CMHC	C	0		0	99
10 09910 CORF 1.00 10100 HOME HEALTH AGENCY	1, 366, 339	0	1, 366, 3	20	99
SPECIAL PURPOSE COST CENTERS	1, 300, 339	U U	1, 300, 3	57	101
9. 00 10900 PANCREAS ACQUI SI TI ON	C	0		0	109
D. 00 11000 INTESTINAL ACQUISITION	C	0		0	110
1. 00 11100 I SLET ACQUI SI TI ON		0		0	111
6.00 11600 HOSPICE 3.00 SUBTOTALS (SUM OF LINES 1-117)	104,077		104, 0		11 <i>6</i> 118
NONREIMBURSABLE COST CENTERS	36, 434, 941	0	36, 434, 9	41	118
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	ol		0	190
1. 00 19100 RESEARCH	C	o o		0	191
1.01 19101 FMH DIAGNOSTIC CENTER	299, 214		299, 2		191
1. 02 19102 WELLNESS	416, 241	1	416, 2		191
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	216, 258	1	216, 2		192
2. 01 19201 RFE 2. 02 19202 MARKETI NG	16	1	370, 8	16 42	192 192
2. 03 19203 FOUNDATI ON	49, 252		49, 2		192
2. 04 19204 BROOKVI LLE CLINIC	0	1		0	192
2. 05 19205 ATOD	C	0		0	192

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2552	2-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0064	Peri od:	Worksheet B	
				From 10/01/2015 To 09/30/2016	Part I Date/Time Prepar	ed:
					2/23/2017 9:30 a	im
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
192.06 19206 HEART CENTER	31, 647	0	31, 6	47	192	2.06
192. 07 19207 WVCP	3, 924, 635	0	3, 924, 6	35	192	2.07
192.08 19208 OCCUPATI ONAL MED	11, 818	0	11, 8	18	192	2.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0	192	2.09
192. 10 19210 HOSPI TALI ST	1, 482, 386	0	1, 482, 3	36	192	2. 10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	383, 531	0	383, 5	31	194	4.00
200.00 Cross Foot Adjustments	0	0		0	200	0.00
201.00 Negative Cost Centers	0	0		0	201	1.00
202.00 TOTAL (sum lines 118-201)	43, 620, 781	0	43, 620, 7	81	202	2.00

Heal th	Fina	nci	al	Syste	ems	
		0F	CAL		PELATED	C

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

		2	FAYETTE REGIONAL				u of Form CMS-2	2552-10
ALLOCA	ATION O	F CAPITAL RELATED COSTS		Provider CC		eriod: rom 10/01/2015 o 09/30/2016	Worksheet B Part II Date/Time Pre 2/23/2017 9:3	pared:
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
			0	1.00	2A	4.00	5.00	
	GENERA	AL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11, 276	11, 276	11, 276		4.00
5.00		ADMINISTRATIVE & GENERAL	0			1, 108	181, 383	5.00
7.00		OPERATION OF PLANT	0	1, 187, 420	1, 187, 420	142	14, 631	7.00
7.01		OPERATION OF PLANT	0	0	0	0	4, 298	
3.00		LAUNDRY & LINEN SERVICE	0	3, 480	3, 480		632	
9.00		HOUSEKEEPI NG	0	14, 324				
10.00		DIETARY	0	18, 789				1
11.00 13.00		CAFETERIA NURSI NG ADMINI STRATI ON	0	30, 256 0	30, 256 0			
14.00		CENTRAL SERVICES & SUPPLY		-	-			
15.00		PHARMACY	0		18, 427			
16.00		MEDICAL RECORDS & LIBRARY	0					1
10.00		ENT ROUTINE SERVICE COST CENTERS		21,020	27,020		1,077	10.00
30.00	-	ADULTS & PEDIATRICS	0	153, 605	153, 605	649	7, 056	30.00
31.00	1 1	INTENSIVE CARE UNIT	0					
40.00	04000	SUBPROVIDER - IPF	0	55, 955	55, 955	358	7, 838	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	10	41.00
12.00	04200	SUBPROVI DER	0	0	0	0	0	42.00
43.00		NURSERY	0	36, 188	36, 188	0	1, 978	43.00
		ARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	0				5, 490	
52.00	1 1	DELIVERY ROOM & LABOR ROOM	0	-	0	-	0	
54.00		RADI OLOGY-DI AGNOSTI C	0	157, 255			14, 820	
57.00		CT SCAN	0	0	0	-	0	
58.00		MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	-	0	
59.00		CARDI AC CATHETERI ZATI ON	0		0	-	0 241	
50.00 50.01		LABORATORY BLOOD LABORATORY	0	50, 604	50, 604	355 0	9, 341 0	
55.00		RESPI RATORY THERAPY	0	23, 778	23, 778	-		
56. 00		PHYSI CAL THERAPY		52, 248	52, 248		2, 860	
59.00		ELECTROCARDI OLOGY	0	02,210	02, 210		0	
59.01		CARDI AC REHAB	0	21, 135	-		1,006	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	326	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0 0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		FIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC	0					
		FEDERALLY QUALIFIED HEALTH CENTER	0		-	-		
		EMERGENCY	0	58, 754	58, 754	576	7, 504	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)		100.010	0			92.00
93.00		CLINIC	0	189, 212	189, 212			
93.01	04950		0	0	0	331	5, 054	
93.02 93.03	04951 04952		0		0	-	0	
93.03 93.04	04952				0	-	0	
		PODIATRY			0	-	18	
	-	REIMBURSABLE COST CENTERS	. 0	0	0	2	10	1 . 0. 00
95.00		AMBULANCE SERVICES	0	0	0	30	233	95.00
99.00			0		0		0	
	09910		0	-	0	0	0	
101.00	10100	HOME HEALTH AGENCY	0	21, 624	21, 624	396	4, 720	101.00
		AL PURPOSE COST CENTERS						4
		PANCREAS ACQUISITION	0	0	0			109. 00
		INTESTINAL ACQUISITION	0	0	0	0		110.00
		I SLET ACQUI SI TI ON	0	0	0	0		111.00
			0		0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2, 573, 594	2, 573, 594	10, 036	157, 410	1118.00
		MBURSABLE COST CENTERS	-		-		-	100.00
100 00	119000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-				190.00
				0	0	-	0	191.00
191.00	19100	RESEARCH	0		<u>^</u>	107	1 1 1 1	1101 01
191.00 191.01	0 19100 19101	FMH DIAGNOSTIC CENTER	0	0	0		1,244	
191.00 191.01 191.02) 19100 19101 2 19102	FMH DIAGNOSTIC CENTER WELLNESS		0 0	0	48	1, 038	191.02
191.00 191.01 191.02 192.00) 19100 19101 2 19102 19200	FMH DIAGNOSTIC CENTER WELLNESS PHYSICIANS' PRIVATE OFFICES		0 0 0 40, 589	0	48 2	1, 038 288	191. 02 192. 00
191.00 191.01 191.02 192.00 192.01	19100 19101 19102 19102 19200 19201	FMH DIAGNOSTIC CENTER WELLNESS PHYSICIANS' PRIVATE OFFICES RFE		0 0 0 40, 589 0 0	0 40, 589 0	48 2 0	1, 038 288 0	191. 02 192. 00 192. 01
191.00 191.01 191.02 192.00 192.01 192.02	19100 19101 219102 19200 19201 219202	FMH DIAGNOSTIC CENTER WELLNESS PHYSICIANS' PRIVATE OFFICES		0 0	0 40, 589 0 9, 249	48 2 0 36	1, 038 288 0 1, 398	191. 02 192. 00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 10/01/2015 To 09/30/2016		oared:) am
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
	0	1.00	2A	4.00	5.00	
192. 05 19205 ATOD	0	0	0	0 0	0	192.05
192.06 19206 HEART CENTER	0	6, 683	6, 683	0	33	192.06
192. 07 19207 WVCP	0	149, 431	149, 431	890	13, 167	192. 07
192.08 19208 OCCUPATI ONAL MED	0	0	0) 4	49	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0 0	0	192.09
192. 10 19210 HOSPI TALI ST	0	0	0	153	6, 156	192. 10
194.00079500THER NONREIMBURSABLE COST CENTERS	0	112, 860	112, 860	0 0	551	194.00
200.00 Cross Foot Adjustments			0)		200. 00
201.00 Negative Cost Centers		0	C	0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	2, 902, 399	2, 902, 399	11, 276	181, 383	202.00

	Financial Systems F TION OF CAPITAL RELATED COSTS	AYETTE REGIONAL	Provi der C	CN: 15-0064 P	<u>In Lie</u> eriod: rom 10/01/2015	u of Form CMS- Worksheet B Part II	2552-10
					09/30/2016	Date/Time Pre	
	Cost Center Description	OPERATI ON OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	2/23/2017 9:3 DI ETARY	0 am
		PLANT	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	7.00	7.01	8.00	9.00	10.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1 000 100					5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT	1, 202, 193	4, 298				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 399	4, 290				8.00
9.00	00900 HOUSEKEEPI NG	9, 876			28, 232		9.00
10.00	01000 DI ETARY	12, 954	76		325	35, 467	
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	20, 860	123	0		0	
13.00	01400 CENTRAL SERVICES & SUPPLY	13, 130	-		329	0	
15.00	01500 PHARMACY	12, 705		°		0	
16.00	01600 MEDICAL RECORDS & LIBRARY	19, 042	112	0	477	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	105 004	(22	1 (04	2 (54	10.071	1 20 00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	105, 904 45, 400		1, 604 586		13, 371 2, 760	30.00
40.00	04000 SUBPROVIDER - IPF	38, 578				3, 688	
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0		0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	24, 950	147	0	625	0	43.00
50.00	05000 OPERATING ROOM	121, 673	715	574	3, 049	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	108, 420		851	2, 717	0	54.00
57.00 58.00	05700 CT SCAN	0	0	0		0	57.00 58.00
59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION				-	0	59.00
60.00	06000 LABORATORY	34, 889	-	-	-	0	1
60. 01	06001 BLOOD LABORATORY	0	0		-	0	60.01
65.00	06500 RESPI RATORY THERAPY	16, 394				0	65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	36, 023	212	730	903 0	0	66.00 69.00
69.01	06901 CARDI AC REHAB	14, 571	86		365	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	-		0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	-			0	
74.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	/4.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	40, 509	238	1, 123	1, 015	0	91.00 92.00
	04050 CLINIC	134, 025	182	4	3, 058	0	1
	04950 BI C	103, 852		0		0	
	04951 UCI C	0	0	0	0	0	
	04952 CI C 04953 RI C	0			0	0	
	04954 PODI ATRY	0	0	0	0	0	1
	OTHER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVICES	0	0	0	0	0	
	09900 CMHC 09910 CORF	0	0	0	-	0	
	10100 HOME HEALTH AGENCY	14, 909	88	-	-	-	101.00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0	0		110.00 111.00
	11600 HOSPI CE	0			0		116.00
118.00		931, 063	4, 030	6, 402	22, 724		118.00
	NONREI MBURSABLE COST CENTERS	-	1				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-	-		190.00
	19100 RESEARCH 19101 FMH DIAGNOSTIC CENTER		0	0	0		191.00 191.01
	19102 WELLNESS	44, 432	0	0	1, 113		191.02
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	27, 985	164	102	701	0	192.00
	19201 RFE	0	0		-		192.01
	2 19202 MARKETI NG 3 19203 FOUNDATI ON	6, 377 6, 890	37		160 173		192.02 192.03
	19203 FOUNDATION 19204 BROOKVILLE CLINIC	0, 890	40		0		192.03
	19205 ATOD	0	0	-	0		192.05
	19206 HEART CENTER	4,608					192.06
	19207 WVCP 19208 OCCUPATIONAL MED	103, 026		21			192.07 192.08
192.08	117200 UCUPATIONAL MED	0	<u> </u>	1 U	0	0	1192.08

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				From 10/01/2015		
				To 09/30/2016	Date/Time Pr 2/23/2017 9:	
Cost Center Description	OPERATION OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT	LINEN SERVICI			
	7.00	7.01	8.00	9.00	10.00	
192. 09 19209 HOME MEDI CAL EQUI PMENT	0	0		0 0		0 192. 09
192. 10 19210 HOSPI TALI ST	0	0		0 0		0 192. 10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	77, 812	0	1	0 706		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)	1, 202, 193	4, 298	6, 52	5 28, 232	35, 46	7 202. 00

	1 Financial Systems F ATION OF CAPITAL RELATED COSTS	AYETTE REGIONAL	Provider CC	CN: 15-0064	Peri od:	u of Form CMS- Worksheet B	2002-10
					From 10/01/2015 To 09/30/2016	Part II Date/Time Pre 2/23/2017 9:3	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00 5.00 7.00 7.01 8.00 9.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1.00 4.00 5.00 7.00 7.01 8.00 9.00
10.00 11.00 13.00 14.00 15.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	53, 507 1, 651 381 938	6, 588 0 216	37, 1	0 49, 642		10.00 11.00 13.00 14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,854	0		0 0	55, 041	16.00
30.00 31.00 40.00 41.00 42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER	3, 427 2, 544 2, 634 0 0 934	587 607 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 071 737 2, 005 2 0	31.00 40.00 41.00 42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	934	215		0 0	184	43.00
50.00 52.00 54.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	3, 837 C 4, 056	0 0		0 0 0 0 0 0	4, 517 0 12, 383	52.00
57.00 58.00 59.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION				0 0 0 0 0 0	0 0 0	57.00 58.00 59.00
60. 00 60. 01 65. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	2, 905 C 2, 091	0		0 0 0 0 0 0	8, 708 0 1, 680	60. 01
66. 00 69. 00 69. 01	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	1, 327 C 592	0		0 0 0 0 0 0	937 0 205	69. 00 69. 01
71.00 72.00 73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		-	37, 1	0 0 0 49,642	1, 363 78 5, 831	72.00 73.00
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	C	0		0 0	0	74.00
88.00 89.00 91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 3, 534	0		0 0 0 0 0 0	0 0 6, 929	89.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04050 CLINIC 04950 BIC	7, 259			0 0	5, 654	92.00 93.00
93.02	04951 UCI C 04952 CI C					1, 198 0 0	93. 02 93. 03
	04953 RI C 04954 PODI ATRY	24	0 0		0 0	0	
95.00 99.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09900 CMHC	381	88		0 0	60 0	
	09910 CORF D 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 901	0 0 669		0 0 0 0	0 389	99. 10 101. 00
110. 00 111. 00	10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION 0 11100 ISLET ACQUISITION	C C C	0 0 0 0		0 0 0 0 0 0	0	109.00 110.00 111.00
116.00 118.00	D 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	44, 270	0 6, 588	37, 1	0 0 69 49, 642		116.00 118.00
191. 00 191. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19101 FMH DIAGNOSTIC CENTER 219102 WELLNESS				0 0 0 0 0 0	0 0	190.00 191.00 191.01 191.01
192. 00 192. 0	2 19102 WELLNESS D 19200 PHYSI CLANS' PRI VATE OFFI CES 1 19201 RFE 2 19202 MARKETI NG	0 0 168				0 0	191. 02 192. 00 192. 01 192. 02
192. 03 192. 04	2 19202 MARKETTING 3 19203 FOUNDATION 4 19204 BROOKVILLE CLINIC 5 19205 ATOD	196				0 0	192. 02 192. 03 192. 04 192. 05
192.0	5 19206 HEART CENTER 7 19207 WVCP	8, 685			0 0 0 0	0	192.03 192.06 192.07

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 10/01/2015 To 09/30/2016		nored.
				10 09/30/2016	Date/Time Pre 2/23/2017 9:3	pareu: O am
Cost Center Description	CAFETERI A	NURSING	CENTRAL	PHARMACY	MEDICAL	
Cost center bescription		ADMI NI STRATI ON		FHANWACT	RECORDS &	
		ADMINI STRATI ON				
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
192.08 19208 OCCUPATI ONAL MED	0	0		0 0	0	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0 0	0	192.09
192. 10 19210 HOSPI TALI ST	188	0		0 0	0	192.10
194.0007950 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)	53, 507	6, 588	37, 16	9 49, 642	55, 041	202.00

Heal th	Fina	nci al	Syste	ems		
ALL 00A	TLON			DEL	ATED	

ALI DCATION OF CAPITAL BELATED COSTS	Health Financial Systems	FAYETTE REGIONAL	_ HEALTH SYSTEM		In Lieu of Form	CMS-2552-10
Cash Dariter Description Submitted Fragment Total 12/23/2017 9.30 mm Beneral: Structure A Adjective Cost Centrals Products Structure 29:00 Total Total Total Cent Dariter Description 24:00 25:00 26:00 26:00 Cent Dariter Description 10:0 000000000000000000000000000000000000	ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN:		Period: Workshee From 10/01/2015 Part II	et B
Line Line <thline< th=""> Line Line <thl< th=""><th></th><th></th><th></th><th></th><th></th><th></th></thl<></thline<>						
ENTRIES SPENDE - DOOT OFFITTER 24.00 26.00 COUND DEPUTY COUNT OF CONTRACT 20.00	Cost Center Description	Subtotal	Residents Cost & Post Stepdown	Total		
1.00 0.00 <td< th=""><th></th><th>24.00</th><th></th><th>26.00</th><th></th><th></th></td<>		24.00		26.00		
4.00 MAND MARLINE: BURNING IN STANT OF A REPARTMENT 4.00 7.00 DESDA OFFANT ION OF A REPARTMENT 7.00 7.00 DESDA OFFANT ION OFFANT 7.00 7.00 DESDA OFFANT ION OFFANT ION 11.00 7.00 DESDA OFFANT ION OFF			<u> </u>			1.00
5.00 DODDOL AGMUNISTRATURE & CENERAL 7.00 7.00 DOZDOU FORMATION OF PLANT 9.00 7.00 DOZDOU FORMATION OF PLANT 11.00 7.00 DOZDOU FORMATION OF PLANT 11.00 7.00 DOZDOU FORMATION OF PLANT 11.00 7.00 DOZDOU FORMATION OF PLANT 13.00 7.00 DOZDOU FORMATION OF PLANT 12.00 13.00 7.00 DOZDOU FORMATION OF PLANT 12.00 13.00 7.00 DOZDOU FORMATION OF PLANT 12.00 13.00 7.00 DOZDOU F						
7.01 0.701						
0.00 00000 AURREY & LINER SERVICE 8.00 0.00 00000 AURREY A 11 KAY 0.00 0100 0110 AUR 11 AUR 0.00 0100 0100 CHTERL AL IN ITSATION 11 3.00 14.00 10400 CHTERL AL IN ITSATION 11 3.00 14.00 10400 CHTERL AL INTERVICE & SIPPLY 121,733 0 15.00 10500 AURT IS & PD ATRICE 001 112,430 111,2400 41.00 14.00 10400 SUPROVIDER - IFF 121,733 0 111,2400 41.00 14.00 10400 SUPROVIDER - IFF 0 0 0 40.00 14.00 10400 SUPROVIDER - IFF 0,241 0 41.00 40.00 14.00 10400 SUPROVIDER - IFF 0,242 0 30.242 42.00 14.00 11400 SUPROVIDER - IFF 0,521 0 0,521 0 0 0						
0.00 00000 HOUSEKEEPI NG 9.00 0.00 00000 HOUSEKEEPI NG 10.00 11.00 0.01 0000 10.00 10.00 11.00 0.01 0.00 10.00 10.00 10.00 11.00 0.01 0.00 10.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
0.000 Ditcolog LIFTARY 0						
13.00 DI 200 HURSI NG. ADMUNI STRATI ON 13.00 15.00 DI 200 HURSI NG. ADMUNI STRATI ON 14.00 15.00 DI 1000 HURRAL SERVICE S SUPERV 16.00 00 DI 1000 HURRAL SERVICE S SUPERV 16.00 00 DI 1000 HURRAL SERVICE SUPERV 0 1724, 493 31.00 00 DI 0100 HURRAL SERVICE SUPERV 0 1724, 493 41.00 00 DI 0100 HURRAL SERVICE SUPERV 0 124, 493 41.00 00 DI 0100 HURRAL SERVICE SUPERV 0 12 41.00 01 DI 0100 HURRAL SERVICE SUPERV 0 517, 557 57.00 00 DI 0100 HURRAL SERVICE SUPERV 0 0 0 52.00 00 DI 0100 HURRAL SERVICE SUPERV 0 0 0 57.00 00 DI 0100 SI 000						
14.00 CHENDAL, STEWICS, & SUPPLY 14.00 15.00 DISSOR MURITS & PERATRICS 291, 753 0 291, 753 0 30.00 16.00 DISSOR MURITS & PERATRICS 291, 753 0 291, 753 0 30.00 10.00 DISSOR MURITS & PERATRICS 291, 753 0 291, 753 0 30.00 10.00 DISSOR MURITS & PERATRICS 291, 753 0 122, 630 30.00 10.00 DISSOR MURITS & PERATRICS 291, 753 0 122, 630 40.00 10.00 DISSOR MURSLEY 65, 221 0 65, 221 43.00 10.00 DISSOR MURSLEY ROW MIRES 80.00 65, 221 50.00 10.00 DISSOR MURSLEY ROW MIRES 80.00 65, 221 50.00 10.00 DISSOR MURSLEY ROW MIRES 80.00 65, 221 50.00 10.00 DISSOR MURSLEY ROW MIRES 80.00 50.00 50.00 10.00 DISSOR MURTIC RESONNORE INSON 0 0 0<						
15.00 DISOD PIARBACY 15.00 15.00 15.00 15.00 15.00 16.00						
10 00 D1400/MUDICAL RECORDS & LIBRARY						
30.00 30000 ADULTS & PEDLATRICS 291,753 0 291,753 30.00 30.00 30000 ADULTS & PEDLATRICS 291,753 0 291,753 31.00 30.00 30000 ADUDTS & PEDLATRICS 0 1124,904 41.00 40.00 ADA000 SUBPROV DER - IFF 112,530 0 112,530 41.00 41.00 OH300 SUBPROV DER - IFF 65,221 0 65,221 43.00 42.00 ADA200 SUBPROV DER - IFF 65,221 0 30.00 50.00 50.00 RAULLARY SUBPROV DER - IFF 0 0 0 0 0 50.00 SADO RAUDI OLOV-FON KONGSTIC 302,642 0 30.00 50.00 50.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 60.						
31.00 03100 11TENSUR CARE UNIT 124,904 91.00 41.00 04000 SUBPROVIDER - IPF 112,630 41.00 41.00 04100 SUBPROVIDER - IFF 122 0 122 41.00 42.00 04200 MIRSTER 65.221 0 65.221 42.00 00 0500 DELVIENT KOLE COST CENTERS 0 65.221 0 65.221 43.00 00 05200 DELVIENT KODU & LAOR ROOM 317,557 0 312,62,02 54.00 52.00 05200 DELVIENT KODU & LAOR ROOM 0 0 0 58.00 50.00 0500 CARDIAC CATHETERIZATION 0 0 0 59.00 50.00 0500 CARDIAC CATHETERIZATION 0 0 0 59.00 60.00			- -			
40.00 04000 SUBPROVIDER IPF 112,630 0 112,630 40.00 41.00 04000 SUBPROVIDER 187 12 0 12 0 41.00 42.00 04200 SUBPROVIDER 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
11.00 DURIOD SUBPROVIDER - I RF 12 0 12 41.00 12.00 04200 MACELLARY SERVICE COST CENTERS 0 0 0 MACELLARY SERVICE COST CENTERS 0 0 0 50.00 0 50.00						
41 00 0 04200 NURSERY 65, 221 0 65, 221 43, 00 ANCLLARY SERVICE COST CENTERS						
MACL LARY SERVICE COST CENTERS 52.00 055000 (PERATINE ROM 317.557 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 52.00 52.00 05500 CT SCAN 0 0 0 0 52.00 55.00 55.00 52.00 55.00 56.00 55.00 56.00 55.00 73.00 55.473 55.473 55.473 55.473 55.473 57.00		-				
50.00 DÓCODO JOPERATING ROOM 317, 557 0 317, 557 50.00 550.00 650.00 660.00		65, 221	0	65, 22	1	43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 5500 CT SCAN 0 0 0 0 0 54.00 55.00 55.00 55.00 0		317 557	0	317 55	7	50.00
57.00 05700 CT SCAN 0 0 0 57.00 58.00 55.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 <td></td> <td>C</td> <td></td> <td></td> <td></td> <td></td>		C				
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 50.00 60.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00						
59.00 0 6900 CARDIACC CATHETER ZATION 0 0 59.00 0 59.00 0 59.00 0 59.00 59.00 59.00 59.00 50.00 60.00 71.00 <td< td=""><td></td><td></td><td>-</td><td></td><td>0</td><td></td></td<>			-		0	
60.00 06000 LABORATORY 0					0	
65. 00 06500 RESPI RATORY THERAPY 47, 719 0 47, 719 65. 00 660, 00 71, 00 72, 00 72, 00 72, 00 72, 00 72, 00 72, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 73, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74	60. 00 06000 LABORATORY	108, 551	0	108, 55	1	60.00
66.00 06600 PHYSI CAL THERAPY 95,781 0 95,781 66.00 690 71.00 710.00 710.00 710.00 710.00 710.00 710.00 710.00 710.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00		-	-			
69:00 71:00 73:00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
71.00 07100 NepL ECX CHARGED TO PATIENTS 38, 532 0 38, 532 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 404 0 404 72.00 73.00 07200 DRUGS CHARGED TO PATIENTS 55, 473 0 0 73.00 74.00 D7400 REMAL DIAL/SIS 0 0 0 0 74.00 00/07201 REM SERVICE COST CENTERS 0 0 0 0 88.00 0 0 0 88.00 99.00 <		0,70	0			
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 1404 0 404 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 55.473 0 55.473 73.00 00 0000 DUTPATIENT SERVICE COST CENTERS 0 0 0 74.00 00 00000 RUBAL HEALTH CLINIC 0 0 0 88.00 80.00 089000 EHERCALLY JUALIFIED HEALTH CENTER 0 0 0 89.00 91.00 09700 DEKERCARDRY 120.182 0 120.182 91.00 92.00 09520 CLINIC 366.206 0 366.206 93.00 93.00 0450 BIC 113.037 0 113.037 93.01 93.02 04951 UCIC 0 0 0 93.03 93.03 04952 CIC 0 0 0 93.03 93.04 04953 RIC 0 0 0 0 94.05 09900 CMHC 0 0 0 0						
73:00 073:00 RUSS CHARGED TO PATLENTS 55, 473 0 55, 473 73.00 00 07400 RENAL DI ALYSIS 0 0 0 74.00 00 07400 RENAL DI ALYSIS 0 0 0 74.00 00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 00 09100 FEDERALLY OUALL FIED HEALTH CENTER 0 0 0 91.00 92.00 92.00 92.00 92.00 92.00 93.00 0856RVATI ON BEDS (NON-DI STINCT PART) 366, 206 0 366, 206 93.00 93.00 93.00 93.02 9450 BIC 93.00 93.02 9450 BIC 93.02 9451 UCIC 0 0 93.02 9450 BIC 93.04 9453 RIC 93.05 93.04 9453 RIC 95.00 95.00 95.00 95.00 95.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00			1			
74.00 074.00 REAL DIALYSIS 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 74.00 0 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 89.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 93.00 93.00 93.02 93.02 93.02 93.02 93.02 93.02 93.02 93.03 94.952 CIC 0 0 0 93.02 93.03 94.952 CIC 0 0 0 93.03 94.952 CIC 0 0 0 93.05 95.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00						
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89.00 000 00000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 99.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
91.00 09100 EMERCENCY 120,182 0 120,182 0 200 09200 09200 09200 005ERVATI ON BEDS (NON-DI STI NCT PART) 366,206 0 366,206 93.00 92.00 09200 005ERVATI ON BEDS (NON-DI STI NCT PART) 366,206 0 366,206 93.00 92.00 93.01 04950 BLC 1LINE C 100 0 0 0 90 0 93.01 93.02 04951 UC1 C 0 0 0 0 0 93.02 93.03 04952 CLC 0 0 0 0 0 0 93.03 93.04 04953 RLC 0 0 0 0 0 0 93.03 93.04 04953 RLC 0 0 0 0 0 0 0 93.03 93.04 04953 RLC 0 0 0 0 0 0 93.00 0 93.05 04954 PODI ATRY 50 0 0 50 93.00 0 90 0 93.00 0 99.00 09900 CMHC 99.00 0 99.00 09900 CMHC 99.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		-				
92.00 09200 095200 0052RVATION BEDS (NON-DISTINCT PART) 0 92.00 04050 CLINIC 366,206 93.00 93.00 93.00 04950 CLINIC 366,206 93.00 93.00 93.00 04950 CLINIC 93.00 93.01 93.01 93.01 04950 BIC 93.01 93.03 94.920 0 0 0 93.03 94.920 95.00 93.01 99.00 90.00 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td>91.00</td></td<>			-			91.00
93. 01 04950 BLC 113,037 0 113,037 93. 01 93. 02 04951 UCI C 0 0 0 93. 03 93. 03 04952 CI C 0 0 0 93. 03 93. 04 04953 RI C 0 0 0 93. 03 93. 05 04954 PODI ATRY 50 0 50 93. 05 OTHER REI MURSABLE COST CENTERS 792 0 792 95. 00 99.00 09900 CMHC 0 0 99. 00 99.00 09910 CORE 99.00 99.00 09910 COREA 0 0 99.00 99.00 99.00 09900 CMHC 0 0 0 99.00 99.00 00 99.00 00 99.00 00 99.00 00 0 101.00 10.00 1000 NEESE ACCU IS IT ION 0 0 0 100.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 0 0 110.00 110.00 101.01 11	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					
93. 02 04951 UCI C 0 0 0 93. 02 93. 03 04952 CI C 0 0 0 93. 03 93. 04 04953 RI C 0 0 0 93. 03 93. 05 04954 PODI ATRY 50 0 95.00 95.00 93. 05 07HER REI MBURSABLE COST CENTERS 792 0 792 95.00 99.00 90.00 90.00 90.00 90.00 90.00<						
93.03 04952 C1 C 0 0 93.03 93.04 04953 R1 C 0 0 0 93.03 93.05 04954 PODI ATRY 50 0 50 93.05 04950 REI MBURSABLE COST CENTERS 95.00 0 50 95.00 0 0 0 0 97.00 99.00 99.00 09900 CMHC 0 0 0 99.00 99.00 99.00 99.10 09910 CORF 0 0 0 0 99.10 101.00 HEALTH AGENCY 46.263 0 46.263 101.00 101.00 100.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 100.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 <		113,037				
93.05 04954 PODI ATRY 50 0 50 93.05 0THER REI MBURSABLE COST CENTERS 792 0 792 95.00 99.00 99.00 99.00 09900 CMRC SERVI CES 792 0 792 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 101.00 1000 HORE HEALTH AGENCY 46.263 0 46.263 0 99.00 99.10 101.00 1000 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 111.00 114.00 152.07 0 527 116.00 111.00 152.07 527 166.00 111.00 111.00 152.07 527 166.00 111.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 <td>93. 03 04952 CI C</td> <td>C</td> <td>0</td> <td></td> <td>0</td> <td>93.03</td>	93. 03 04952 CI C	C	0		0	93.03
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 792 0 792 95.00 99.00 99.00 09900 CMHC 0 0 0 99.00 99.00 99.00 0 0 0 0 0 99.00 90.00 109.00 109.00 110.00 110.00 110.00 110.00 111.00 111.00 </td <td></td> <td>0</td> <td>0</td> <td>-</td> <td>0</td> <td></td>		0	0	-	0	
95.00 09500 AMBULANCE SERVICES 792 0 792 95.00 99.00 09900 CMHC 0 0 0 99.00 99.10 09900 CORF 0 0 0 99.00 99.10 010100 HOME HEALTH AGENCY 46,263 0 46,263 101.00 101.00 10100 PARCREAS ACQUISITION 0 0 0 109.00 109.00 109.00 100.01 100.01 110.00 111.00 110.00 110.00 110.00 <		50		5	0	93.05
99.10 09910 CORF 0 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 46,263 0 46,263 101.00 SPECIAL PURPOSE COST CENTERS	95. 00 09500 AMBULANCE SERVICES	792	2 0	79	2	95.00
101.00 HOME HEALTH AGENCY 46,263 0 46,263 101.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 109.00 109.00 101.00 1100 INTESTI NAL ACQUI SI TI ON 0 0 0 101.00 1110.00 118.00 100.00 100.00 <td>99. 00 09900 CMHC</td> <td>C</td> <td></td> <td></td> <td>0</td> <td>99.00</td>	99. 00 09900 CMHC	C			0	99.00
SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 ISLET ACQUISITION 0 0 0 110.00 111.00 ISLET ACQUISITION 0 0 0 111.00 116.00 H60PICE 527 0 527 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,246,467 0 2,246,467 118.00 119.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.01 19100 RESEARCH 0 0 0 191.00 191.01 19101 FMH DI AGNOSTIC CENTER 1,351 0 1,351 191.01 191.02 19200 PHYSICIANS' PRIVATE OFFICES 69,831 0 69,831 192.00 192.01 RFE 0 0 0 192.01 192.02 MARKETI		46 262		14 24	0	
109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109.00 109.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 111.00 110.00 111.00 110.00 111.00 110.00 111.00 110.00 111.00 110.00 111.00 110.00 111.00 110.00 111.00 112.01 112.01 112.01 112.01 112.01		40, 203		40, 20	5	101.00
111.00 11100 I SLET ACQUI SI TI ON 0 0 111.00 116.00 11600 HOSPI CE 527 0 527 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,246,467 0 2,246,467 118.00 NONREL MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.01 19101 FMH DI AGNOSTI C CENTER 1,351 0 1,351 191.01 191.02 19102 WELLNESS 46,631 0 46,631 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 69,831 69,831 192.00 192.01 19201 RFE 0 0 0 192.01 192.02 IARKETI ING 17,425 0 17,425 192.03 192.04 19204 BROKVI LLE CLINI C 0 0 0 192.04	109. 00 10900 PANCREAS ACQUI SI TI ON	C	0		0	109.00
116.00 11600 HOSPI CE 527 0 527 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,246,467 0 2,246,467 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 191.00 191.01 19101 FMH DI AGNOSTI C CENTER 1,351 0 1,351 191.01 191.02 19102 WELLNESS 46,631 0 46,631 192.02 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 69,831 0 69,831 192.00 192.01 19201 RFE 0 0 0 192.01 192.02 19202 MARKETI NG 17,425 0 17,425 192.03 192.04 19204 BROOKVI LLE CLINI C 0 0 0 192.04	110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0	110.00
SUBTOTALS (SUM OF LINES 1-117) 2, 246, 467 0 2, 246, 467 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 191.00 191.00 191.00 191.00 191.01 191.01 191.01 FMH DI AGNOSTI C CENTER 1, 351 0 1, 351 191.01 191.01 191.02 192.03 192.00 192.01 RFE 0 0 0 192.01 192.01 RFE 0 0 0 0 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.03 192.03 192.04 192.04 192.04 192.04		507		۲ 2	7	
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 P100 RESEARCH 0 0 0 191.00 191.01 P101 FMH DI AGNOSTI C CENTER 1, 351 0 1, 351 191.01 191.02 19102 WELLNESS 46, 631 0 46, 631 191.02 192.01 19200 PHYSI CI ANS' PRI VATE OFFICES 69, 831 0 69, 831 192.00 192.01 RFE 0 0 0 192.02 19202 MARKETI NG 17, 425 192.02 192.03 100.047, 425 192.02 192.03 192.04						
191.00 19100 RESEARCH 0 0 191.00 191.01 FMH DI AGNOSTI C CENTER 1, 351 0 1, 351 191.01 191.02 19102 WELLNESS 46, 631 0 46, 631 191.02 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 69, 831 0 69, 831 192.00 192.01 IP200 RFE 0 0 0 192.01 192.02 MARKETI NG 17, 425 0 17, 425 192.02 192.02 192.02 192.03 192.04 192.0	NONREI MBURSABLE COST CENTERS					
191.01 IPH DI AGNOSTI C CENTER 1, 351 0 1, 351 191.01 191.02 19102 WELLNESS 46, 631 0 46, 631 191.02 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 69, 831 0 69, 831 192.00 192.01 19201 RFE 0 0 0 192.01 192.02 MARKETI NG 17, 425 0 17, 425 192.03 192.03 FOUNDATI ON 17, 341 0 17, 341 192.03 192.04 19204 BROOKVI LLE CLINI C 0 0 0 192.04						
191.02 19102 WELLNESS 46, 631 0 46, 631 191.02 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 69, 831 0 69, 831 192.00 192.01 19201 RFE 0 0 0 192.01 192.02 19202 MARKETI NG 17, 425 0 17, 425 192.02 192.03 19203 FOUNDATI ON 17, 341 0 17, 341 192.03 192.04 19204 BROOKVI LLE CLINIC 0 0 0 192.04		-	-			
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 69, 831 0 69, 831 192.00 192.01 19201 RFE 0 0 0 192.01 192.02 19202 MARKETI NG 17, 425 0 17, 425 192.02 192.03 19203 FOUNDATI ON 17, 341 0 17, 341 192.03 192.04 19204 BROOKVI LLE CLINIC 0 0 0 192.04	191. 02 19102 WELLNESS					191.02
192. 02 192. 02 MARKETING 17, 425 0 17, 425 192. 02 192. 03 1903 FOUNDATION 17, 341 0 17, 341 192. 03 192. 04 19204 BROOKVILLE CLINIC 0 0 0 192. 04	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	69, 831	0			192.00
192. 03 19203 FOUNDATION 17, 341 0 17, 341 192. 03 192. 04 19204 BROOKVILLE CLINIC 0 0 0 192. 04		17 400				
192. 04 19204 BROOKVILLE CLINIC 0 0 0 192. 04						
192. 05 19205 ATOD 0 0 192. 05	192.04 19204 BROOKVILLE CLINIC		1			192.04
	192. 05 19205 ATOD	0	0		0	192.05

Health Financial Systems Fi	FAYETTE REGIONAL HEALTH SYSTEM			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS	Provider CC	CN: 15-0064	Period: From 10/01/2015			
				To 09/30/2016	Date/Time Prepared: 2/23/2017 9:30 am	
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
192.06 19206 HEART CENTER	11, 466	0	11, 4	66	192.06	
192. 07 19207 WVCP	293, 408	0	293, 4	28 2	192.07	
192.08 19208 OCCUPATI ONAL MED	53	0		53	192.08	
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0	192.09	
192. 10 19210 HOSPI TALI ST	6, 497	0	6, 4	97	192.10	
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	191, 929	0	191, 9	29	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)	2, 902, 399	0	2, 902, 3	99	202.00	

	Financial Systems Fi LLOCATION - STATISTICAL BASIS	AYETTE REGIONAL	Provider C	CN: 15-0064 P	Period:	u of Form CMS- Worksheet B-1	
					rom 10/01/2015 o 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared:
	Cost Center Description	CAPI TAL RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	4.00	5A	5.00	7.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	409, 516					1.00
4.00 5.00 7.00 7.01 8.00 9.00 10.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	1, 591 25, 436 167, 540 0 491 2, 021 2, 651 4, 269	20, 121, 491 1, 979, 265 253, 305 0 514, 447 509, 314 0	-6, 475, 610 C C C C C	2, 996, 257	246, 026 0 491 2, 021 2, 651 4, 269	4.00 5.00 7.00 7.01 8.00 9.00 10.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 2, 687	743, 044 69, 895		925, 822 853, 871	0 2, 687	
	01500 PHARMACY	2,600	200, 770			2, 600	
	01600 MEDICAL RECORDS & LIBRARY	3, 897	641, 318			3, 897	
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	21, 673	1, 159, 502	2	1, 445, 083	21, 673	30.00
40. 00 41. 00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	9, 291 7, 895 0 0	648, 815 639, 548 110 0		1, 605, 159 2, 103	9, 291 7, 895 0 0	40. 00 41. 00
43.00		5, 106	0	C	405, 074	5, 106	43.00
50.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM	24, 900	608, 189	C	1, 124, 263	24, 900	50.00
54.00 57.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN	0 22, 188 0	0 1, 011, 974 0		0 3, 034, 973 0	0 22, 188 0	54.00 57.00
59. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0 7, 140	0 0 633, 143		0 0 1, 913, 022	0 0 7, 140	59. 00 60. 00
65.00 66.00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 355 7, 372	0 374, 229 419, 520		527, 673 585, 697	0 3, 355 7, 372 0	65. 00 66. 00
69. 01 71. 00 72. 00 73. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 982 0 0	143, 149 0 0 0		206, 123 0 66, 678 0	2, 982 0 0 0	69.01 71.00 72.00 73.00
	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	C	0 0	0	74.00
88. 00 89. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 8, 290	0 0 1, 028, 751		0 0 1, 536, 776	0 0 8, 290	89.00
93. 00 93. 01 93. 02	04050 CLI NI C 04950 BI C 04951 UCI C 04952 CI C	26, 697 0 0	4, 974, 691 591, 493 0		4, 917, 966 1, 034, 976 0	27, 428 21, 253 0 0	93.00 93.01 93.02
93.04	04953 RI C 04954 PODI ATRY	0	0 2, 981		0 0 3, 743	0	93.04
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	53, 171	C	47, 624	0	95.00
99. 10	09900 CMHC 09910 CORF	0 0	0 0		0 0	0 0	99.10
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 051	706, 464	C	966, 700	3, 051	101.00
110. 00 111. 00	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11600 HOSPICE	000000000000000000000000000000000000000	0 0 0		0 0 0 0 86, 655	0 0	109. 00 110. 00 111. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	363, 123	17, 907, 088	1	32, 235, 826	190, 540	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0 0				190.00 191.00
191. 01 191. 02 192. 00	19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS 19200 PHYSICIANS' PRIVATE OFFICES	0 0 5, 727	191, 291 85, 658 3, 085	C	254, 795 212, 500 58, 914	0 9, 093 5, 727	191. 01 191. 02 192. 00
192.02	19201 RFE 19202 MARKETI NG 19203 FOUNDATI ON	0 1, 305 1, 410	0 64, 263 0) 14 286, 331 9, 993	1, 305	192. 01 192. 02 192. 03

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
Cost Center Description	CAPI TAL RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT	
	1.00	4.00	5A	5.00	7.00	
192. 04 19204 BROOKVI LLE CLINIC	0	C)	0 0		192.04
192. 05 19205 ATOD	0	C		0 0	0	192. 05
192. 06 19206 HEART CENTER	943	C) (0 6, 683	943	192.06
192. 07 19207 WVCP	21, 084	1, 589, 924	. (2, 696, 442	21, 084	192.07
192.08 19208 OCCUPATI ONAL MED	0	7, 333		0 10, 064	0	192. 08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0) (0 0	0	192.09
192. 10 19210 HOSPI TALI ST	0	272, 849	(1, 260, 749	0	192.10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	15, 924	0		0 112, 860	15, 924	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 902, 399	4, 265, 280		6, 475, 610	3, 518, 600	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 087389	0. 211976		0. 174332	14. 301740	203.00
204.00 Cost to be allocated (per Wkst. B,		11, 276		181, 383		
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 000560		0.004883	4. 886447	205. 00
	I I		1	1	I	I

	Financial Systems F LLOCATION - STATISTICAL BASIS	AYETTE REGIONAL			In Lie eriod:	u of Form CMS-: Worksheet B-1	
0001 //				F	rom 10/01/2015 o 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	1	1		1 1 00
1.00 4.00 5.00 7.00 7.01 8.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	149, 680 491					1.00 4.00 5.00 7.00 7.01 8.00
13. 00 14. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 021 2, 651 4, 269 0 2, 687	6, 817 0 0 0	2, 651 4, 269 C 2, 687	60, 734 0 0 0	595, 518 18, 370 4, 242	13.00 14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2,600		_,		10, 439 31, 766	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 877	0	3,077	<u> </u>	31,700	10.00
42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	21, 673 9, 291 0 0 0 0 5, 106	5, 851 0 0 0 0 0	9, 291 7, 895 C	4, 727 6, 316 0 0	38, 144 28, 316 29, 315 0 10, 290	31.00 40.00 41.00 42.00
43.00	ANCI LLARY SERVI CE COST CENTERS	5, 100		5, 106		10, 390	43.00
50.00 52.00 54.00 57.00	05200 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	24, 900 0 22, 188 0	0 8, 498	C 22, 188	0 0	42, 707 0 45, 137 0	50.00 52.00 54.00 57.00
58.00 59.00 60.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 7, 140		C C 7, 14C		0 0 32, 337	58.00 59.00 60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	3, 355		, c	Ŭ	0 23, 273	60.01 65.00
66.00	06600 PHYSI CAL THERAPY	7, 372				14, 770	•
72.00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS	0 2, 982 0 0	0 535 0 0 0	C 2, 982 C C		0 6, 589 0 0	69.00 69.01 71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	, °	-	0	73.00
74.00	OUTPATIENT SERVICE COST CENTERS	0	<u>/</u>		vi	0	74.00
91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 8, 290	-	C	0	0 0 39, 334	88.00 89.00 91.00 92.00
93. 00 93. 01 93. 02	04050 CLINIC 04950 BIC 04951 UCIC	6, 331 0 0	40 0 0	24, 991 21, 253 C		80, 791 0 0	93.00 93.01 93.02
93.04	04952 CI C 04953 RI C 04954 PODI ATRY	0				0 0 265	93.04
	OTHER REIMBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	,		
99. 00 99. 10	09500 AMBULANCE SERVICES 09900 CMHC 09910 CORF 10100 HOME HEALTH AGENCY	0 0 0 3, 051	0 0 0 1, 924	C C C 3, 051	0	4, 236 0 0 32, 285	99.00
100.00	SPECIAL PURPOSE COST CENTERS			-		-	100.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION						109.00 110.00
	11100 I SLET ACQUI SI TI ON	0	0	C	0 O		111.00
116. 00 118. 00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 140, 295	0 63, 948	C 185, 591	0 33, 940	0 492, 706	116. 00 118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
191.00	19100 RESEARCH	0	0	d c	o o	0	191.00
	19101 FMH DIAGNOSTIC CENTER	0	0	0.000	0		191.01
	19102 WELLNESS 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 727	0 0 1,019	9, 093 5, 727			191.02 192.00
192.01	19201 RFE	0	0	C	0	0	192.01
	19202 MARKETI NG	1,305		1, 305			192.02
	19203 FOUNDATION 19204 BROOKVILLE CLINIC	1, 410		1, 410 0			192.03 192.04
192.05	19205 ATOD	0	0	C	0	0	192.05
192.06	19206 HEART CENTER	943	0	943	0	0	192.06

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		eri od:	Worksheet B-1	
				rom 10/01/2015 o 09/30/2016	Date/Time Pre	pared:
					2/23/2017 9:3	<u>0 am</u>
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.01	8.00	9.00	10.00	11.00	
192. 07 19207 WVCP	0	205	20, 745	26, 794	96, 670	192.07
192.08 19208 OCCUPATI ONAL MED	0	0	C	0	0	192.08
192.09 19209 HOME MEDI CAL EQUI PMENT	0	0	C	0	0	192.09
192. 10 19210 HOSPI TALI ST	0	0	C	0	2, 087	192.10
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	5, 770	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,	1,033,539	162, 447	929, 348	650, 187	527, 428	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 904991	2. 492589	4.030410	10. 705486	0. 885663	203.00
204.00 Cost to be allocated (per Wkst. B,	4, 298	6, 525	28, 232	35, 467	53, 507	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 028715	0. 100120	0. 122437	0. 583973	0. 089850	205.00

	Financial Systems F LLOCATION - STATISTICAL BASIS	AYETTE REGIONAL	HEALTH SYSTEM	CN: 15-0064	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
					From 10/01/2015 To 09/30/2016	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (FTE' S)	CENTRAL SERVI CES & SUPPLY (100%)	PHARMACY (100%)	MEDI CAL RECORDS & LI BRARY (GROSS	272372017 7.30 am
		12.00	14.00	15.00	CHARGES)	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	
1.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00 11.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA					1.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00 11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	15, 286 0 502	100 0	1	00	13. 00 14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 102, 865, 736	16. 00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1,834	0		0 3, 871, 479	30.00
31.00 40.00 41.00 42.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	1, 361 1, 409 0 0 500	0 0 0 0		0 1, 378, 465 0 3, 747, 948 0 3, 644 0 0 0 343, 401	31. 00 40. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS	1	-1			
52.00 54.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 053 0 2, 170 0	0 0 0		0 8, 442, 721 0 0 0 23, 127, 950 0 0	50.00 52.00 54.00 57.00
58.00 59.00 60.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0 0 1, 555	0 0 0		0 0 0 0 0 16, 277, 350	58. 00 59. 00 60. 00 60. 01
65.00 66.00 69.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 119 710 0	0 0 0		0 3, 140, 613 0 1, 750, 561 0 0	65.00 66.00 69.00
71.00 72.00 73.00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	317 0 0 0	0 100 0 0	1	0 384, 070 0 2, 548, 564 0 145, 524 00 10, 898, 480	69. 01 71. 00 72. 00 73. 00
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	74.00
89. 00 91. 00	09100 FATTENT SERVICE COST CENTERS 08900 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	0 0 0		0 0 0 0 0 12, 951, 767	88. 00 89. 00 91. 00 92. 00
93. 00 93. 01 93. 02	04050 CLINIC 04950 BIC 04951 UCIC 04952 CIC	0	0 0 0		0 10, 567, 297 0 2, 240, 054 0 0	93. 00 93. 01 93. 02 93. 02 93. 03
93.04	04953 RI C 04954 PODI ATRY OTHER REI MBURSABLE COST CENTERS	0	0		0 0 0 11, 936	93. 04 93. 05
	09500 AMBULANCE SERVI CES 09900 CMHC	204	0		0 111, 946	95. 00 99. 00
99.10	09900 CMHC 09910 CORF 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 1, 552	0		0 0 0 727, 974	99.00 99.10 101.00
110. 00 111. 00 116. 00	10900 PANCREAS ACQUI SI TI ON 11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON 11600 HOSPI CE	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 193, 992	109.00 110.00 111.00 111.00 116.00
118.00	NONREI MBURSABLE COST CENTERS	15, 286	100	1	00 102, 865, 736	118.00
191.00 191.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS	000000000000000000000000000000000000000	0 0 0		0 0 0 0 0 0 0 0	190.00 191.00 191.01 191.01 191.02
192.00 192.01 192.02	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 RFE 19202 MARKETI NG	0	0 0 0			192. 00 192. 01 192. 02
192.04	19203 FOUNDATI ON 19204 BROOKVI LLE CLI NI C 19205 ATOD	0 0 0	0 0 0		0 0 0 0 0 0	192. 03 192. 04 192. 05

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1
				From 10/01/2015 To 09/30/2016	Date/Time Prepared: 2/23/2017 9:30 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	ADMI NI STRATI ON		(100%)	RECORDS &	
		SUPPLY		LI BRARY	
	(FTE'S)	(100%)		(GROSS	
				CHARGES)	
	13.00	14.00	15.00	16.00	
192.06 19206 HEART CENTER	0	0		0 0	192.06
192. 07 19207 WVCP	0	0		0 0	192.07
192.08 19208 OCCUPATI ONAL MED	0	0		0 0	192.08
192.09 19209 HOME MEDI CAL EQUI PMENT	0	0		0 0	192.09
192. 10 19210 HOSPI TALI ST	0	0		0 0	192.10
194.0007950 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,	1, 103, 492	1, 074, 298	4, 163, 77	6 1, 227, 271	202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part		10, 742. 980000			
204.00 Cost to be allocated (per Wkst. B, Part II)	6, 588	37, 169	49, 64:	2 55, 041	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 430983	371. 690000	496. 42000	0. 000535	205.00
	I	I	I	1	Ι

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE			DATIO	0E	COSTS	ΤO	C

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

Health Financial Systems	F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO	CHARGES		Provider C		Period: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	2/23/2017 9:3 PPS	0 am
					Costs	PP5	
Cost Conton Decerint		Total Cost	Thomany Limit	Total Costs	RCE	Tatal Coata	
Cost Center Descripti	1011	(from Wkst. B,	Therapy Limit Adj.	TOTAL COSTS	Di sal l owance	Total Costs	
		Part I, col.	Auj.		DISALLOWALICE		
		26)					
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE	COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	COST CENTERS	2, 741, 462		2, 741, 46	2 0	2, 741, 462	30.00
31. 00 03100 I NTENSI VE CARE UNI T		1, 563, 389		1, 563, 38		1, 563, 389	•
40. 00 04000 SUBPROVIDER - I PF		2, 269, 733		2, 269, 73		2, 269, 733	•
40. 00 04000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF							
42. 00 04200 SUBPROVIDER - TRF		2, 513		2, 51		2, 513 0	
							•
43.00 04300 NURSERY	TEDC	653, 946		653, 94	0 0	653, 946	43.00
ANCI LLARY SERVICE COST CEN	TERS	2 240 712		0.040.71	2 0	2 240 712	50.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABO		2, 249, 712		2, 249, 71		2, 249, 712	•
	R RUUM	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		4, 617, 759		4, 617, 75		4, 617, 759	
57.00 05700 CT SCAN		0			0 0	0	
58.00 05800 MAGNETIC RESONANCE II		0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZAT	ION	0			0 0	0	•
60. 00 06000 LABORATORY		2, 761, 816		2, 761, 81		2, 761, 816	
60.01 06001 BLOOD LABORATORY		0			0 0	0	00101
65. 00 06500 RESPI RATORY THERAPY		843, 196	0			843, 196	•
66.00 06600 PHYSI CAL THERAPY		977, 246	0	977, 24		977, 246	
69. 00 06900 ELECTROCARDI OLOGY		0			0 0	0	
69. 01 06901 CARDI AC REHAB		351, 951		351, 95	1 0	351, 951	69.01
71.00 07100 MEDICAL SUPPLIES CHAI		1, 104, 705		1, 104, 70	5 0	1, 104, 705	71.00
72.00 07200 IMPL. DEV. CHARGED TO		80, 038		80, 03	8 0	80, 038	72.00
73.00 07300 DRUGS CHARGED TO PAT	IENTS	4, 293, 806		4, 293, 80	6 0	4, 293, 806	73.00
74.00 07400 RENAL DIALYSIS		0			0 0	0	74.00
OUTPATIENT SERVICE COST CE	NTERS						
88.00 08800 RURAL HEALTH CLINIC		0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED I	HEALTH CENTER	0			0 0	0	89.00
91.00 09100 EMERGENCY		2, 231, 214		2, 231, 21	4 0	2, 231, 214	91.00
92.00 09200 OBSERVATION BEDS (NO	N-DISTINCT PART)	597, 667		597,66	7	597, 667	92.00
93. 00 04050 CLINIC		6, 509, 781		6, 509, 78	1 95, 258	6, 605, 039	93.00
93. 01 04950 BIC		1, 631, 744		1, 631, 74	4 5, 257	1, 637, 001	93.01
93. 02 04951 UCI C		0			0 0	0	93.02
93. 03 04952 CI C		0			0 0	0	93.03
93. 04 04953 RIC		0			0 0	0	93.04
93. 05 04954 PODI ATRY		4, 773		4, 77	3 0	4, 773	93.05
OTHER REIMBURSABLE COST CE	NTERS		·	·			1
95.00 09500 AMBULANCE SERVICES		75, 741		75, 74	1 0	75, 741	95.00
99.00 09900 CMHC		0			0	0	99.00
99. 10 09910 CORF		0			0	0	99.10
101.00 10100 HOME HEALTH AGENCY		1, 366, 339		1, 366, 33	9	1, 366, 339	101.00
SPECIAL PURPOSE COST CENTE	RS						1
109.00 10900 PANCREAS ACQUI SI TI ON		0			0	0	109.00
110.00 11000 INTESTINAL ACQUISITIC	ON	0			0		110.00
111.00 11100 I SLET ACQUI SI TI ON		0			0	0	111.00
116.00 11600 HOSPI CE		104,077		104, 07	7	104, 077	
200.00 Subtotal (see instruc	ctions)	37, 032, 608	0			37, 133, 123	•
201.00 Less Observation Bed		597,667	0	597,66		597,667	
202.00 Total (see instructio		36, 434, 941	0				
	,	00, 101, 711		1 00, 101, 71		00,000,100	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016		parec 0 am
			XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 205, 272		3, 205, 2	72		30.
31. 00 03100 I NTENSI VE CARE UNI T	1, 378, 465		1, 378, 40	55		31.
0. 00 04000 SUBPROVIDER - IPF	3, 747, 948		3, 747, 94	18		40.
1. 00 04100 SUBPROVIDER - IRF	3,644		3, 64	14		41.
2. 00 04200 SUBPROVI DER	0			0		42.
3. 00 04300 NURSERY	343, 401		343, 40	01		43.
ANCI LLARY SERVI CE COST CENTERS			1			
0.00 05000 OPERATING ROOM	1, 088, 461	7, 354, 260	8, 442, 72			
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 439, 384	21, 688, 566	23, 127, 9		0. 000000	
7.00 05700 CT SCAN	0	0		0 0. 000000	0. 000000	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000	0. 000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0. 000000	
D. 00 06000 LABORATORY	2, 022, 573	14, 254, 777	16, 277, 3		0. 000000	
0.01 06001 BLOOD LABORATORY	0	0		0 0.000000	0. 000000	
5. 00 06500 RESPI RATORY THERAPY	799, 868	2, 340, 745			0. 000000	
6. 00 06600 PHYSI CAL THERAPY	97, 420	1, 653, 141	1, 750, 56		0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	0	C		0 0. 000000	0. 000000	
9. 01 06901 CARDI AC REHAB	0	384, 070			0. 000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	712, 224	1, 836, 340			0.00000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 590	126, 934			0.00000	
3.00 07300 DRUGS CHARGED TO PATIENTS	2, 299, 060	8, 599, 420			0. 000000	
4. 00 07400 RENAL DIALYSIS	0	0		0 0.000000	0.00000	74.
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0	C		0		88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.
1.00 09100 EMERGENCY	756, 297	12, 195, 470			0.00000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	666, 207	666, 20		0.00000	
3. 00 04050 CLINIC	2,200	10, 565, 097			0.00000	
3. 01 04950 BIC	16	2, 240, 038	2, 240, 0		0.00000	
3. 02 04951 UCI C	0	0		0 0.000000	0.00000	
3. 03 04952 CI C	0	0		0 0.000000	0.00000	
3. 04 04953 RIC	0	0		0 0.000000		
3. 05 04954 PODI ATRY	0	11, 936	11, 93	0. 399883	0.00000	93.
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES	0	111, 946			0. 000000	
9. 00 09900 CMHC	0	0		0		99.
9. 10 09910 CORF	0		707.0	0		99.
01.00 10100 HOME HEALTH AGENCY	0	727, 974	727, 9	/ 4		101.
SPECIAL PURPOSE COST CENTERS			1	0		100
09.00 10900 PANCREAS ACQUISITION	0	0		0		109.
10. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.
11. 00 11100 I SLET ACQUI SI TI ON	0			0		111.
16. 00 11600 HOSPI CE	0	193, 992				116.
00.00 Subtotal (see instructions)	17, 914, 823	84, 950, 913	102, 865, 73	30		200
	1			1		1711

17, 914, 823

84, 950, 913

102, 865, 736

200. 00 201. 00 202. 00

200. 00 201. 00

202.00

Less Observation Beds

Total (see instructions)

nour th	FINANCIAI Systems	FAYEITE REGIONAL F		111 210	U OF FORM CMS-2552-
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared 2/23/2017 9:30 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient		nosprear	110
	bost bontor boson prion	Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11100			
	03000 ADULTS & PEDIATRICS				30.
	03100 I NTENSI VE CARE UNI T				31.
	04000 SUBPROVI DER – I PF				40.
	04100 SUBPROVIDER - IRF				40.
	04200 SUBPROVI DER				41.
	04300 NURSERY				42.
					43.
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0.24440			FO
		0. 266468			50.
	05200 DELIVERY ROOM & LABOR ROOM	0.00000			52.
	05400 RADI OLOGY-DI AGNOSTI C	0. 199661			54.
	05700 CT SCAN	0. 000000			57.
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.
	06000 LABORATORY	0. 169672			60.
0. 01	06001 BLOOD LABORATORY	0. 000000			60.
5.00	06500 RESPI RATORY THERAPY	0. 268481			65.
6.00	06600 PHYSI CAL THERAPY	0. 558247			66.
9.00	06900 ELECTROCARDI OLOGY	0. 000000			69.
9.01	06901 CARDI AC REHAB	0. 916372			69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 433462			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 549999			72.
	07300 DRUGS CHARGED TO PATIENTS	0. 393982			73.
	07400 RENAL DI ALYSI S	0. 000000			74.
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC				88.
	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.
	09100 EMERGENCY	0. 172271			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 897119			92.
	04050 CLINIC	0. 625045			93.
	04950 BIC	0. 730786			93.
	04951 UCI C				93.
	04951 001 C 04952 CI C	0. 000000			
	04952 CTC 04953 RTC	0. 000000 0. 000000			93.
	04954 PODI ATRY	0. 399883			93.
	OTHER REIMBURSABLE COST CENTERS	0 (7/505			
	09500 AMBULANCE SERVICES	0. 676585			95.
	09900 CMHC				99.
	09910 CORF				99.
	10100 HOME HEALTH AGENCY				101.
	SPECIAL PURPOSE COST CENTERS				
	10900 PANCREAS ACQUISITION				109.
	11000 INTESTINAL ACQUISITION				110.
11.00	11100 I SLET ACQUI SI TI ON				111.
	11600 HOSPI CE				116.
16.00		1			
	Subtotal (see instructions)				200.
16.00 200.00 201.00					200. 201.

Heal th	Fi nan	ci a	I Syst	ems			
COMPLIE		OF	DATIO	OF	COSTS	ΤO	0

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

TH to XIX Hospitul Cost Cost Center Description Total Cost (Frem Mixst. B, Part L, col.) Total Costs Adj. Total Costs (Frem Mixst. B, Part L, col.) Total Costs (Frem Mixst. B, Part L, col.) RCE Disul Description RCE (Frem Mixst. B, Part L, col.) RCE (Fr	COMPUTATION OF RATIO OF COSTS TO CHARGES	ATTITE REGIONAL	Provi der C	CN: 15-0064	Period: Erom 10/01/2015	Worksheet C Part I Date/Time Pre 2/23/2017 9:3	
Cost Center Description Total Cost Part I, col. Total Cost Adj. Total Costs Adj. RCE Disal Iowance Total Costs 1000 1000 2.00 3.00 4.00 5.00 1000 2.00 3.00 4.00 5.00 1000 000000 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.741,462 0 2.747,73 0 2.747,73 0 2.747,73 0 2.747,73 0 2.747,73 0 2.747,73 0 2.747,75 0			Ti tl	e XIX	Hospi tal	Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.000 4.00 5.00 30.00 03000 ADULTS SERVICE COST CENTERS 2.741.462 2.741.462 0.2741.462 0.0741.462	Cost Center Description	(from Wkst. B, Part I, col.		Total Costs	RCE	Total Costs	
INPART ENT ROUTINE SERVICE COST CENTERS 0.0 03.000 03100 AULTS & PEDATRICS 2,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,741,462 0,733,40,00 2,269,733,40,00 0,259,733,40,00 0,259,733,40,00 0,259,733,40,00 0,259,733,40,00 0,253,340,00 0,253,340,00 0,042,00 0,00,00 0,00,00,00 0,00,00,00 0,00,00,00,00,00 2,269,733,40,00 0,0 0			2 00	3 00	4.00	5.00	
30.00 03000 ADULTS & PEDLATRICS 2,741,462 0,2741,462 0,2741,462 0,2741,462 30.00 30.00 03000 INTENSIVE CARE UNIT 1,563,389 1,563,389 30.00 1,563,389 30.00 1,563,389 30.00 40.00 04000 SUBPROVIDER IFF 2,269,733 2,269,733 0,253 0,209,733 2,269,733 0,253 0,000<	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
31.00 03100 INTENSIVE CARE UNIT 1, 563, 389 1, 563, 589 3, 56 653, 946 653, 946 653, 946 653, 946 653, 946 653, 946 1, 563, 389 1, 563, 589 3, 50 50 50 50 50 50 50 50 50 50 50 50 50 50 50		2, 741, 462		2, 741, 46	2 0	2, 741, 462	30.00
40.00 04000_SUBPROV DER - 1 PF 2, 269, 733 0 2, 269, 733 0 2, 363, 733 40.00 41.00 04200_SUBPROV DER 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
41.00 04100 SUBPROVIDER - IBF 2,513 0 2,513 0 2,513 0 2,513 0 0,513 41.00 42.00 04300 NURSERV 653,946 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 653,946 0 0 52,00 0 52,00 0 2,249,712 0 2,249,712 0 52,00 0 52,00 0 52,00 0 52,00 0 57,00 57,00 57,00 57,00 57,00 57,00 58,00 0 0 0 0 0 0 59,00 99,00 0 0 0 0 60,01 66,01 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
43. 00 04300 NURSERY 653.946 653.946 653.946 653.946 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 [DEVICEY ROW & LABOR ROOM 2.249,712 0.249,712 0.0 2.249,712 50.00 0.0 0.0 0.0 52.00 52.00 52.00 0.0 0.0 0.0 52.00 52.00 0.0 0.0 0.0 0.0 52.00 0.0 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 0.0 0.0 0.0 0.0 58.00 0.0 0.0 0.0 58.00 0.0		2, 513		2, 51	3 0	2, 513	41.00
NOLL LARY SERVICE COST CENTERS 1 <th< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td>0</td><td>42.00</td></th<>		0			0 0	0	42.00
50. 00 05000 0FEART ING. ROOM 2, 249, 712 2, 249, 712 0 2, 249, 712 50. 00 50. 00 05000 DELIVERY. ROM & LABOR ROOM 0 0 65.00 50. 00 05000 RADI LOGY-DI AGNOSTI C 4, 617, 759 0 4, 617, 759 0 67.00 50. 00 05000 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 00 00000 CABDIA C CATHETERIZATION 0 0 0 66.00 60.00 60.	43. 00 04300 NURSERY	653, 946		653, 94	6 0	653, 946	43.00
50. 00 05000 0FEART ING. ROOM 2, 249, 712 2, 249, 712 0 2, 249, 712 50. 00 50. 00 05000 DELIVERY. ROM & LABOR ROOM 0 0 65.00 50. 00 05000 RADI LOGY-DI AGNOSTI C 4, 617, 759 0 4, 617, 759 0 67.00 50. 00 05000 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 00 00000 CABDIA C CATHETERIZATION 0 0 0 66.00 60.00 60.	ANCILLARY SERVICE COST CENTERS						
54. 00 054.00 NADIOLOGY-DIAGNOSTIC 4, 617, 759 4, 617, 759 4, 617, 759 6, 617, 759 54. 00 57. 00 <		2, 249, 712		2, 249, 71	2 0	2, 249, 712	50.00
57. 00 057.00 CT SCAN 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0		1	0 0	0	52.00
58. 00 OSB00 MARETIC RESONANCE LIAGENC (MRL) 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 617, 759		4, 617, 75	9 0	4, 617, 759	54.00
59. 00 OS900 (ARDIA C CATHETREI ZATION 0 0 0 59. 00 0 0 59. 00 0 0 0 0 0 59. 00 <	57.00 05700 CT SCAN	0		1	0 0	0	57.00
59. 00 OS900 (ARDIA C CATHETREI ZATION 0 0 0 59. 00 0 0 59. 00 0 0 0 0 0 59. 00 <	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60.01 0 <td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>59.00</td>	59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
65.00 0c500 RESPIRATORY THERAPY 843,196 0 843,196 0 843,196 0 843,196 0 843,196 65.00 66.00 06000 PHYSICAL THERAPY 977,246 0 977,246 0 977,246 66.00 69.00 977,246 66.00 69.00 977,246 66.00 69.00 977,246 66.00 69.00 977,246 66.00 69.00 977,246 60.00 69.00 977,246 69.01 77.00 77.67 597.667 597.667 597.667 597.667 597.667 597.667 597.667 597.667 597.667 597.667 597.67 597.67 597.67 <	60. 00 06000 LABORATORY	2, 761, 816		2, 761, 81	6 0	2, 761, 816	60.00
66.00 06600 PHYSICAL THERAPY 977, 246 0 977, 246 0 977, 246 66.00 069.00 06900 CARDIAC REHAB 351, 951 351, 951 0 351, 951 69.00 07.00 0101 CAL SUPPLIES CHARGED TO PATIENTS 1, 104, 705 1, 104, 705 1, 104, 705 71.00 72.00		0			0 0	0	60.01
66.00 06600 PHYSICAL THERAPY 977, 246 0 977, 246 0 977, 246 66.00 069.00 06900 CARDIAC REHAB 351, 951 351, 951 0 351, 951 69.00 07.00 0101 CAL SUPPLIES CHARGED TO PATIENTS 1, 104, 705 1, 104, 705 1, 104, 705 71.00 72.00	65. 00 06500 RESPI RATORY THERAPY		0	843, 19	6 0		
69:00 06900 ELECTROCARDIOLOGY 0 0 0 69:00 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 69:01 71:00 <th< td=""><td>66. 00 06600 PHYSI CAL THERAPY</td><td>977, 246</td><td>0</td><td>977, 24</td><td>6 0</td><td>977, 246</td><td>66.00</td></th<>	66. 00 06600 PHYSI CAL THERAPY	977, 246	0	977, 24	6 0	977, 246	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 104, 705 1, 104, 705 0 1, 104, 705 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENTS 80,038 80,038 0 80,038 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4,293,806 4,293,806 0 4,293,806 0 4,293,806 0	69. 00 06900 ELECTROCARDI OLOGY	0			0 0		
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 80,038 80,038 4,293,806 72.00 73.00 07300 RRUGS CHARGED TO PATIENTS 4,293,806 4,293,806 0 4,293,806 0 0 0 0 73.00 00100 RENAL DIALYSIS 0 0 0 0 0 0 74.00 001700 RENAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 88.00 91.00 09100 EMERGENCY 2,231,214 2,231,214 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 597,667 597,667 597,667 93.01 04950 BLIC 1,631,744 1,631,744 5,257 1,637,001 93.01 93.02 04951 ICI C 0 0 0 0 93.03 93.03 04952 ICI C 0 0 0 93.04 93.05 04954 PODIARY 4,773 0 4,773 <td< td=""><td>69. 01 06901 CARDI AC REHAB</td><td>351, 951</td><td></td><td>351, 95</td><td>1 0</td><td>351, 951</td><td>69.01</td></td<>	69. 01 06901 CARDI AC REHAB	351, 951		351, 95	1 0	351, 951	69.01
73:00 DRUGS CHARED TO PATIENTS 4, 293, 806 4, 293, 806 0 4, 293, 806 73:00 74:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 88:00 89:00 99:00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 104, 705		1, 104, 70	5 0	1, 104, 705	71.00
74.00 07400 RENAL DIALYSIS 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 88.00 088000 RURAL HEALTH CLINIC 0 0 0 0 0 89.00 91.00 09100 EBREGENCY 2, 231, 214 2, 231, 214 0 2, 231, 214 0 2, 231, 214 92.00 9200 (BRERGENCY 2, 31, 214 0 2, 231, 214 92.00 9200 (DBREGENCY 2, 31, 214 0 2, 231, 214 92.00 92.00 9200 (BREGENCY 1, 631, 744 1, 631, 744 5, 257 1, 637, 001 93. 01 93.01 04950 BI C 1, 631, 744 1, 631, 744 5, 257 1, 637, 001 93. 02 93.02 04951 UC C 0 0 0 0 93. 02 93.04 04953 RI C 0 0 0 0 93. 03 9452 CI C 0 0 0 0 0 93. 03 95.00 09500 AMBURANCE SERVICES	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80, 038		80, 03	8 0	80, 038	72.00
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 90 08000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 91.00 09100 EMERGENCY 2, 231, 214 2, 231, 214 0 2, 231, 214 91.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 597, 667 597, 667 597, 667 92.00 93.00 04050 CLINIC 6, 509, 781 6, 509, 781 6, 605, 039 93.00 93.00 93.00 04950 BIC 1, 631, 744 1, 631, 744 5, 257 1, 637, 001 93.01 93.02 04951 UCI C 0 0 0 93.02 93.02 04951 UCI C 0 0 0 93.02 04951 UCI C 0 0 0 0 93.02 04953 RIC 0 0 0 0 93.02 04954 POILATRY 4, 773 0 4, 773 93.05 0	73.00 07300 DRUGS CHARGED TO PATIENTS	4, 293, 806		4, 293, 80	6 0	4, 293, 806	73.00
88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 89.00 90.00 Experimental and	74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY 2, 231, 214 2, 231, 214 0 2, 231, 214 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 597, 667 597, 667 597, 667 597, 667 597, 667 92.00 93.00 04050 CLI NI C 6, 509, 781 6, 509, 781 95, 258 6, 6005, 039 93.00 93.00 93.01 04950 BI C 1, 631, 744 1, 631, 744 5, 509, 781 95, 258 6, 6005, 039 93.00 93.02 93.03 04952 CI NI C 0 0 0 93.02 93.03 04952 CI C 0 0 0 93.03 04953 RI C 0 0 0 0 93.03 04953 RI C 0 0 0 0 93.03 04954 POI ATRY 4, 773 0 4, 773 93.05 0 95.05 0 95.00 0 0 0 0 0 95.00 99.00 0 0 0 0 95.00 99.00	88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 597,667 597,667 92.00 93.00 04050 CLINIC 6,509,781 6,509,781 95,258 6,605,039 93.01 93.01 04950 BIC 1,631,744 1,631,744 5,257 1,637,001 93.01 93.02 04951 UCIC 0 0 0 93.02 93.03 04952 CIC 0 0 0 93.03 93.04 04953 RIC 0 0 0 93.03 93.05 04954 PODIATRY 4,773 4,773 0 4,773 95.00 09500 AMBULANCE SERVICES 75,741 75,741 0 75,741 99.00 99.00 09900 CMHC 0 0 0 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
93.00 04050 CLINIC 6,509,781 6,509,781 95,258 6,605,039 93.00 93.01 04950 BIC 1,631,744 1,631,744 5,257 1,637,001 93.02 93.02 04951 UCIC 0 0 0 0 93.02 93.03 04952 CIC 0 0 0 93.03 93.04 04953 RIC 0 0 0 93.03 93.05 04954 PODIATRY 4,773 0 4,773 93.05 04950 MBULANCE SERVICES 75,741 75,741 0 75,741 95.00 99.00 09900 CMHC 0 0 0 99.00		2, 231, 214		2, 231, 21	4 0	2, 231, 214	91.00
93.01 04950 BI C 1, 631, 744 1, 631, 744 5, 257 1, 637, 001 93.01 93.02 04951 UCI C 0 0 0 0 93.02 93.03 04952 CI C 0 0 0 0 93.03 93.04 04953 RI C 0 0 0 0 93.03 93.04 04954 PODI ATRY 4, 773 0 4, 773 0 4, 773 04954 PODI ATRY 4, 773 0 4, 773 0 4, 773 04950 CMBULANCE SERVICES 75, 741 75, 741 0 75, 741 93.05 99.00 09900 CMHC 0 0 0 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 09910 CORF 0 0 0 99.00 99.10 1, 366, 339 1, 366, 339 101.00 101.00 100.00 10100 HOME HEALTH AGENCY 1, 366, 339 1, 366, 339 101.00 101.00 100.00 110.00							
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60.00 06000 LABORATORY 2,022,573 14,254,777 16,277,350 0.169672 0. 60.01 06001 BLODD LABORATORY 0 0 0 0.000000 0. 65.00 OESDI RATORY THERAPY 799,868 2,340,745 3,140,613 0.268481 0. 66.00 OGOO DECTROCARDI OLOGY 0 0 0 0.000000 0. 69.00 O6900 ELECTROCARDI OLOGY 0 0 0.000000 0. 69.01 O6901 CARDI AC REHAB 0 384,070 384,070 0.916372 0. 71.00 OTIO MEL DEV. CHARGED TO PATI ENTS 718,590 126,934 145,524 0.549999 0. 73.00 O7300 DRUGS CHARGED TO PATI ENTS 18,590 126,934 145,524 0.549999 0. 74.00 OT400 RENAL DI ALYSIS 0 0 0 0 0.000000 0. 72.00 O7400 RENAL DI ALYSIS </td <td>0. 000000 58. C</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>	0. 000000 58. C			0	0	0	
60.01 06001 BLOOD LABORATORY 0 0 0 0.000000 0. 65.00 06500 RESPI RATORY THERAPY 799, 868 2, 340, 745 3, 140, 613 0.268481 0. 66.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0. 69.01 06901 CARDI AC REHAB 0 384, 070 384, 070 0.916372 0. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 712, 224 1, 836, 340 2, 548, 554 0. 433462 0. 72.00 07200 IMULS CHARGED TO PATI ENTS 18, 590 126, 934 145, 524 0. 549999 0. 73.00 07300 RUGS CHARGED TO PATI ENTS 2, 299, 060 8, 599, 420 10, 898, 480 0. 393982 0. 0 0 0.000000 0. 700 DRUGS CHARGED TO PATI ENTS 2, 299, 060 8, 599, 420 10, 898, 480 0. 393982 0. 0 0 0.000000 0. 71.00 07400 RENAL DI ALYSI S	0. 000000 59. 0			0	0	0	
65.00 06500 RESPI RATORY THERAPY 799,868 2,340,745 3,140,613 0.268481 0. 66.00 06600 PHYSI CAL THERAPY 97,420 1,653,141 1,750,561 0.558247 0. 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0. 69.01 06901 CARDI AC REHAB 0 384,070 384,070 0.916372 0. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 712,224 1,836,340 2,548,564 0.433462 0. 72.00 07200 IPUL. DEV. CHARGED TO PATI ENTS 2,299,060 8,599,420 10,898,480 0.399382 0. 74.00 07400 RENAL DI ALYSI S 0 0 0 0.000000 0. 0100 DUPATI ENT SERVI CE COST CENTERS 0 0 0 0.000000 0. 88.00 08900 REGENCY 756,297 12,195,470 12,951,767 0.172271 0. 91.00 DMERGENCY 756,297 12,195,470 12,951,767 0.728440 0.	0. 000000 60. 0	0.0000	0. 169672	16, 277, 350	14, 254, 777	2, 022, 573	
66.00 06600 PHYSI CAL THERAPY 97, 420 1, 653, 141 1, 750, 561 0.558247 0. 69.00 06901 CARDI AC REHAB 0 384, 070 384, 070 0.916372 0. 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 712, 224 1, 836, 340 2, 548, 564 0.433462 0. 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 18, 590 126, 934 145, 524 0.549999 0. 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 299, 060 8, 599, 420 10, 898, 480 0.393982 0. 0 07400 RENAL DI ALYSI S 0 0 0 0.000000 0. 0 0800 RURAL HEALTH CLINIC 0 0 0 0.000000 0. 92.00 08200 RERGENCY 756, 297 12, 195, 470 12, 951, 767 0.172271 0. 93.01 04950 BIC 16 2, 240, 038 2, 240, 034 2, 240, 034 0. 0.000000 0. 93.02 04951 UC1 C 0 0 <	0. 000000 60. C			0	0	0	
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 0. 69.01 06901 CARDIAC REHAB 0 384,070 384,070 0.916372 0. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 712,224 1,836,340 2,548,564 0.433462 0. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 18,590 126,934 145,524 0.549999 0. 73.00 07300 DRUGS CHARGED TO PATIENTS 2,299,060 8,599,420 10,898,480 0.393982 0. 0 0 0 0 0 0 0.000000 0. 0 0 0 0 0 0 0.000000 0. 0 0 0 0 0 0 0.000000 0. 0 0 0 0 0 0 0.000000 0. 0 0 0 0 0 0 0.000000 0. <	0. 000000 65. C			3, 140, 613	2, 340, 745	799, 868	
69.01 06901 CARDI AC REHAB 0 384,070 384,070 0.916372 0. 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 712,224 1,836,340 2,548,564 0.433462 0. 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 18,590 126,934 145,524 0.549999 0. 73.00 O7300 DRUGS CHARGED TO PATI ENTS 2,299,060 8,599,420 10,898,480 0.393982 0. 07400 RENAL DI ALYSI S 0 0 0 0.000000 0. 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0.000000 0. 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0. 92.00 09200 DBERVATI ON BEDS (NON-DI STINCT PART) 0 666,207 666,207 0.897119 0. 93.01 04950 BI C 11 C 2,200 10,565,097 10,567,297 0.616031 0. 93.01 04950 BI C 16 2,240,038 2,240,054 0.728440 0. 93.02	0.000000 66.C			1, 750, 561	1, 653, 141	97, 420	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 712, 224 1, 836, 340 2, 548, 564 0. 433462 0. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 18, 590 126, 934 145, 524 0. 549999 0. 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 299, 060 8, 599, 420 10, 898, 480 0. 393982 0. 74.00 07400 RENAL DI ALYSIS 0 0 0 0.000000 0. 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0.000000 0. 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0. 99.00 09900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0. 91.00 09100 EMERGENCY 756, 297 12, 195, 470 12, 951, 767 0. 172271 0. 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 666, 207 666, 207 0. 897119 0. 93.01 04950 BI C 116 2, 240, 038 2, 240, 054 0. 728440 0.	0.000000 69.0		0.000000	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 18,590 126,934 145,524 0.549999 0. 73.00 07300 DRUGS CHARGED TO PATIENTS 2,299,060 8,599,420 10,898,480 0.393982 0. 74.00 07400 RENAL DIALYSIS 0 0 0 0.000000 0. OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0. 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0. 91.00 09100 EMERGENCY 756,297 12,195,470 12,951,767 0.172271 0. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 666,207 666,207 0.897119 0. 93.01 04950 BIC 116 2,240,038 2,240,054 0.728440 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.03 04952 CI C 0 0 0 0.0000000 0.	0.000000 69.0	0.0000	0. 916372	384, 070	384, 070	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 2, 299, 060 8, 599, 420 10, 898, 480 0. 393982 0. 74.00 07400 RENAL DIALYSIS 0 0 0 0.000000 0. 0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0. 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0. 91.00 09100 EMERGENCY 756, 297 12, 195, 470 12, 951, 767 0. 172271 0. 92.00 09200 0BSERVATION BEDS (NON-DI STINCT PART) 0 666, 207 666, 207 0.616031 0. 93.01 04950 BI C 16 2, 240, 038 2, 240, 054 0. 728440 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.03 04952 CI C 0 0 0.000000 0. 93.03 04952 CI C 0 0 0.000000 0. 93.04 04953 RI C 0 0 <td>0.000000 71.C</td> <td>0.0000</td> <td>0. 433462</td> <td>2, 548, 564</td> <td>1, 836, 340</td> <td>712, 224</td> <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td>	0.000000 71.C	0.0000	0. 433462	2, 548, 564	1, 836, 340	712, 224	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS
74.00 07400 RENAL DI ALYSI S 0 0 0 0.0000000 0.0000000 <td>0.000000 72.0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	0.000000 72.0						
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0. 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0. 91.00 09100 EMERGENCY 756,297 12,195,470 12,951,767 0.172271 0. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 666,207 666,207 0.897119 0. 93.00 04950 BI C 16 2,240,038 2,240,054 0.728440 0. 93.01 04950 BI C 0 0 0 0.000000 0. 93.02 04951 UCI C 0 0 0.000000 0. 93.03 04952 CI C 0 0 0.000000 0. 93.04 04953 RI C 0 0 0.000000 0. 93.05 04954 POLIATRY 0 11,936 11,936 0.399883 0. <t< td=""><td>0.000000 73.C</td><td>0.0000</td><td>0. 393982</td><td>10, 898, 480</td><td>8, 599, 420</td><td>2, 299, 060</td><td></td></t<>	0.000000 73.C	0.0000	0. 393982	10, 898, 480	8, 599, 420	2, 299, 060	
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0. 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.000000 0. 91.00 09100 EMERGENCY 756, 297 12, 195, 470 12, 951, 767 0. 172271 0. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 666, 207 666, 207 0. 616031 0. 93.00 04050 CLINIC 2, 200 10, 565, 977 10, 567, 297 0. 616031 0. 93.01 04950 BIC 16 2, 240, 038 2, 240, 054 0. 728440 0. 93.02 04951 UCI C 0 0 0.000000 0. 93.03 04952 CI C 0 0 0.000000 0. 93.04 04953 RI C 0 0 0 0.000000 0. 93.04 04954 POLI ATRY 0	0.000000 74.C	0.0000	0.000000	0	0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0. 91.00 09100 EMERGENCY 756,297 12,195,470 12,951,767 0.172271 0. 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 666,207 666,207 0.897119 0. 93.00 04050 CLINIC 2,200 10,565,097 10,567,297 0.616031 0. 93.01 04950 BIC 16 2,240,038 2,240,054 0.728440 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.03 04952 CI C 0 0 0 0.000000 0. 93.04 04953 RI C 0 0 0 0.000000 0. 93.04 04952 RI C 0 0 0 0.000000 0. 93.04 04953 RI C 0 0 0 0.000000 0. <							
91.00 09100 EMERGENCY 756, 297 12, 195, 470 12, 951, 767 0. 172271 0. 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 666, 207 666, 207 0.897119 0. 93.00 04050 CLI NI C 2, 200 10, 565, 097 10, 567, 297 0. 616031 0. 93.01 04950 BI C 16 2, 240, 038 2, 240, 054 0. 728440 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.03 04952 CI C 0 0 0 0.000000 0. 93.04 04953 RI C 0 0 0 0.000000 0. 93.04 04953 RI C 0 0 0.000000 0. 93.05 04954 POI ATRY 0 11, 936 11, 936 0.39983 0. 93.06 09500 AMBULANCE SERVI CES 0 111, 946 0.676585 0. <td>0. 000000 88. 0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>	0. 000000 88. 0			0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 666, 207 666, 207 0.897119 0. 93.00 04050 CLINIC 2,200 10,565,097 10,567,297 0.616031 0. 93.01 04950 BIC 16 2,240,038 2,240,054 0.728440 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.02 04951 UCI C 0 0 0 0.000000 0. 93.02 04952 CI C 0 0 0 0.000000 0. 93.04 04953 RI C 0 0 0 0.000000 0. 93.05 04954 PODIATRY 0 11,936 11,936 0.399883 0. 0THER REI MBURSABLE COST CENTERS 0 111,946 0.676585 0.	0. 000000 89. 0	0.0000	0. 000000	0	0	0	
93.00 04050 CLINIC 2,200 10,565,097 10,567,297 0.616031 0. 93.01 04950 BIC 16 2,240,038 2,240,054 0.728440 0. 93.02 04951 UCIC 0 0 0 0.000000 0. 93.03 04952 CIC 0 0 0 0.000000 0. 93.04 04953 RIC 0 0 0 0.000000 0. 93.05 04954 PODI ATRY 0 0 0 0.399883 0. 95.00 09500 AMBULANCE SERVICES 0 111,946 111,946 0.676585 0.	0.000000 91.C	0.0000	0. 172271	12, 951, 767	12, 195, 470	756, 297	
93. 01 04950 BI C 16 2, 240, 038 2, 240, 054 0. 728440 0. 93. 02 04951 UCI C 0 0 0 0.000000 0. 93. 03 04952 CI C 0 0 0 0.000000 0. 93. 04 04953 RI C 0 0 0 0.000000 0. 93. 05 04954 PODI ATRY 0 11, 936 11, 936 0.399883 0. 93. 05 04954 PODI ATRY 0 111, 946 0.676585 0.	0.000000 92.0					0	
93. 02 04951 UCI C 0 0 0 0.000000 0. 93. 03 04952 CI C 0 0 0 0.000000 0. 93. 04 04953 RI C 0 0 0 0.000000 0. 93. 05 04954 PODI ATRY 0 11, 936 11, 936 0.399883 0. 0 04954 PODI ATRY 0 111, 946 0.676585 0.	0.000000 93.C					2, 200	
93.03 04952 CI C 0 0 0.00000 0. 93.04 04953 RI C 0 0 0 0.00000 0. 93.04 04953 RI C 0 0 0 0.000000 0. 93.05 04954 PODI ATRY 0 11,936 11,936 0.399883 0. 0THER REI MBURSABLE COST CENTERS 0 111,946 0.676585 0.	0.000000 93.0			2, 240, 054	2, 240, 038	16	
93.04 04953 RIC 0 0 0.00000 0. 93.05 04954 PODI ATRY 0 11,936 11,936 0.399883 0. 0THER REI MBURSABLE COST CENTERS 0 111,946 0.676585 0.	0.000000 93.C			, v	0	0	
93. 05 04954 PODI ATRY 0 11, 936 11, 936 0. 399883 0. 0THER REI MBURSABLE COST CENTERS 0 111, 946 0. 676585 0. 95. 00 09500 AMBULANCE SERVICES 0 111, 946 0. 676585 0.	0.000000 93.0			0	0	0	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 111, 946 0. 676585 0.	0.000000 93.0			U U	0	0	
95.00 09500 AMBULANCE SERVICES 0 111,946 0.676585 0.	<u>0.000000</u> 93.0	0.0000	0. 399883	11, 936	11, 936	0	
99. 00 09900 CMHC 0 0 0	0.000000 95.0	0.0000	0. 676585			1	
	99. C			, s	0		
99.10 09910 CORF 0 0 0	99. 1				0		
101.00 10100 HOME HEALTH AGENCY 0 727,974 727,974	101. C			727, 974	727, 974	0	
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION 0 0 0	109. C					0	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0	110. C			0	0	0	
111.00 11100 I SLET ACQUI SI TI ON 0 0 0	111. C			0	0	0	
116.00 11600 H0SPI CE 0 193, 992 193, 992	116. C					0	
200.00 Subtotal (see instructions) 17, 914, 823 84, 950, 913 102, 865, 736	200. 0			102, 865, 736	84, 950, 913	17, 914, 823	
201.00 Less Observation Beds	201.0						
202.00 Total (see instructions) 17,914,823 84,950,913 102,865,736	202.0			102, 865, 736	84, 950, 913	17, 914, 823	202.00 Total (see instructions)

Heal th	Financial Systems	FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-C		Worksheet C Part I Date/Time Prepared: 2/23/2017 9:30 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 I NTENSI VE CARE UNI T				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY				42.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS				43.00
50.00	05000 OPERATI NG ROOM	0.000000			50, 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00	05700 CT SCAN	0. 000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60.00	06000 LABORATORY	0. 000000			60.00
60.00	06001 BLOOD LABORATORY	0. 000000			60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
69.01	06901 CARDI AC REHAB	0. 000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DI ALYSI S	0.000000			74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04050 CLI NI C	0.000000			93.00
93.01	04950 BI C	0.000000			93.01
93.02	04951 UCI C	0. 000000			93.02
93.03	04952 CI C	0. 000000			93.03
93.04	04953 RI C	0. 000000			93.04
93.05	04954 PODI ATRY	0.000000			93. 05
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
					99.00
99.10					99.10
101.00	10100 HOME HEALTH AGENCY				101.00
100.00	SPECIAL PURPOSE COST CENTERS				100.00
	10900 PANCREAS ACQUISITION				109.00
	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
200.00	11600 HOSPI CE				116. 00 200. 00
200.00					200.00
201.00					201.00
202.00		I I			1202.00

Health Financial Systems	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 10/01/2015 To 09/30/2016		pared: 0 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	291, 753	0	291, 75		125.70	30.00
31.00 INTENSIVE CARE UNIT	124, 904		124, 90	4 498	250.81	31.00
40. 00 SUBPROVIDER - IPF	112, 630	0	112, 63	0 2, 098	53.68	40.00
41. 00 SUBPROVIDER - IRF	12	0	1 1	2 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	65, 221		65, 22	1 306	213.14	43.00
200.00 Total (lines 30-199)	594, 520		594, 52	0 5, 223		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 ADULTS & PEDI ATRI CS	1, 012					30.00
31.00 INTENSIVE CARE UNIT	230					31.00
40. 00 SUBPROVI DER – I PF	1, 320	70, 858				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	2, 562	255, 752				200. 00

ealth Financial Systems F PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AYETTE REGIONAL	Provider C		Peri od:	u of Form CMS-2 Worksheet D	2002-
	12 00010	in ovraci o		From 10/01/2015	Part II	
				To 09/30/2016		pared
					2/23/2017 9:3	0 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(COI. I ÷ COI 2)	. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 05000 OPERATING ROOM	317, 557	8, 442, 721	0. 03761	3 334, 481	12, 581	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0				12, 301	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	302, 642	0			13, 383	
7. 00 05700 CT SCAN	302, 042	23, 127, 930	0.00000		13, 303	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.00000		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.00000		0	59.0
0. 00 06000 LABORATORY	108, 551	16, 277, 350			-	
			0.00000			
	0	0			0	
	47,719					
6.00 06600 PHYSI CAL THERAPY	95, 781		0.05471			
9.00 06900 ELECTROCARDI OLOGY	0	-	0.00000		0	
9. 01 06901 CARDI AC REHAB	38, 231				0	69.0
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	38, 532					
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	404					
3.00 07300 DRUGS CHARGED TO PATIENTS	55, 473				4, 022	
4.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.0
OUTPATI ENT SERVICE COST CENTERS			0.0000		0	
8. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	100 100		0.00000		0	
1.00 09100 EMERGENCY	120, 182					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3.00 04050 CLINIC	63, 605				0	1
	366, 206				74	93.0
3. 01 04950 BLC 3. 02 04951 UCLC	113, 037	2, 240, 054			1	93.0
	0	0	0.00000		0	
3. 03 04952 CI C	0	0	0.00000		0	93.0
3. 04 04953 RIC	0	11 00	0.00000		0	
3. 05 04954 PODI ATRY	50	11, 936	0.00418	59 O	0	93. (
			1			
5. 00 09500 AMBULANCE SERVICES	1 / / 7 070	02 152 004		F 00/ 700	(0.0/0	95.0
00.00 Total (lines 50-199)	1, 667, 970	93, 153, 094	1	5, 036, 732	62, 062	1200. (

Health Financial Systems	FAYETTE REGIONAL	_ HEALTH SYSTEM	I	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Period: From 10/01/2015 To 09/30/2016		epared: 80 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0 0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	0		0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	C	0)	0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0		o o	0	41.00
42. 00 04200 SUBPROVI DER	0	0		o o	0	42.00
43. 00 04300 NURSERY	C	0		0	0	43.00
200.00 Total (lines 30-199)	C	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 321	0.00	1, 01	2 0		30.00
31.00 03100 INTENSIVE CARE UNIT	498					31.00
40. 00 04000 SUBPROVIDER - IPF	2,098		-	-		40.00
41. 00 04100 SUBPROVIDER - IRF	2,0,0	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER		0.00		0 0		42.00
43. 00 04300 NURSERY	306					43.00
200.00 Total (lines 30-199)	5, 223		2, 56	2 0		200.00
	0,220	1	1 2,50	-1 0	1	1200.00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Pre 2/23/2017 9:3	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	4) 5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		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 DI ALYSI S	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
93. 00 04050 CLI NI C	0	0		0 0	0	93.00
93. 01 04950 BI C	0	0		0 0	0	93.01
93. 02 04951 UCI C	0	0		0 0	0	93.02
93. 03 04952 CI C	0	0		0 0	0	93.03
93. 04 04953 RIC	0	0		0 0	0	93.04
93. 05 04954 PODI ATRY	0	0		0 0	0	93.05
	1		1	-		05.00
95.00 09500 AMBULANCE SERVICES		0		0	0	95.00
200.00 Total (lines 50-199)	0	0	1	0 0	0	200. 00

		HEALTH SYSTEM			u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Period: From 10/01/2015	Worksheet D Part IV	
THROUGH COSTS				To 09/30/2016		nared
				10 077 007 2010	2/23/2017 9:3	0 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		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						
50.00 05000 OPERATI NG ROOM	0	8, 442, 721			334, 481	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	23, 127, 950			1, 022, 662	
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	0.000000	0	59.0
50. 00 06000 LABORATORY	0	16, 277, 350	0.00000	0.000000	1, 185, 250	60.0
50. 01 06001 BLOOD LABORATORY	0	0	0.00000	0.000000	0	60.0
55. 00 06500 RESPI RATORY THERAPY	0	3, 140, 613	0.00000	0.000000	637, 298	65.0
56. 00 06600 PHYSI CAL THERAPY	0	1, 750, 561			57, 028	
59. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0.000000	0	69.0
59. 01 06901 CARDI AC REHAB	0	384, 070	0.00000	0.000000	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 548, 564	0.00000	0.000000	339, 509	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	145, 524	0. 00000	0.000000	6, 083	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 898, 480	0. 00000	0.000000	790, 131	73.0
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0.000000	0	74.0
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0.00000	0	88.0
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0.000000	0	89.0
91. 00 09100 EMERGENCY	0	12, 951, 767	0. 00000	0.000000	662, 133	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	666, 207	0. 00000	0.000000	0	92.0
93. 00 04050 CLINIC	0	10, 567, 297	0. 00000	0.000000	2, 146	93.0
93. 01 04950 BI C	0	2, 240, 054	0. 00000	0.000000	11	93.0
93. 02 04951 UCI C	0	0	0. 00000	0.00000	0	93.0
93. 03 04952 CI C	0	0	0.00000	0.000000	0	93.0
93. 04 04953 RI C	0	0	0. 00000	0.000000	0	93.0
93. 05 04954 PODI ATRY	0	11, 936	0. 00000	0.000000	0	93.0
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.0
200.00 Total (lines 50-199)	0	93, 153, 094			5, 036, 732	200.0

alth Financial Systems F PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provider C		Peri od:	Worksheet D	2552
IROUGH COSTS				From 10/01/2015 To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	<u>y am</u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	- I		1			l
0. 00 05000 OPERATI NG ROOM	0	2, 700, 870		0		50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 805, 443		0		54
7. 00 05700 CT SCAN	0	0		0		57
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58
0. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59
. 00 06000 LABORATORY	0	2, 609, 804		0		60
. 01 06001 BLOOD LABORATORY	0	0		0		60
00 06500 RESPI RATORY THERAPY	0	1, 191, 225		0		65
. 00 06600 PHYSI CAL THERAPY	0	10, 138		0		66
0. 00 06900 ELECTROCARDI OLOGY	0	0		0		69
2. 01 06901 CARDI AC REHAB	0	228, 319		0		69
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	512,065		0		71
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	49, 476		0		72
8. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 802, 758		0		73
I. 00 07400 RENAL DI ALYSI S	0	0		0		74
OUTPATIENT SERVICE COST CENTERS			1	-		
. 00 08800 RURAL HEALTH CLINIC	0	0		0		88
. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89
. 00 09100 EMERGENCY	0	2, 708, 320		0		91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	505, 949		0		92
. 00 04050 CLINIC	0	1, 907, 796		0		93
. 01 04950 BIC	0	66, 585		0		93
. 02 04951 UCI C	0	0		0		93
8. 03 04952 CI C	0	0		0		93
. 04 04953 RIC	0	0		0		93
3. 05 04954 PODI ATRY	0	0		0		93
OTHER REIMBURSABLE COST CENTERS			1	- 1		
5. 00 09500 AMBULANCE SERVICES						95
00.00 Total (lines 50-199)	0	24, 098, 748		0		200

Health Financial Systems F.	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0064	Peri od:	Worksheet D	
				From 10/01/2015	Part V Date/Time Pre	norod
				To 09/30/2016	2/23/2017 9:3	
		Title	e XVIII	Hospi tal	PPS	
			Charges	noopi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 OPERATING ROOM	0. 266468			0 0	719, 695	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 199661			0 0	1, 558, 443	
57.00 05700 CT SCAN	0. 000000			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
60. 00 06000 LABORATORY	0. 169672			0 0	442, 811	
60.01 06001 BLOOD LABORATORY	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 268481	1, 191, 225		0 0	319, 821	
66. 00 06600 PHYSI CAL THERAPY	0. 558247		1	0 0	5, 660	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
69. 01 06901 CARDI AC REHAB	0. 916372		1	0 0	209, 225	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 433462			0 0	221, 961	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 549999		1	0 0	27, 212	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 393982			0 11, 409	1, 498, 218	
74.00 O7400 RENAL DI ALYSI S	0. 000000	C		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS		1	1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
91.00 09100 EMERGENCY	0. 172271			0 0	466, 565	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 897119			0 0	453, 896	
93. 00 04050 CLINIC	0. 616031			0 0	1, 175, 261	
93. 01 04950 BIC	0. 728440			0 0	48, 503	
93. 02 04951 UCI C 93. 03 04952 CI C	0.000000			0 0	0	
	0. 000000			0 0	0	
93. 04 04953 RIC	0. 000000 0. 399883			0 0 0 0	0	
93. 05 04954 PODI ATRY OTHER REI MBURSABLE COST CENTERS	0. 399883		1	0 0	0	93.05
95. 00 09500 AMBULANCE SERVICES	0. 676585	1		0		95.00
200.00 Subtotal (see instructions)	0. 070303	24, 098, 748		-	7 147 271	
201.00 Less PBP Clinic Lab. Services-Program		24,090,748		0 11,409 0 0	7, 147, 271	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 +/- line 201)		24, 098, 748		0 11, 409	7, 147, 271	202 00
202.00 [Not ond ges (The 200 +/ - The 201)	T	27,070,740	1	SI 11, 409	1 1, 147, 271	1-02.00

ealth Financial Systems F PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		<u>HEALTH SYSTEM</u> Provider C(Peri od: From 10/01/2015 To 09/30/2016	u of Form CMS Worksheet D Part V Date/Time Pr 2/23/2017 9:	epared
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				_
ANCI LLARY SERVICE COST CENTERS	-	-	1			_
0.00 05000 OPERATING ROOM	0					50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.
7.00 05700 CT SCAN	0	0				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.
0. 00 06000 LABORATORY	0	0				60.
0.01 06001 BLOOD LABORATORY	0	0				60.
5. 00 06500 RESPI RATORY THERAPY	0	0				65.
6. 00 06600 PHYSI CAL THERAPY	0	0				66.
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.
9. 01 06901 CARDI AC REHAB	0	0				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 495				73.
4. 00 07400 RENAL DIALYSIS	0	0				74.
OUTPATIENT SERVICE COST CENTERS	-	1				
8.00 08800 RURAL HEALTH CLINIC	0					88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.
1.00 09100 EMERGENCY	0	0				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.
3. 00 04050 CLINIC	0	0				93.
3. 01 04950 BIC	0	0				93.
3. 02 04951 UCI C	0	0				93.
3. 03 04952 CI C	0	0				93.
3. 04 04953 RIC	0					93.
3. 05 04954 PODI ATRY	0	0				93.
OTHER REIMBURSABLE COST CENTERS		1				
5. 00 09500 AMBULANCE SERVICES	0					95.
00.00 Subtotal (see instructions)	0	4, 495				200.
01.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
02.00 Net Charges (line 200 +/- line 201)	0	4, 495				202.

	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CCN: 15-0064		Peri od:	Worksheet D	
		Component	CCN: 15-S064	From 10/01/2015 To 09/30/2016	Part II Date/Time Pre	norod.
		component	CCN: 15-5064	10 09/30/2016	2/23/2017 9:3	pareu: O am
		Title	e XVIII	Subprovider -	PPS	
	T	-		I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	-1					
50. 00 05000 OPERATI NG ROOM	317, 557	8, 442, 721			100	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 00	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	302, 642	23, 127, 950	0.0130	36 72, 031	943	54.00
57.00 05700 CT SCAN	0	0	0.0000	0 00	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000	0 00	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 00	0	59.00
60. 00 06000 LABORATORY	108, 551	16, 277, 350	0.0066	59 191, 033	1, 274	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0.0000	0 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY	47, 719	3, 140, 613	0.0151	94 4, 571	69	65.00
66. 00 06600 PHYSI CAL THERAPY	95, 781	1, 750, 561	0.0547	14 17, 434	954	66.00
69.00 06900 ELECTROCARDI OLOGY	0					69.00
69. 01 06901 CARDI AC REHAB	38, 231	384, 070			0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38, 532				60	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	404				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	55, 473				-	
74. 00 07400 RENAL DIALYSIS	00,170		1			
OUTPATIENT SERVICE COST CENTERS		<u> </u>	0.0000	50 0	<u> </u>	1 1.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		-	
91. 00 09100 EMERGENCY	120, 182	12, 951, 767			760	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
93. 00 04050 CLINIC	366, 206				-	93.00
93. 01 04950 BLC	113, 037	2, 240, 054			0	
93. 02 04951 UCI C	113,037	2, 240, 004	0.0000		0	
93. 02 04951 0010 93. 03 04952 010	0		0.0000		0	
93. 04 04952 CTC 93. 04 04953 RIC	0		0.0000			
	0	11 024				
93. 05 04954 PODIATRY	50	11, 936	0.0041	59 0	0	93.05
			1			05 00
95. 00 09500 AMBULANCE SERVICES	1 404 345	02 152 004		724 450	4 000	95.00 200.00
200.00 Total (lines 50-199)	1, 604, 365	93, 153, 094	1	736, 650	I 0, 009	I∠00. 00

Health Financial Systems F	AYETTE REGIONAL HI	EALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CC	CN: 15-0064	Peri od:	Worksheet D	
THROUGH COSTS		Component C	CN. 15 5044	From 10/01/2015 To 09/30/2016		parad
		component c	CN. 13-3004	10 09/30/2010	2/23/2017 9:3	n am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician Nu	rsing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	0.00	0.00	4.00	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	1
57. 00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDIAC CATHETERIZATION	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0		•
	0	0		0 0	, s	
	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	12.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
OUTPATI ENT SERVICE COST CENTERS		0		0 0	0	88.00
	0	0		0 0	-	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91.00 09100 EMERGENCY	0	0		0 0	0	1
	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04050 CLINIC	0	0		0 0		
93. 00 04050 CLINIC 93. 01 04950 BLC	0	0		0 0	0	
93. 01 04950 BTC 93. 02 04951 UCI C	0	0		0 0	0	
93. 02 04951 0C1 C 93. 03 04952 C1 C	0	0		0 0	0	
93. 03 04952 010 93. 04 04953 RLC	0	0		0 0		•
93. 04 04953 RTC 93. 05 04954 PODI ATRY	0	0			, s	1
07104954 PODIATRY OTHER REIMBURSABLE COST CENTERS		0		0 0	0	93.05
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
200.00 [101a] (11165 30-177)	, O	ų		0	0	1200.00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S064	From 10/01/2015 To 09/30/2016	Part IV Date/Time Pre	narod
		component	CCN. 13-3004	10 09/30/2010	2/23/2017 9:3	pareu. O am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	8, 442, 721			2, 671	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	23, 127, 950			72, 031	
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (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, 277, 350			191, 033	
60.01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	3, 140, 613			4, 571	•
66. 00 06600 PHYSI CAL THERAPY	0	1, 750, 561	0.00000		17, 434	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00
69. 01 06901 CARDI AC REHAB	0	384, 070			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 548, 564			3, 939	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	145, 524			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 898, 480			363, 063	
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0.00000	0	74.00
OUTPATIENT SERVICE COST CENTERS	-	-				
88.00 08800 RURAL HEALTH CLINIC	0	-	0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0.00000		0	89.00
91.00 09100 EMERGENCY	0	12, 951, 767			81, 881	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	666, 207	0.00000		0	92.00
93. 00 04050 CLINIC	0	10, 567, 297			22	93.00
93. 01 04950 BIC	0	2, 240, 054			5	93.01
93. 02 04951 UCI C	0	0	0.00000		0	93.02
93. 03 04952 CI C	0	0	0.00000		0	93.03
93. 04 04953 RIC	0	0	0.00000		0	93.04
93. 05 04954 PODI ATRY	0	11, 936	0.00000	0.00000	0	93.05
OTHER REIMBURSABLE COST CENTERS	1		1			0.5.05
95. 00 09500 AMBULANCE SERVICES	-	00 450 007			70/ /50	95.00
200.00 Total (lines 50-199)	0	93, 153, 094			736, 650	200.00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0064	Peri od:	Worksheet D
THROUGH COSTS		Component	CON. 15 CO(4	From 10/01/2015 To 09/30/2016	Part IV Date/Time Prepared:
		component	CCN: 15-S064	To 09/30/2016	2/23/2017 9:30 am
		Title	e XVIII	Subprovider -	PPS
				IPF	
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug		
	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 OPERATI NG ROOM	0	C		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. OC
57.00 05700 CT SCAN	0	0		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		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 RESPIRATORY THERAPY	0	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	73.00
74.00 07400 RENAL DIALYSIS	0	C		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	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)	0	92.00
93. 00 04050 CLINIC	0	C)	0	93.00
93. 01 04950 BIC	0	C)	0	93.01
93. 02 04951 UCI C	0	C		0	93. 02
93. 03 04952 CI C	0	C		0	93.03
93. 04 04953 RIC	0	C		0	93.04
93. 05 04954 PODI ATRY	0	C		0	93.05
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (lines 50-199)	0	C		0	200.00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Control	CN: 15-0064 CCN: 15-T064	Period: From 10/01/2015 To 09/30/2016		
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Related Cost (from Wkst. B, Part II, col. 26)	8)	to Charges (col. 1 ÷ col 2)	Program L. Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	317, 557	8, 442, 721			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	302, 642	23, 127, 950			0	
57.00 05700 CT SCAN	0	0	0.0000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000		0	
60. 00 06000 LABORATORY	108, 551	16, 277, 350			0	
60. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	
65. 00 06500 RESPI RATORY THERAPY	47,719				0	
66. 00 06600 PHYSI CAL THERAPY	95, 781	1, 750, 561			0	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000		0	
69. 01 06901 CARDI AC REHAB	38, 231	384, 070			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	38, 532	2, 548, 564			0	
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS	404 55, 473	145, 524 10, 898, 480			0	•
	55,473	10, 898, 480			0	•
74. 00 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	0.0000	0	0	74.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	
91. 00 09100 EMERGENCY	120, 182	12, 951, 767			0	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	120, 102	666, 207			0	
93. 00 04050 CLINIC	366, 206	10, 567, 297			0	•
93. 01 04950 BLC	113,037	2, 240, 054			0	
93. 02 04951 UCI C	113,037	2, 240, 034	0.0000		0	
93. 03 04952 CI C		0	0.0000		0	•
93. 04 04953 RIC	0	0	0.0000		0	•
93. 05 04954 PODI ATRY	50	11, 936			0	
OTHER REIMBURSABLE COST CENTERS		11, 930	0.00410	0	0	/3.03
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 604, 365	93, 153, 094		0	0	200.00

Health Financial Systems F	AYETTE REGIONAL HI	EALTH SYSTEM		In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0064	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T064	From 10/01/2019 To 09/30/2010		narod
		Component (JUN: 15-1004	10 09/30/2010	2/23/2017 9:3	ipareu. 10 am
		Title	XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description	Non Physician Nu	rsing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cos	t through col.	
	1.00	0.00		1.00	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0		0	o lc	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		
57. 00 05700 CT SCAN	0	0		0		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		
60. 00 06000 LABORATORY	0	0		0		
60. 01 06001 BLOOD LABORATORY	0	0		0		
65. 00 06500 RESPI RATORY THERAPY	0	0		0		
66. 00 106600 PHYSI CAL THERAPY	0	0		0		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		
69. 01 06901 CARDI AC REHAB	0	0		0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	
74.00 07400 RENAL DIALYSIS	0	0		0	o l	74.00
OUTPATIENT SERVICE COST CENTERS			•			
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	0		0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0 ס	1 /2.00
93. 00 04050 CLINIC	0	0		0	0 0	
93. 01 04950 BIC	0	0		0	0 ס	
93. 02 04951 UCI C	0	0		0	0 ס	
93. 03 04952 CI C	0	0		0	0 0	
93. 04 04953 RIC	0	0		0	0 0	
93. 05 04954 PODI ATRY	0	0		0	0 0	93.05
					1	
95.00 09500 AMBULANCE SERVICES		0				95.00
200.00 Total (lines 50-199)	0	0	I	0	0 0	200.00

Health Financial Systems F	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T064	From 10/01/2015 To 09/30/2016		norod.
		component	UCIN: 15-1064	10 09/30/2016	2/23/2017 9:3	pareu: O am
		Title	XVIII	Subprovider -	PPS	o un
				IRF		
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		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						
50. 00 05000 OPERATI NG ROOM	0	8, 442, 721				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	23, 127, 950				54.00
57.00 05700 CT SCAN	0	0	0.00000			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000			59.00
60. 00 06000 LABORATORY	0	16, 277, 350				60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000			60.01
65. 00 06500 RESPI RATORY THERAPY	0	3, 140, 613				65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 750, 561				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000			69.00
69. 01 06901 CARDI AC REHAB	0	384, 070				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 548, 564				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	145, 524				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 898, 480				73.00
74. 00 07400 RENAL DIALYSIS	0	0	0.00000	0.00000	0	74.00
OUTPATIENT SERVICE COST CENTERS	1	-	1	- I.		
88.00 08800 RURAL HEALTH CLINIC	0	0				
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000			89.00
91. 00 09100 EMERGENCY	0	12, 951, 767				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	666, 207				92.00
93. 00 04050 CLINIC	0	10, 567, 297				93.00
93. 01 04950 BIC	0	2, 240, 054				93.01
93. 02 04951 UCI C	0	0	0.00000			93.02
93. 03 04952 CI C	0	0	0.00000			93.03
93. 04 04953 RIC	0	0	0.00000			93.04
93. 05 04954 PODI ATRY	0	11, 936	0.00000	0.00000	0	93.05
OTHER REIMBURSABLE COST CENTERS	-		1	_		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	93, 153, 094			0	200.00

Health Financial Systems	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0064	Peri od:	Worksheet D
THROUGH COSTS		Component	CCN: 15-T064	From 10/01/2015 To 09/30/2016	
		component	CCN. 15-1004	10 09/30/2010	2/23/2017 9:30 am
		Title	XVIII	Subprovider -	PPS
				IRF	
Cost Center Description	I npati ent	Outpati ent	Outpatient		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug		
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE 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 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	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. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	69.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	71.00
72. 00 07200 I MPL. 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			1		
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91.00 09100 EMERGENCY	0	0		0	89.00 91.00
	0	0		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93. 00 04050 CLINIC	0	0		0	92.00
	0	0		0	93.00
	0	0		0	93.01
	0	0		0	93.02
93. 03 04952 CI C 93. 04 04953 RI C	0	0		0	93.03
	0	0		-	
93. 05 04954 PODI ATRY	0	0		0	93. 05
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES					95.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50-199)		0		0	200.00
	0	0	1	0	1200.00

Health Financial Systems

			-				
FAYETTE	REGI ONAL	ΗE	ALTH	S	YST	EM	

In Lieu of Form CMS-2552-10

eal th	Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	u of Form CMS-2	2552
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Peri od:	Worksheet D-1	
			From 10/01/2015 To 09/30/2016	Date/Time Pre	pare
			10 07/00/2010	2/23/2017 9:3	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed da	avs. excluding newborn)		2, 321	1 1.
	Inpatient days (including private room days, excluding swing			2, 321	2.
. 00	Private room days (excluding swing-bed and observation bed o	days). If you have only pr	ivate room days,	0	3.
	do not complete this line.				
. 00	Semi-private room days (excluding swing-bed and observation			1, 815	
. 00	Total swing-bed SNF type inpatient days (including private r	room days) through Decembe	r 31 of the cost	0	5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6.
. 00	reporting period (if calendar year, enter 0 on this line)	toolii days) arter beeenber	ST OF the cost	0	0.
. 00	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7.
	reporting period	<i>,</i> 3			
. 00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	1, 012	9.
0.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	oply (including private r	oom dave)	0	10.
0.00	through December 31 of the cost reporting period (see instru		oon days)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,		5 /		
2.00	Swing-bed NF type inpatient days applicable to titles V or >	XIX only (including privat	e room days)	0	12
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or > after December 31 of the cost reporting period (if calendar			0	13
1 00	Medically necessary private room days applicable to the Proc			0	14
	Total nursery days (title V or XIX only)	gram (exer during swring bed	uuys)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 o	f the cost	202.51	17
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost	202.51	18
0 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 of	the cost	134.09	10
7.00	reporting period	ces thiodgh becember 51 of	the cost	154.07	17
0. 00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of t	he cost	137.30	20
	reporting period				
	Total general inpatient routine service cost (see instruction			2, 741, 462	
2.00	Swing-bed cost applicable to SNF type services through Decen	mber 31 of the cost report	ing period (line	0	22
2 00	5 x line 17) Swing had cost applicable to SNE type corvices after December	or 21 of the cost reportin	a pariod (lipa 4	0	23
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	er al of the cost reportin	g period (ine o	0	23
4.00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	na period (line	0	24
	7 x line 19)		ng por ou (rino	Ũ	
5.00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		2, 741, 462	27
8 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	bed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)	bed and observation bed ch	ai yes)	0	
	Semi-private room charges (excluding swing bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m	, ,	tions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fforontial (line	0 2 741 462	36
1.00	27 minus line 36)	t and private room cost di	inerential (IThe	2, 741, 462	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
-	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	DJUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se			1, 181. 16	38
9.00	Program general inpatient routine service cost (line 9 x lir	ne 38)		1, 195, 334	39
	Medically necessary private room cost applicable to the Prog			0	
	Total Program general inpatient routine service cost (line 3	$xy \perp \text{line}(40)$		1, 195, 334	

COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0064	Period: From 10/01/2015		
					To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
		7-+-1		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	0	0) 42.
~~	Intensive Care Type Inpatient Hospital Units	1 5 (2 200	400	3, 139, 3	24 220	722, 048	1 42
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 563, 389	498	3, 139	34 230	/22,048	3 43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
. 00	Program inpatient ancillary service cost (Wks			>		1, 274, 578	
00	Total Program inpatient costs (sum of lines / PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		3, 191, 960) 49
. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sur	n of Parts I and	184, 894	1 50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	ationt ancillar	u convioos (fr	om Wkat D	sum of Dorte II	62.042	2 51
. 00	and IV)		y services (II	UNI WKSL. D, S	Sum OF Parts II	62, 062	2 51
. 00	Total Program excludable cost (sum of lines !	,				246, 956	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9		lated, non-phy	sician anesti	netist, and	2, 945, 004	1 53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
. 00	Program discharges					C	
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount (l	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	ng cost and ta	get amount (i				
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period of	endi ng 1996, u	pdated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	C	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	f the target		
2. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				c c	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			C	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Dooo	where 21 of the	aget reporti	ng paried (Cae	C	
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is through becer		cost reporti	ng period (see		64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportino	g period (See	c c	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line)	61 nlus line 6	5) (+i +l 🗛 XV/I I	Loply) For	c c	66
. 00	CAH (see instructions)			5)(thte xin	i oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	C	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	68
	(line 13 x line 20)			the cost rep	i ting por ou		
9.00	Total title V or XIX swing-bed NF inpatient					C) 69
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line			>			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 35)			73
. 00	Capital -related cost allocated to inpatient	•	,	orksheet B, A	Part II, column		75
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess		rovider record	s)			79
00	Total Program routine service costs for compa		ost limitation	(line 78 mir	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li)				81
. 00	Reasonable inpatient routine service cost film tation (in						82
. 00	Program inpatient ancillary services (see ins		- /				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86
. 00	Total observation bed days (see instructions)					506	5 87
8.00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 181. 16	88
. 00	Observation bed cost (line 87 x line 88) (see	instructions)				597,667	1 89

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2015	Worksheet D-1	
				To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	291, 753	2, 741, 462	0. 10642	2 597, 667	63, 605	90.00
91.00 Nursing School cost	0	2, 741, 462	0.00000	597, 667	0	91.00
92.00 Allied health cost	0	2, 741, 462	0.00000	597, 667	0	92.00
93.00 All other Medical Education	0	2, 741, 462	0.00000	597, 667	0	93.00

PUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Pre 2/23/2017 9:3	pare
		Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		2, 098	1 1
0	Inpatient days (including private room days, excluding swing-			2, 098	
0	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	ivate room days,	0	3
0	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 098	4
0	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	r 31 of the cost	0	5
0	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
0	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7
0	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8
0	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 320	9
	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	0 1 0	0	0	
	through December 31 of the cost reporting period (see instruc	tions)			
00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0.00	1 17
	reporting period	5			
	Medicare rate for swing-bed SNF services applicable to servic reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0.00	20
00	Total general inpatient routine service cost (see instruction	s)		2, 269, 733	21
00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
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	x line 20) Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 269, 733	
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		<u> </u>	0	
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	and private see+ "	fforontial (1)-	0	
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	Tierential (Tine	2, 269, 733	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-
	Adjusted general inpatient routine service cost per diem (see			1, 081. 86	38
	Program general inpatient routine service cost (line 9 x line			1, 428, 055	
	Medically necessary private room cost applicable to the Progr			0	
00 1	medically necessary private room cost appricable to the produ				

	Financial Systems FA ATION OF INPATIENT OPERATING COST	YETTE REGIONAL		CN: 15-0064	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S064	From 10/01/2015 To 09/30/2016	Date/Time Pre	
			Title	e XVIII	Subprovider -	2/23/2017 9:3 PPS	<u>30 ani</u>
	Cost Center Description	Total Inpatient Costl	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	(00 () 42.
	Intensive Care Type Inpatient Hospital Units				00		1 42
3.00 4.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	C	0.	00 0	C C) 43. 44.
5.00	BURN I NTENSI VE CARE UNI T						45.
5.00	SURGICAL INTENSIVE CARE UNIT						46.
/. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
				-		1.00	
3.00 9.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ns)		217, 337	
. 00	PASS THROUGH COST ADJUSTMENTS	<u> </u>					
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, su	um of Parts I and	70, 858	3 50.
. 00	Pass through costs applicable to Program inpa	atient ancillary	y services (fr	rom Wkst. D,	sum of Parts II	6, 009	51
2. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51				76, 867	7 52
2.00	Total Program inpatient operating cost exclude	,	ated, non-phy	vsi ci an anest	hetist. and	1, 568, 525	
	medical education costs (line 49 minus line 5						
I. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					С	54
5.00	Target amount per discharge					0.00	
b. 00	Target amount (line 54 x line 55)					C	
. 00	Difference between adjusted inpatient operati	ng cost and tar	rget amount (I	ine 56 minus	s line 53)	C	
8.00 9.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period (nding 1996	undated and c	compounded by the) 58) 59
. 00	market basket		sharing 1770, t		compounded by the	0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
1.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	61
	amount (line 56), otherwise enter zero (see i		s (TTHES 54 X	00), 01 1% C	n the target		
2.00	Relief payment (see instructions)	,				C	
3.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			C) 63
I. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decer	mber 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)						
5. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportir	ng period (See	C) 65
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	64 plus line 6	55)(title XVI	II only). For	C	66
	CAH (see instructions)						
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	of the cost r	reporting period	C	67
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	C	68
<u> </u>	(line 13 x line 20)	autina aaata (l	ing (7 . ling	. (0)			
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU			,		C) 69
0. 00	Skilled nursing facility/other nursing facili				7)		70
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
2.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			72
4.00	Total Program general inpatient routine servi						74
5.00	Capital -related cost allocated to inpatient i	routine service	costs (from V	Vorksheet B,	Part II, column		75
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
. 00	Inpatient routine service cost (line 74 minus			1-2			78
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 70)		80
. 00	Inpatient routine service cost per diem limit			. (1110-70-111			81
. 00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82
3.00	Reasonable inpatient routine service costs (s		s)				83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ne)				84
. 00 . 00	Total Program inpatient operating costs (sum	•					85
	PART IV - COMPUTATION OF OBSERVATION BED PASS					·	
	Total observation bed days (see instructions))				C	
7.00 3.00	Adjusted general inpatient routine cost per o	diam (11 07	1 :			0.00	

Health Financial Systems Fi	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2015	Worksheet D-1	
		Component (To 09/30/2016		pared: 0 am
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	112, 630	2, 269, 733	0. 04962	3 0	0	90.00
91.00 Nursing School cost	0	2, 269, 733	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 269, 733	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 269, 733	0.00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Period:	Worksheet D-1	
		Component CCN: 15-T064	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			0	1.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	5,7	ivato room dave	0	2
50	do not complete this line.	ays). If you have only pr	I vate i oolii uays,	0	3
00	Semi-private room days (excluding swing-bed and observation b	bed days)		0	4
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5
20	reporting period		21 - 6 + 6 +	0	,
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 OF the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7
	reporting period			Ũ	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	swing-bed and	0	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruc			-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		a raam daya)	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	oos ofter December 21 of	the cost	0.00	18
. 00	reporting period	ces al tel December 51 01		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
~ ~	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		2, 513	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0	23
.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)		517 22 2		
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing had cost (see instructions)			0	24
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 513	26
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	(<u> </u>		1
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lino 28)		0 0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instruc	tions)	0.00	34
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost pet of swing bed cost	and private room cost di	fforential (line	0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	inerentiar (IINE	2, 513	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			0.00	
	PROFILM GARAFAL INDATIONT FOUTING CARVICA COST (LING U V LING	e 30)		0	39
. 00	Medically necessary private room cost applicable to the Progr			0	40

COMPUT	Financial Systems F/ ATION OF INPATIENT OPERATING COST	AYETTE REGIONAL		CN: 15-0064	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T064	From 10/01/2015 To 09/30/2016	Date/Time Pre	
			Title	e XVIII	Subprovider -	2/23/2017 9:3 PPS	30 am
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
				<u>col 2)</u> 3.00		4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00 C		4.00 00 0	5.00 C) 42.
00	Intensive Care Type Inpatient Hospital Units	0	(0) 43.
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	Ĺ	0.0	0) 43. 44.
	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1.00) 48.
. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ons)		C) 49.
	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	y services (fr	rom Wkst. D, s	sum of Parts II	(C	51.
2. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)					52.
3. 00	Total Program inpatient operating cost exclusion medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-phy	ysician anestr	netist, and	C	
	Program di scharges					0	54.
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (1	ine 56 minus	line 53)		
	Bonus payment (see instructions)		inger amount (i	The 50 minus	Title 55)		
. 00	0.00	59					
	market basket					0.00	
 40.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 41.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 							0 60 0 61
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive payment (see instructions)) 62) 63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	5			51		64
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reportino	g period (See	C	65
o. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I only). For	c	66
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	C	67
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	C	68
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					(69
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70
	Adjusted general inpatient routine service of						71
	Program routine service cost (line 9 x line	,		25)			72
	Medically necessary private room cost application Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient (26, line 45)	•	,		Part II, column		75
	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 minu:	,					78
	Aggregate charges to beneficiaries for excess		rovider record	ts)			79
	Total Program routine service costs for compa		ost limitation	n (line 78 mir	nus line 79)		80
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation ()				81
. 00	Reasonable inpatient routine service cost (83
	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation						85
5.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86
	Total observation bed days (see instructions					0	87
8. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88.
1 00	Observation bed cost (line 87 x line 88) (see	e instructions)				() 89

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2015	Worksheet D-1	
			CCN: 15-T064	To 09/30/2016	Date/Time Prep 2/23/2017 9:30	pared: 0 am
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	12	2, 513	0.00477	5 0	0	90.00
91.00 Nursing School cost	0	2, 513	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 513	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 513	0.00000	0 0	0	93.00

FAYETTE	REGI ONAL	HEALTH	SYS	TEM	
		-			

	Financial Systems FAYETTE REGIONAL H			u of Form CMS-2				
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Period: From 10/01/2015	Worksheet D-1				
			To 09/30/2016	Date/Time Pre 2/23/2017 9:3				
	Cost Center Description	Title XIX	Hospi tal	Cost				
				1.00				
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-			
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		2, 321	1.00			
2.00 3.00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.							
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	r 31 of the cost	1, 815 0					
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom 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 roo reporting period	om days) through December	31 of the cost	0	7.00			
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8.00			
9.00	Total inpatient days including private room days applicable t newborn days)		0	42				
10. 00 11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	tions)	5,	0				
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI	enter 0 on this line)	5,	0				
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00			
14. 00 15. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)			0 306				
16.00	Nursery days (fitle V of XIX only) SWING BED ADJUSTMENT			16				
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 c	f the cost	202. 51	17.00			
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period			202.51	18.00			
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	C		134.09				
20.00 21.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction		he cost	137.30 2,741,462				
21.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1}		ing period (line	2, 741, 402				
23.00	Swing-bed cost applicable to SNF type services after December x line 18) $$	31 of the cost reportin	g period (line 6	0	23.00			
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)			0				
25. 00 26. 00	Swing-bed cost applicable to NF type services after December x line 20) Total swing bed cost (see instructions)	31 of the cost reporting	period (line 8	0				
27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 741, 462				
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0				
29.00	Private room charges (excluding swing-bed charges)			0				
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000				
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00000				
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 mi	nus line 33)(see instruc	tions)	0.00				
35.00	Average per diem private room cost differential (line 34 x li		· ···-/	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 27 minus line 36) DADT LL HOSDITAL AND SUDDOV/LDEDS ONLY	and private room cost di	fferential (line	2, 741, 462	37.00			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-			
38.00	Adjusted general inpatient routine service cost per diem (see			1, 181. 16				
39.00	Program general inpatient routine service cost (line 9 x line			49, 609				
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 49, 609				

OMPUTATION OF INPATIENT OPERATI	NG CUST		Provi der	CCN: 15-0064	Period: From 10/01/2015	Worksheet D-1	
					To 09/30/2016		
				tle XIX	Hospi tal	Cost	
Cost Center Descrip	i on	Total Inpatient Costl	Total npatient Da	Average P ysDiem (col. col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX or Intensive Care Type Inpat		653, 946	3	06 2, 137	7.08 16	34, 193	42
00 INTENSIVE CARE UNIT	Tent nospital onits	1, 563, 389	4	98 3, 139	9. 34 C	0	43
. OO CORONARY CARE UNIT		, ,					44
. 00 BURN INTENSIVE CARE UNIT							45
. 00 SURGICAL INTENSIVE CARE L							46
00 OTHER SPECIAL CARE (SPECI Cost Center Descrip	/						47
						1.00	
.00 Program inpatient ancilla						19, 969	
.00 Total Program inpatient of PASS THROUGH COST ADJUSTM		1 through 48)(see instruct	ions)		103, 771	49
. 00 Pass through costs applic		tient routine :	services (fr	om Wkst. D. s	um of Parts I and	0	50
111)	0 1						
.00 Pass through costs applic	able to Program inpa	tient ancillar	y services (from Wkst. D,	sum of Parts II	0	51
and IV) .00 Total Program excludable	cost (sum of lines 5	i0 and 51)				0	52
.00 Total Program inpatient of			lated, non-p	hysi ci an anes	thetist, and	0	
medical education costs (line 49 minus line 5						
. 00 Program discharges	OMPUTATI ON						54
.00 Program discharges .00 Target amount per dischar	ae					0.00	
.00 Target amount (line 54 x						0.00	
. 00 Difference between adjust		ng cost and ta	rget amount	(line 56 minu	ıs line 53)	0	57 58
0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59
0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60
.00 If line 53/54 is less that						0	61
which operating costs (li amount (line 56), otherwi			s (lines 54	x 60), or 1%	of the target		
. 00 Relief payment (see instr		instructions)				0	62
.00 Allowable Inpatient cost		ent (see instru	ctions)			0	63
PROGRAM INPATIENT ROUTINE							1
.00 Medicare swing-bed SNF ir instructions)(title XVIII		s through Dece	mber 31 of t	he cost repor	ting period (See	0	64
5.00 Medicare swing-bed SNF in		s after Decemb	er 31 of the	cost reporti	ng period (See	0	65
instructions) (title XVIII							
0.00 Total Medicare swing-bed CAH (see instructions)	SNF inpatient routin	e costs (line)	64 plus line	65)(title XV	(III only). For	0	66
. 00 Title V or XIX swing-bed	NF inpatient routine	costs through	December 31	of the cost	reporting period	0	67
(line 12 x line 19)	·	Ū					
8.00 Title V or XIX swing-bed	NF inpatient routine	e costs after De	ecember 31 o	f the cost re	porting period	0	68
(line 13 x line 20) 0.00 Total title V or XIX swir	a-bed NF inpatient r	outine costs (line 67 + li	ne 68)		0	69
PART III - SKILLED NURSIN	<u>v</u> i	· · · ·		/		-	
.00 Skilled nursing facility/					37)		70
.00 Adjusted general inpatier .00 Program routine service of			ine /0 ÷ lin	e 2)			71
. 00 Medically necessary priva			(line 14 x	line 35)			73
. 00 Total Program general inp							74
. 00 Capital-related cost allo	cated to inpatient r	outine service	costs (from	Worksheet B,	Part II, column		75
26, line 45) .00 Per diem capital-related	costs (line 75 - lin	ie 2)					76
.00 Program capital -related of							77
00 Inpatient routine service	cost (line 74 minus	ine 77)					78
00 Aggregate charges to bene				· · · · · · · · · · · · · · · · · · ·	>		79
00 Total Program routine ser 00 Inpatient routine service			ost limitati	on (line 78 m	ninus line 79)		80
00 Inpatient routine service 00 Inpatient routine service)				81
00 Reasonable inpatient rout							83
00 Program inpatient ancilla	ry services (see ins	tructions)					84
.00 Utilization review - phys	-						85
. 00 Total Program inpatient c PART IV - COMPUTATION OF			ougn 85)			I	86
2.00 Total observation bed day						506	87
8.00 Adjusted general inpatier			line 2)			1, 181. 16	
.00 Observation bed cost (lir						597, 667	1 00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CM						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2015	Worksheet D-1	
				To 09/30/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	291, 753	2, 741, 462	0. 10642	2 597, 667	63, 605	90.00
91.00 Nursing School cost	0	2, 741, 462	0.00000	597, 667	0	91.00
92.00 Allied health cost	0	2, 741, 462	0.00000	597, 667	0	92.00
93.00 All other Medical Education	0	2, 741, 462	0.00000	597, 667	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Pre 2/23/2017 9:3	pare
		Title XIX	Subprovider - IPF	2,20,201, ,10	<u>o an</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	. excluding newborn)		2,098	1 1
00	Inpatient days (including private room days, excluding swing-b	ed and newborn days)	iveta reem deve	2, 098	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). IF you have only pr	ivate room days,	0	3
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo	5 /	r 31 of the cost	2, 098 0	
00	reporting period Total swing-bed SNF type inpatient days (including private roc	<i>y</i> , <i>y</i>		0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room reporting period			0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	62	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11
. 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 Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar yew Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			306 16	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 g	f the cost	0.00	1
	Medicare rate for swing-bed SNF services applicable to service	0		0.00	
	reporting period Medicaid rate for swing-bed NF services applicable to services			0.00	
	reporting period	C C			
	Medicaid rate for swing-bed NF services applicable to services reporting period		ne cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	2, 269, 733 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23
	x line 18) Swing-bed cost applicable to NF type services through December			0	
	7 x line 19)		0 1 1		
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	on on the cost reporting		0	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (<u>line 21 minus line 2</u> 6)		0 2, 269, 733	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		a yes	0	
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	Nuc Line 22) (act int	tionc)	0.00	
	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir		(10115)	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost a 7 minus line 36)	nd private room cost di	fferential (line	2, 269, 733	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 001 07	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 081. 86 67, 075	
				07,075	
. 00	Medically necessary private room cost applicable to the Progra				

	Financial Systems F/ ATION OF INPATIENT OPERATING COST	AYETTE REGIONAL		CN: 15-0064	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S064	From 10/01/2015 To 09/30/2016	Date/Time Pre	
			Titl	e XIX	Subprovider -	2/23/2017 9:3	su am
	Cost Center Description	Total Inpatient Costl	Total npatient Days		5	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	C	0.	00 C	C	42.
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0			00 C		43.
1. 00	CORONARY CARE UNI T	0	C	0.			44.
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
00		-+ D 2 2	11			1.00	10
3.00 9.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			ons)		0 67, 075	
	PASS THROUGH COST ADJUSTMENTS						-
). 00	Pass through costs applicable to Program inpa []])	atient routine s	ervices (Tron	n WKST. D, SU	m of Parts I and	C	50.
. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	rom Wkst. D,	sum of Parts II	C	51
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				C	52
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 4		ated, non-phy	/sician anest	hetist, and	67, 075	53
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program di scharges					0	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	-				0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, ι	updated and c	ompounded by the	0.00	59
0. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report und	lated by the m	narket hasket		0.00	60
	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
1.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	e cost report	ing period (See	C	64
6.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	cost reportin	g period (See	C	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no coste (lino f	4 plus lipo 4	5) (titlo VVI		c c	66
. 00	CAH (see instructions)		4 prus rine c	55)(title xi	ri oniy). Toi		/ 00
7.00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost r	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rep	ortina period	0	68
	(line 13 x line 20)				511		
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
0. 00	Skilled nursing facility/other nursing facil)		70
	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72
	Total Program general inpatient routine serv						74
5. 00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		75
	Per diem capital-related costs (line 75 ÷ li						76
	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	ts)			79
	Total Program routine service costs for compa				nus line 79)		80
	Inpatient routine service cost per diem limi						81
	Inpatient routine service cost limitation (I	,					82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		·)				83
	Utilization review - physician compensation	,	is)				85
	Total Program inpatient operating costs (sum	of lines 83 thr					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
7.00 3.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per o		line 2)			0.00	
	ing asted general impatrent routine cost per (1115 ZJ			0.00	1 00

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2015	Worksheet D-1	
			CCN: 15-S064	To 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared: 0 am
		Titl	e XIX	Subprovider - IPF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	0	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Health Financial Systems FAYETTE REGIONAL F	HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0064	Peri od:	Worksheet D-3	
			From 10/01/2015		
			To 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared:
	Title	× XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 394, 750		30.00
31.00 03100 INTENSIVE CARE UNIT			599, 664		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			2, 992		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 26646		89, 128	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19966	1, 022, 662	204, 186	54.00
57.00 05700 CT SCAN		0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59.00
60. 00 06000 LABORATORY		0. 16967	1, 185, 250	201, 104	60.00
60.01 06001 BLOOD LABORATORY		0.00000	0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY		0. 26848		171, 102	
66. 00 06600 PHYSI CAL THERAPY		0. 55824		31, 836	
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01 06901 CARDI AC REHAB		0. 91637		0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 43346		147, 164	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 54999		3, 346	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 39398		311, 297	
74. 00 07400 RENAL DI ALYSI S		0.0000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS		1			
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
91.00 09100 EMERGENCY		0. 17227		114, 066	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 89711		0	
93. 00 04050 CLI NI C		0. 62504		1, 341	93.00
93. 01 04950 BI C		0. 73078		8	
93. 02 04951 UCI C		0.00000		0	
93. 03 04952 CI C		0.00000		0	
93. 04 04953 RI C		0.00000		0	
93. 05 04954 PODI ATRY		0. 39988	33 0	0	93.05
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVICES			F 00/ 700	1 074 570	95.00
200.00 Total (sum of lines 50-94 and 96-98)	(1) (3)		5, 036, 732	1, 274, 578	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	5, 036, 732	l	202.00

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTE	EM	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 15-0064	Peri od:	Worksheet D-3	
Component	CCN: 15-S064	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
Titl	e XVIII	Subprovider -	PPS	
Cost Center Description	Ratio of Co		Inpatient	
	To Charges		Program Costs	
	J	Charges	(col. 1 x col.	
		Ŭ	2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1			
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		2, 292, 317		40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER		0		41.00
43. 00 04300 NURSERY		0		42.00
ANCI LLARY SERVICE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0.2664	68 2, 671	712	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 2002		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1996		14, 382	•
57. 00 05700 CT SCAN	0.0000		0	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.0000		0	
60. 00 06000 LABORATORY	0. 1696		-	
60. 01 06001 BLOOD LABORATORY	0.0000		02,110	
65. 00 06500 RESPIRATORY THERAPY	0. 2684		1, 227	
66. 00 06600 PHYSI CAL THERAPY	0. 5582		9, 732	
69. 00 06900 ELECTROCARDI OLOGY	0.0000		0	•
69. 01 06901 CARDI AC REHAB	0. 9163		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 4334		1, 707	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 5499	99 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 3939		143, 040	73.00
74.00 07400 RENAL DIALYSIS	0.0000	000 0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.0000	000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000	000	0	89.00
91. 00 09100 EMERGENCY	0. 1722		14, 106	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 8971		0	
93. 00 04050 CLINIC	0. 6250		14	
93. 01 04950 BI C	0. 7307		4	93.01
93. 02 04951 UCI C	0.0000		-	
93. 03 04952 CI C	0.0000		0	
93. 04 04953 RI C	0.0000		0	93.04
93. 05 04954 PODI ATRY	0. 3998	83 0	0	93.05
OTHER REI MBURSABLE COST CENTERS				1
95. 00 09500 AMBULANCE SERVICES		70/ /50	017 007	95.00
200.00 Total (sum of lines 50-94 and 96-98)		736, 650	217, 337	•
201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)202.00Net Charges (line 200 minus line 201)		736, 650		201.00 202.00
zoz. obj priet onal yes (TTHE 200 millings TTHE 201)	I	130,000	I	1202.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMEN	T Provi der C	CN: 15-0064	Peri od:	Worksheet D-3	
			From 10/01/2015		
			To 09/30/2016	Date/Time Pre	pared:
	T: +1	e XIX	llooni tol	2/23/2017 9:3	0 am
Cast Contar Description		Ratio of Cos	Hospi tal	Cost	
Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
		TO charges	Charges	(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			60, 119		30.00
31. 00 03100 I NTENSI VE CARE UNI T			12, 213		31.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			34, 979		43.00
ANCI LLARY SERVICE COST CENTERS		1	34,777		+5.00
50. 00 05000 OPERATING ROOM		0. 26646	8 5, 837	1, 555	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19966		2, 324	
57. 00 05700 CT SCAN		0. 00000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60. 00 06000 LABORATORY		0. 16967		3, 742	
60. 01 06001 BLOOD LABORATORY		0.00000		0,772	1
65. 00 06500 RESPI RATORY THERAPY		0. 26848		844	1
66. 00 06600 PHYSI CAL THERAPY		0. 55824		74	
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01 06901 CARDI AC REHAB		0. 91637		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	INTS	0. 43346		2, 192	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 54999		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39398		7, 537	
74. 00 07400 RENAL DI ALYSI S		0.00000		0	
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
91.00 09100 EMERGENCY		0. 17227		1, 701	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART)	0. 89711		0	1
93. 00 04050 CLI NI C	,	0. 61603		0	93.00
93. 01 04950 BI C		0. 72844		0	93.01
93. 02 04951 UCI C		0.00000		0	93.02
93. 03 04952 CI C		0.00000		0	93.03
93. 04 04953 RIC		0.00000		0	
93. 05 04954 PODI ATRY		0. 39988	3 0	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-	.98)		76, 867	19, 969	200.00
201.00 Less PBP Clinic Laboratory Service	es-Program only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line	201)		76, 867		202.00
· · · - ·				-	

Health Financial Systems FA	YETTE REGIONAL HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Component	CCN: 15-SO64	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
	Titl	e XIX	Subprovider -	2/23/2017 9.3	U alli
			I PF		
Cost Center Description		Ratio of Cos		Inpatient	
		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 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVIDER - IPF			21, 995		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		43.00
50. 00 05000 OPERATI NG ROOM		0.0000	00 1, 196	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0000		0	
57. 00 05700 CT SCAN		0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00 06000 LABORATORY		0.0000	00 4, 520	0	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	00 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY		0.0000	00 644	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.0000	00 27	0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
69. 01 06901 CARDI AC REHAB		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.0000		0	
74.00 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	74.00
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
91. 00 09100 EMERGENCY		0.0000		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.0000		0	92.00
93. 00 04050 CLINIC		0.0000		0	
93. 01 04950 BI C		0.0000		0	93.01
93. 02 04951 UCI C		0.0000		0	93.02
93. 03 04952 CI C		0.0000	00 00	0	93.03
93. 04 04953 RI C		0.0000	00 0	0	93.04
93. 05 04954 PODI ATRY		0.0000	000	0	93.05
OTHER REI MBURSABLE COST CENTERS					1 05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50-94 and 96-98)			15, 755	_	95.00 200.00
200.00 Total (sum of Tines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Prod	aram only charges (Line 41)		15, /55	0	200.00
202.00 Net Charges (line 200 minus line 201)	gram only charges (TTTE 01)		15, 755		201.00
		I	1 10,700	I	1202.00

Health Fina	ncial Systems	FAYETTE REGIONAL HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0064	Period:	Worksheet D-3	:
		Component C	CCN: 15-U064	From 10/01/2015 To 09/30/2016	Date/Time Pre	pared:
		T; +1	e XIX	Swing Beds - SNF	2/23/2017 9:3 PPS	iu am
	Cost Center Description		Ratio of Cos		Inpatient	
	cost center bescription		To Charges		Program Costs	
				Charges	$(col. 1 \times col.)$	
				charges	2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	DADULTS & PEDIATRICS			0		30.00
31.00 0310	INTENSIVE CARE UNIT			0		31.00
	SUBPROVIDER - IPF			0		40.00
41.00 0410	SUBPROVIDER - IRF			0		41.00
	O SUBPROVI DER			0		42.00
	O NURSERY			0		43.00
	LARY SERVICE COST CENTERS				1	
	O OPERATING ROOM		0. 2664	68 0	0	50.00
52.00 0520	DELIVERY ROOM & LABOR ROOM		0. 0000	00 00	0	52.00
	RADI OLOGY-DI AGNOSTI C		0. 1996	61 0	0	54.00
57.00 0570	D CT SCAN		0. 0000	00 00	0	57.00
	D MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.00
	O CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
	DLABORATORY		0. 1696		0	60,00
	1 BLOOD LABORATORY		0.0000		0	60, 01
	O RESPI RATORY THERAPY		0. 2684		0	65.00
	O PHYSI CAL THERAPY		0. 5582		0	66.00
	D ELECTROCARDI OLOGY		0.0000		0	69.00
	1 CARDI AC REHAB		0. 9163		0	69.01
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4334		0	71.00
	DIMPL. DEV. CHARGED TO PATIENTS		0. 5499		0	72.00
	D DRUGS CHARGED TO PATIENTS		0. 3939		0	73.00
	D RENAL DI ALYSI S		0.0000		0	74.00
	ATIENT SERVICE COST CENTERS					1
	RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89.00 0890	FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 00	0	89.00
91.00 0910	EMERGENCY		0. 1722	.71 0	0	91.00
92.00 0920	OBSERVATION BEDS (NON-DISTINCT PART)		0. 8971	19 0	0	92.00
			0. 6160	031 0	0	93.00
93.01 0495	рвіс		0. 7284	40 0	0	93.01
93.02 0495			0.0000	000 0	0	93.02
93.03 0495	2 0 0		0.0000	000 0	0	93.03
93.04 0495	3 RI C		0. 0000	00 0	0	93.04
93.05 0495	4 PODI ATRY		0. 3998	83 0	0	93.05
	REIMBURSABLE COST CENTERS					
95.00 0950	O AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50-94 and 96-98)			0	0	200.00
201.00	Less PBP Clinic Laboratory Services-			0		201.00
	Net Charges (line 200 minus line 201		1	0	1	202.00

CALCUL	Financial Systems FAYETTE REGIONAL HI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Peri od: From 10/01/2015 To 09/30/2016		pared:		
		Title XVIII	Hospi tal	2/23/2017 9:30 PPS	u am		
				1.00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 ((see	0 0			
. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	2, 290, 738	1. 02		
. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	prior to October	0	1. 03			
. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1. 04		
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.01		
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	i ons)		0	2.02 3.00		
1.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	48.62	4.00		
5. 00	FTE count for all opathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00		
o. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0.00	6.00		
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(1		0. 00 0. 00			
3. 00	If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						
3. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.						
3. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)						
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02) ((see	0.00	9.00		
0. 00 1. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	rds	0.00 0.00	10.00 11.00		
2.00	Current year allowable FTE (see instructions)				12.00		
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ar ended on or after Sep	otember 30, 1997,	0. 00 0. 00			
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.00		
6.00	Adjustment for residents in initial years of the program			0.00	16.00		
	Adjustment for residents displaced by program or hospital clo	sure			17.00		
8.00 9.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	`		0.00	18.0		
20.00	Prior year resident to bed ratio (see instructions)).		0.000000			
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000			
22.00	IME payment adjustment (see instructions)			0	1		
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22.0		
23.00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resident		Sec. 412.105	0.00	23.00		
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00			
25.00	If the amount on line 24 is greater than -O-, then enter the instructions) $% \left({{\left[{{{\left[{{\left[{\left({{\left[{{\left[{{\left[{$	lower of line 23 or line	e 24 (see		25.00		
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000			
28.00	IME add-on adjustment amount (see instructions)			0.000000			
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0			
29.00 29.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	,		0	29.0		
	Disproportionate Share Adjustment						
80.00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	6.46			
31.00	Percentage of Medicaid patient days (see instructions)			32.41			
32.00 33.00	Sum of lines 30 and 31	N		38.87			
	Allowable disproportionate share percentage (see instructions)		12.00	33.0		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prep	
		Title XVIII	Hospi tal	2/23/2017 9: 30 PPS	U alli
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0		
5.01	Factor 3 (see instructions)		0. 00000000	0. 000039041	35.0
5.02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line)	0	250, 102	35.0
5.03	(see instructions) Pro rata share of the hospital uncompensated care payment amou	int (soo instructions)	0	250, 102	35.0
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		250, 102	230, 102	36.0
0.00	Additional payment for high percentage of ESRD beneficiary dis				00.0
0.00	Total Medicare discharges on Worksheet S-3, Part I excluding d		0		40.0
	652, 682, 683, 684 and 685 (see instructions)				
			Before 1/1	On/After 1/1	
4 00			1.00	1.01	44.0
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33, 684 an 685. (see	0	0	41.0
1.01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-D)RGS 652 682 683 68	4 0	0	41.0
1. 01	an 685. (see instructions)			0	-1.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualif	fy for adjustment)	0.00		42.0
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (se	e 0		43.0
	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0.00000		44.0
5.00	days) Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.0
6.00	Total additional payment (line 45 times line 44 times line 41.		0.00	0.00	45.0
7.00	Subtotal (see instructions)	51)	2, 609, 562		47.0
8.00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	0		48.0
	only. (see instructions)	· · · · · · · · · · · · · · · · · · ·			
				Amount	
0.00				1.00	40.0
9.00	Total payment for inpatient operating costs (see instructions)		`	2, 609, 562	
	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.)	180, 578 0	51.0
2.00	Direct graduate medical education payment (from Wkst. E-4, lin			0	52.0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
4.00	Special add-on payments for new technologies			0	54.0
4.01	Islet isolation add-on payment				54.C
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55. C
6.00	Cost of physicians' services in a teaching hospital (see intru	-	through 25)	0	56. C
7.00	Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I		through 35).	0	57.C
9.00	Total (sum of amounts on lines 49 through 58)	v, cor. If fine 200)		2, 790, 140	
0.00	Primary payer payments			2, 332	
1.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		2, 787, 808	
2.00	Deductibles billed to program beneficiaries			391, 608	62.0
3.00	Coinsurance billed to program beneficiaries				63.0
4.00	Allowable bad debts (see instructions)			39, 453	
5.00	Adjusted reimbursable bad debts (see instructions)			25, 644	
6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63)	uctions)		29, 336 2, 420, 878	
7.00 8.00	Credits received from manufacturers for replaced devices for a	applicable to MS_DRGs (see instructions)	2, 420, 878	68.0
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (0	69.0
0. OO	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.0
0.50	RURAL DEMONSTRATION PROJECT			0	70. 5
0. 88	SCH or MDH volume decrease adjustment			0	70.8
	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)		0	70.8
	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.9
0. 90				0	70.9
0. 90 0. 91	HSP bonus payment HRR adjustment amount (see instructions)			~	1 70 1
0.89 0.90 0.91 0.92	Bundled Model 1 discount amount (see instructions)			0	70.9
0. 90 0. 91				0 6, 325 -13, 745	70. 9

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0064	Peri od: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prep 2/23/2017 9:30	pared: 0 am
		Title	e XVIII	Hospi tal	PPS	
			FF	Y (yyyy)	Amount	
				0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70.96
	the corresponding federal year for the period prior to 10/1)					
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			2016	483, 291	70.9
	the corresponding federal year for the period ending on or aft	ter 10/1)				
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)				0	70.9
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			2, 896, 749	71.0
1.01	Sequestration adjustment (see instructions)				57, 935	71.0
2.00	Interim payments				2, 762, 002	72.0
3.00	Tentative settlement (for contractor use only)				0	73.0
4.00	Balance due provider (Program) (line 71 minus lines 71.01, 72,	and 73)			76, 812	74.C
5.00	Protested amounts (nonallowable cost report items) in accordar	nce with			296, 904	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
	Operating outlier reconciliation adjustment amount (see instru				0	92. C
	Capital outlier reconciliation adjustment amount (see instruct				0	93.0
	The rate used to calculate the time value of money (see instru	uctions)			0.00	
	Time value of money for operating expenses (see instructions)				0	95.0
96.00	Time value of money for capital related expenses (see instruct	tions)			0	96.0
				Prior to 10/1		
				1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)				0	100. 0
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)				0.000000000	
	HVBP adjustment amount for HSP bonus payment (see instructions	5)			0	102. C
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)				0.0000	
04.00	HRR adjustment amount for HSP bonus payment (see instructions))			0	104. C

	Financial Systems		AYETTE REGIONAL	Provider CC	CN: 15-0064	Period: From 10/01/2015	Worksheet E	
						To 09/30/2016		pare
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5. 00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1
01	payments DRG amounts other than outlier payments for discharges	1.01	0	0		0	0	1
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 290, 738	0		2, 290, 738	2, 290, 738	1
)3	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0		0	0	1
14	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
0	Outlier payments for discharges (see instructions)	2.00	0	0		0 0		
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2
00	Operating outlier reconciliation	2. 01	0	0		0 0	0	3
00	Managed care simulated payments	3. 00	0	0		0 0	0	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000	0 0. 000000		!
0	IME payment adjustment (see instructions)	22.00	0	0		0 0	0	
1	IME payment adjustment for managed care (see instructions)	22. 01	0	0		0 0	0	(
~	Indirect Medical Education Adju							
0	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000		0 0.000000		8
1	instructions) IME payment adjustment add on	28.00	0	0		0 0	0	8
	for managed care (see instructions)							
0	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0		0 0 0 0	0	
'	care (sum of lines 6.01 and 8.01)		0	0		0 0	0	
~~	Disproportionate Share Adjustme		0.1000	0 1000	0.100	0 0 1000		1 10
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 120	0 0. 1200		10
00	Disproportionate share adjustment (see instructions)	34.00	68, 722	0		0 68, 722		
01	Uncompensated care payments Additional payment for high per	36.00	250, 102	0 Ni scharges		0 250, 102	250, 102	11
00	Total ESRD additional payment (see instructions)	46. 00		0 0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	2, 609, 562 0	0 0		0 2, 609, 562 0 0	2, 609, 562 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 609, 562	0		0 2, 609, 562	2, 609, 562	15
00	Payment for inpatient program capital	50.00	180, 578	0		0 180, 578	180, 578	16
00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0	0 0		0 0 0 0	0 0	
. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18

Heal th	Financial Systems	F <i>F</i>	YETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0		0 2, 790, 140	2, 790, 140	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	180, 578	0		0 180, 578		20.00
	Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	0	0		0 0	0	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		o o	0	21.01
	outlier payments							-
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0 0.0000		24.00
25.00	Disproportionate share	11.00	0	0		0 0	0	25.00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	180, 578	0		0 180, 578	180, 578	26.00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0 0. 173214		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				483, 291	483, 291	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

OSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	CN: 15-0064	Peri od:	Worksheet E	
					From 10/01/2015 To 09/30/2016		pare
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00					1.
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1.
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2, 290, 738		2, 290, 738	2, 290, 738	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1
00	Outlier payments for discharges (see instructions)	2.00	0		0 0	0	2
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2
. 00	Operating outlier reconciliation	2.01	0		0 0		3
00	Managed care simulated payments	3.00	0		0 0	0	4
	Indirect Medical Education Adjustment						
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.0000	0. 000000		5
00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6
01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6
	Indirect Medical Education Adjustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000			7
00	IME adjustment (see instructions)	28.00	0		0 0	-	8
01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9
	Disproportionate Share Adjustment						
. 00	Allowable disproportionate share percentage	33.00	0. 1200	0.120	0. 1200		10
. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	68, 722		0 68, 722	68, 722	11
. 01	Uncompensated care payments Additional payment for high percentage of ESR	36.00 20. beneficiary	250, 102		0 0	0	11
. 00	Total ESRD additional payment (see instructions)	46. 00	0		0 0	0	12
. 00	Subtotal (see instructions)	47.00	2, 609, 562		0 2, 609, 562	2, 609, 562	13
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14
. 00	Total payment for inpatient operating costs (see instructions)	49.00	2, 609, 562		0 2, 609, 562	2, 609, 562	15
. 00	Payment for inpatient program capital	50.00	180, 578		0 180, 578	180, 578	16
. 00	Special add-on payments for new technologies	54.00	0		0 0	0	17
. 01	Net organ acquisition cost	55.00	0		0 0	0	17
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17
. 00	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18
	amount (see instructions)						

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Li	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CC		Period: From 10/01/201 To 09/30/201		epared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	180, 578		0 180, 57	8 180, 578	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0	0 0	20.01
21.00 Capital DRG outlier payments	2.00	0		0	0 0	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0	o 0	21.01
22.00 Indirect medical education percentage (see	5.00	0.0000	0.000	0. 000	0	22.00
instructions)						
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0	0 0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.000	0. 000	0	24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0	0 0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	180, 578		0 180, 57	8 180, 578	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1,00	2.00	3.00	4,00	
27.00	0	1.00	2.00	3.00	4.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70.97	483, 291		483, 29	-	
30.00 HVBP payment adjustment (see instructions)	70.93	6, 325		0 6, 32		
30.01 HVBP payment adjustment for HSP bonus	70.90	0, 323		0 0, 32	0 0, 323	
payment (see instructions)	70.70	0		0	0	30.01
31.00 HRR adjustment (see instructions)	70, 94	-13, 745		0 -13, 74	5 -13, 745	31 00
31.01 HRR adjustment for HSP bonus payment (see	70, 91	0		0	0 0	
instructions)						
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0 0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	2/23/2017 9: 3	
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
I. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			4, 495	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		7, 147, 271	2.00
3.00	PPS payments			5, 534, 260	
1.00 5.00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		34, 795 0. 000	4.00 5.00
5.00	Line 2 times line 5			0.000	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
3.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	8.00 9.00
	Organ acqui si ti ons	TV, COL. 13, TTHE 200		0	10.00
1.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 495	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
2.00	Ancillary service charges			11, 409	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			11, 409	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
6.00	Amounts that would have been realized from patients liable for	1 3	on a chargebasis	0	16.00
7.00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	.e)		0. 000000	17.00
8.00	Total customary charges (see instructions)			11, 409	
9.00	Excess of customary charges over reasonable cost (complete on	lyifline 18 exceeds li	ne 11) (see	6, 914	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds li	ne 18) (see	0	20.00
	instructions)		Ū	20.00	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH se			21.00	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22.00 23.00
	Total prospective payment (sum of lines 3, 4, 8 and 9)			5, 569, 055	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25.00
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (fo	or CAH, see instructions)		1, 221, 031	25.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	· · · · · · · · · · · · · · · · · · ·		4, 352, 519	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
	Subtotal (sum of lines 27 through 29)			4, 352, 519	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			29 4, 352, 490	
52.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		4, 332, 470	52.00
	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			183, 818 119, 482	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		157, 797	
	Subtotal (see instructions)			4, 471, 972	
	MSP-LCC reconciliation amount from PS&R			0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	is)		0	39.00 39.50
	Partial or full credits received from manufacturers for repla		tions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00 40.01	Subtotal (see instructions) Sequestration adjustment (see instructions)			4, 471, 972 89, 439	
	Interim payments			4, 412, 915	
	Tentative settlement (for contractors use only)			0	
13.00 14.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub. 15-2	chapter 1.	-30, 382 0	
	§115. 2		· ····································		
0 00	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)				93.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0064		Period: From 10/01/2015 To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	
		I npati ent	t Part A	Part 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		2, 681, 54	42 0	4, 263, 776 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	09/30/2016	80, 40	60 09/30/2016	115, 939	3. 01
3.02				0 04/06/2016	33, 200	3. 02
3.03 3.04				0	0	3. 03 3. 04
3.04				0	0	3.04
0.00	Provider to Program	I				0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52 3.53				0	0	3.52 3.53
3.53				0	0	3. 54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		80, 40		149, 139	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)		2, 762, 00	02	4, 412, 915	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	Program to Provider TENTATIVE TO PROVIDER	[0	0	5.01
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program			-		
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)				Ŭ	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		76, 81		0	6.01
6.02	SETTLEMENT TO PROGRAM		2 0 2 0 0	0	30, 382	6.02 7.00
7.00	Total Medicare program liability (see instructions)		2, 838, 8	Contractor	4, 382, 533 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0064 Component CCN: 15-S064		Period: From 10/01/201 To 09/30/201		
		Title XVIII Inpatient Part A		Subprovider -		
					art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 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 List separately each retroactive lump sum adjustment		1, 257, 7	06 0	0	1. (2. (3. (
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3. 3.
04 05				0	0	
55	Provider to Program		I	0	0	J J.
50	ADJUSTMENTS TO PROGRAM			0	0	3
i1				0	0	3
52				0	0	
53				0	0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3. 3.
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)		1, 257, 7	06	0	4.
	TO BE COMPLETED BY CONTRACTOR					
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.
)1	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5
)2	TENTATIVE TO PROVIDER			0	0	
)3				0	0	
	Provider to Program			-1		
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 19	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5. 50-5. 98) Determined net settlement amount (balance due) based on			0		6
-	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		22, 4	16	0	6
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 280, 1		0 NPR Date	7.
				Contractor Number	(Mo/Day/Yr)	
		0		1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0064		ri od:	Worksheet E-1	
		Component (CCN: 15-U064	To	om 10/01/2015 09/30/2016	Date/Time Pre	
		Title	XVIII	Sw	ing Beds - SNF	2/23/2017 9:3 PPS	su am
		Inpatien				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			0		0	1.0
. 00	Interim payments payable on individual bills, either			0		0	2.0
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero						
. 00	List separately each retroactive lump sum adjustment						3.0
. 00	amount based on subsequent revision of the interim rate						0.0
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						1
. 01	ADJUSTMENTS TO PROVIDER			0		0	
. 02 . 03				0		0	
. 03				0		0	
. 05				0		0	
	Provider to Program						
50	ADJUSTMENTS TO PROGRAM			0		0	
51				0		0	
52				0		0	
. 53				0		0	
. 54 . 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0		0	
. 77	3. 50-3. 98)			0		0	
. 00	Total interim payments (sum of lines 1, 2, and 3.99)			0		0	4. (
	(transfer to Wkst. E or Wkst. E-3, line and column as						
	appropri ate)						
00	TO BE COMPLETED BY CONTRACTOR						1
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,						5.0
	write "NONE" or enter a zero. (1)						
	Program to Provider						
01	TENTATI VE TO PROVIDER			0		0	
. 02				0		0	
. 03	Dravidar to Dragram			0		0	5.0
. 50	Provider to Program TENTATIVE TO PROGRAM			0		0	5.
. 50				0		0	
52				0		0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5.
	5. 50-5. 98)						
00	Determined net settlement amount (balance due) based on						6.0
01	the cost report. (1) SETTLEMENT TO PROVIDER			0		0	6.1
. 01	SETTLEMENT TO PROVIDER			0		0	
. 02	Total Medicare program liability (see instructions)			0		0	
				J	Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

Heal th	Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu						
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0064	Peri od:	Worksheet E-1			
			From 10/01/2015 To 09/30/2016		hared		
Title XVIII Hospital PPS							
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			796	1.00		
1.00							
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	12		2, 313	4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			102, 865, 736	5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			1, 088, 576	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00		
9.00	Sequestration adjustment amount (see instructions)			0	9.00 10.00		
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00	31.00 Other Adjustment (specify)						
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	0	32.00		

Heal th	Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0064	Peri od:	Worksheet E-2	
		Component CCN: 15-U064	From 10/01/2015 To 09/30/2016	Date/Time Pre	pared:
				2/23/2017 9:3	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instruction		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for P				3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see				
4.00	Per diem cost for interns and residents not in approved tea	ching program (see		0.00	4.00
	instructions)				
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see			0	
7.00	Utilization review - physician compensation - SNF optional	method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts app professional services)	licable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider recor	ds) (exclude coinsurance	0	0	13.00
	for physician professional services)			-	
	80% of Part B costs (line 12 x 80%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or lin	e 14)	0	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructi	ons)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)	0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
20.00	Interim payments		0	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	
22.00	Balance due provider/program (line 19 minus lines 19.01, 20		0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accor	dance with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				

Heal th	Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0064 Component CCN: 15-U064	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Pre	epared:
		Title XIX	Swing Beds - SNF	2/23/2017 9:3 PPS	<u>30 am</u>
		II the AIA	Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa	rt A, and sum of Wkst. D,	0		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see i	nstructions)			
4.00	Per diem cost for interns and residents not in approved teac	hing 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		0		6.00
7.00	Utilization review - physician compensation - SNF optional m	ethod 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 appl professional services)	icable to physician	0		11.00
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider record for physician professional services)	s) (excl ude coi nsurance	0		13.00
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructio	ns)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)	0		18.00
19.00	Total (see instructions)		0		19.00
19.01	Sequestration adjustment (see instructions)		0		19.01
20.00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20,		0		22.00
23.00	Protested amounts (nonallowable cost report items) in accord chapter 1, $\$115.2$	ance with CMS Pub. 15-2,	0		23.00

		IAL HEALTH SYSTEM		u of Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2015	Worksheet E-3 Part II	
		Component CCN: 15-SO64	To 09/30/2016	Date/Time Pre	
		Title XVIII	Subprovider -	2/23/2017 9: 30 PPS	<u>u a</u>
			I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	d medical education payments)		1, 285, 912	-
00	Net IPF PPS Outlier Payments	, , , , , , , , , , , , , , , , , , ,		95, 677	
00	Net IPF PPS ECT Payments			0	
00	Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions)	ent cost report filed on or b	efore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted wi CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents with teaching program" (see instuctions)			0.00	
00	Intern and resident count for IPF PPS medical education a	adjustment (see instructions)		0.00	
00	Average Daily Census (see instructions)			5.732240	
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	d to the power of .5150 -1}.		0.000000	
	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		0 1, 381, 589	1
	Nursing and Allied Health Managed Care payment (see instr			1, 301, 307	1
-	Organ acquisition (DO NOT USE THIS LINE)			0	1
	Cost of physicians' services in a teaching hospital (see	instructions)		0	1
00	Subtotal (see instructions)	·		1, 381, 589	1
00	Primary payer payments			0	1
	Subtotal (line 16 less line 17).			1, 381, 589	
	Deductibles			93, 380	
	Subtotal (line 18 minus line 19)			1, 288, 209	
	Coinsurance Subtotal (Line 20 minus Line 21)			4,830	
	Subtotal (line 20 minus line 21) Allowable bad debts (exclude bad debts for professional s	carvicas) (see instructions)		1, 283, 379 35, 181	2
	Adjusted reimbursable bad debts (see instructions)			22, 868	
	Allowable bad debts for dual eligible beneficiaries (see	instructions)		31, 401	2
	Subtotal (sum of lines 22 and 24)	,		1, 306, 247	2
	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	2
	Other pass through costs (see instructions)			0	2
	Outlier payments reconciliation			0	2
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	3
	Recovery of Accel erated Depreciation			0	3
	Total amount payable to the provider (see instructions)			1, 306, 247	
	Sequestration adjustment (see instructions) Interim payments			26, 125 1, 257, 706	
	Tentative settlement (for contractor use only)				3
	Balance due provider/program (line 31 minus lines 31.01,	32 and 33)		22, 416	
	<pre>Protested amounts (nonallowable cost report items) in acc §115.2</pre>	-	chapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR	2.2		OE 477	E.
	Original outlier amount from Worksheet E-3, Part II, line Outlier reconciliation adjustment amount (see instruction			95, 677	50 5
	The rate used to calculate the Time Value of Money	13/		0.00	
00	Time Value of Money (see instructions)				53

	Financial Systems FAYETTE REGION/ ATION OF REIMBURSEMENT SETTLEMENT	AL HEALTH SYSTEM Provider CCN: 15-0064	Period:	u of Form CMS-2 Worksheet E-3	
ALCUI	ATTUN OF REIMBURSEMENT SETTLEMENT	Component CCN: 15-T064	From 10/01/2015 To 09/30/2016	Part III Date/Time Pre	pared:
		Title XVIII	Subprovider -	2/23/2017 9: 30 PPS	<u>o am</u>
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			0	1.0
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2.0
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			0	3.0
. 00	Outlier Payments			0	4.0
. 00	Unweighted intern and resident FTE count in the most rece	nt cost reporting period en	ding on or prior	0.00	5.0
	to November 15, 2004 (see instructions)				
5. 01	Cap increases for the unweighted intern and resident FTE			0.00	5.0
	program or hospital closure, that would not be counted wi	thout a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
b. 00	New Teaching program adjustment. (see instructions)			0.00	6.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	7.0
00	teaching program" (see instructions)	his the new preason arouth a	onlod of a "now	0.00	
8.00	Current year's unweighted I&R FTE count for residents wit	nin the new program growth p	errod of a new	0.00	8. C
9. 00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education a	diustmont (soo instructions)		0.00	9. (
0.00	Average Daily Census (see instructions)	ujustillerit (see riistructrons)		0.000000	
1.00	Teaching Adjustment Factor (see instructions)			0.000000	
2.00	Teaching Adjustment (see instructions)			0.000000	12.
3.00				0	13.
4.00	Nursing and Allied Health Managed Care payments (see inst	ruction)		0	
5.00	Organ acquisition (DO NOT USE THIS LINE)			0	14.
6.00	o	instructions)		0	16. (
7.00	Subtotal (see instructions)			0	17.
8.00				0	18.
9.00	Subtotal (line 17 less line 18).			0	19.
20.00				0	20.
1.00				0	21.
2.00				0	22.0
23.00				0	23. (
24.00		ervices) (see instructions)		0	24. (
25.00		, , , , , , , , , , , , , , , , , , , ,		0	25.0
26.00		instructions)		0	26.0
27.00	5	,		0	27. (
28.00	Direct graduate medical education payments (from Wkst. E-	4, line 49)		0	28. (
9.00	Other pass through costs (see instructions)			0	29. (
0. 00	Outlier payments reconciliation			0	30. (
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.0
1. 50	Pioneer ACO demonstration payment adjustment (see instruc	ti ons)		0	31.
1. 99	Recovery of Accel erated Depreciation			0	31.
2.00	Total amount payable to the provider (see instructions)			0	32.
2. 01	Sequestration adjustment (see instructions)			0	32.
3. 00	Interim payments			0	33. (
84.00				0	34.0
35.00	Balance due provider/program (line 32 minus lines 32.01,	33, and 34)		0	35.0
86.00		ordance with CMS Pub. 15-2,	chapter 1,	0	36.0
	<u>§115.2</u> TO BE COMPLETED BY CONTRACTOR				
50.00				0	50.0
51.00		s)		0	51.0
52.00	The rate used to calculate the Time Value of Money				52.0
	Time Value of Money (see instructions)			0	53.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VII Date/Time Pre 2/23/2017 9:3	pare
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	<u> </u>
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR A	IX SERVICES		-
00	Inpatient hospital/SNF/NF services		103, 771		1 1.
00	Medical and other services		100,771	0	2
00	Organ acquisition (certified transplant centers only)		0	-	3
00	Subtotal (sum of lines 1, 2 and 3)		103, 771	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		103, 771	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonable Charges		407.040		
00 00	Routine service charges		107, 312	0	8
). 00	Ancillary service charges Organ acquisition charges, net of revenue		76, 867 0	0	10
1.00	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		184, 179	0	
. 00	CUSTOMARY CHARGES		104,177	0	1 12
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	1 13
	basi s	5			
1.00	Amounts that would have been realized from patients liable for	or payment for services o	on O	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
	Total customary charges (see instructions)		184, 179	0	16
7.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	80, 408	0	17
	line 4) (see instructions)			0	10
3. 00	Excess of reasonable cost over customary charges (complete on 16) (see instructions)	ily II IIIne 4 exceeds III	ie U	0	18
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line	-	103, 771	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1 - 1
2.00	Other than outlier payments	· · ·	0	0	22
3.00	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		103, 771	0	29
D. 00	Excess of reasonable cost (from line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		103, 771	0	31
2.00	Deductiblies	,	103, 771	0	32
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0		35
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	nd 33)	103, 771	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
3. 00	Subtotal (line 36 ± line 37)		103, 771	0	38
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		103, 771	0	40
1.00	Interim payments		353, 051	0	41
	Balance due provider/program (line 40 minus line 41)		-249, 280	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2015	Worksheet E-3 Part VII
		Component CCN: 15-SO64	To 09/30/2016	Date/Time Prep 2/23/2017 9:30
		Title XIX	Subprovider - IPF	
			I npati ent	Outpatient
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	FRVICES FOR TITLES V OR X	1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
00	Inpatient hospital/SNF/NF services		0	
00	Medical and other services			0
00	Organ acquisition (certified transplant centers only)		0	
00	Subtotal (sum of lines 1, 2 and 3)		0	0
00	Inpatient primary payer payments		0	
00	Outpatient primary payer payments			0
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0
	COMPUTATION OF LESSER OF COST OR CHARGES			
00	Reasonable Charges		21, 995	
00 00	Routine service charges Ancillary service charges		15, 755	0
00	Organ acquisition charges, net of revenue		15,755	U
. 00	Incentive from target amount computation		0	
. 00	Total reasonable charges (sum of lines 8 through 11)		37, 750	0
. 00	CUSTOMARY CHARGES		01,100	
. 00	Amount actually collected from patients liable for payment f	or services on a charge	0	0
	basi s	5		
. 00	Amounts that would have been realized from patients liable f	for payment for services o	n 0	0
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)		
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000 37, 750	0.000000
. 00		Fotal customary charges (see instructions)		0
. 00	Excess of customary charges over reasonable cost (complete o	nly if line 16 exceeds	37, 750	0
	line 4) (see instructions)			
. 00	Excess of reasonable cost over customary charges (complete o	niy it line 4 exceeds lin	e 0	0
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0
. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0
. 00	Cost of covered services (enter the lesser of line 4 or line		0	o
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	· · ·		
. 00	Other than outlier payments		0	0
. 00	Outlier payments		0	0
. 00	Program capital payments		0	
. 00	Capital exception payments (see instructions)		0	
. 00	Routine and Ancillary service other pass through costs		0	0
. 00	Subtotal (sum of lines 22 through 26)		0	0
. 00	Customary charges (title V or XIX PPS covered services only)		0	0
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
. 00	Excess of reasonable cost (from line 18)	4)	0	0
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	0)	0	0 0
. 00	Deducti bl es Coi nsurance		0	0
. 00	Allowable bad debts (see instructions)		0	0
. 00	Utilization review		0	U U
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	ind 33)	0	0
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- /	0	0
. 00	Subtotal (line 36 ± line 37)		0	0
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	-
. 00	Total amount payable to the provider (sum of lines 38 and 39)	0	0
. 00	Interim payments		51, 508	0
. 00	Balance due provider/program (line 40 minus line 41)		-51, 508	0
8. 00	Protested amounts (nonallowable cost report items) in accord	lance with CMC Dub 15 0		0

	hancial Systems FAYETTE REGIONAL HEET (If you are nonproprietary and do not maintain	Provider C		Peri od:	Worksheet G	
nd-type ly)	accounting records, complete the General Fund column			From 10/01/2015 To 09/30/2016		
		General Fund	Specific Purpose Fund	Endowment Fund	2/23/2017 9:3 Plant Fund	
		1.00	2.00	3.00	4.00	
	RENT ASSETS	4 404 455	1		0	
	sh on hand in banks	4, 181, 455		0 0	0	
	nporary investments		1	0 0 0 0	0	
	tes receivable	4 004 742		0 0	0	
	counts recei vabl e ner recei vabl e	4, 096, 742 1, 075, 560		0 0	0	
	owances for uncollectible notes and accounts receivable	1,075,560		0 0	0	
	ventory	827, 601		0 0	0	
	epaid expenses	280, 859			0	
	her current assets	200, 007		0 0	0	
	e from other funds			0 0	0	
	tal current assets (sum of lines 1-10)	10, 462, 217		0 0	0	
	ED ASSETS	10, 102, 217		0	<u></u>	1.
00 Lan		1, 094, 402		0 0	0	112
	nd improvements	520, 578		0 0	0	
1	cumul ated depreciation	0		0 0	0	
1	ldings	50, 749, 199		0 0	0	
	cumulated depreciation	-57, 381, 307		0 0	0	
. 00 Lea	asehold improvements	35, 713		0 0	0	17
00 Acc	cumulated depreciation	0)	0 0	0	18
	ked equipment	0		0 0	0	19
.00 Acc	cumulated depreciation	0		0 0	0	20
.00 Aut	tomobiles and trucks	0		0 0	0	21
00 Acc	cumulated depreciation	0		0 0	0	
	or movable equipment	24, 531, 616		0 0	0	1 -
	cumulated depreciation	0		0 0	0	
	nor equipment depreciable	C		0 0	0	
	cumulated depreciation	C		0 0	0	1 -
	designated Assets	0		0 0	0	
	cumulated depreciation	0		0 0	0	1 -
	nor equipment-nondepreciable			0 0	0	
	tal fixed assets (sum of lines 12-29)	19, 550, 201		0 0	0	30
	IER ASSETS vestments	4 174 200		0 0	0	3
	posits on leases	4, 174, 399		0 0	0	
	e from owners/officers			0 0	0	
	ner assets	2, 201, 196		0 0	0	
	tal other assets (sum of lines 31-34)	6, 375, 595		0 0	0	
1	tal assets (sum of lines 11, 30, and 35)	36, 388, 013		0 0	0	
	RENT LIABILITIES	30, 300, 013	1	0	0	
	counts payable	4, 393, 355		0 0	0	37
	aries, wages, and fees payable	1, 241, 849	1	0 0	0	
	roll taxes payable	1,2.1,31,		0 0	0	
	tes and loans payable (short term)	832, 698		0 0	0	
	ferred income	0		0 0	0	
1	celerated payments	0				42
	e to other funds	0		0 0	0	
	ner current liabilities	-30, 671		0 0	0	
. 00 Tot	tal current liabilities (sum of lines 37 thru 44)	6, 437, 231		0 0	0	45
LON	G TERM LIABILITIES					
	rtgage payabl e	0		0 0	0	
	tes payable	0		0 0	0	
	secured Loans	0		0 0	0	
	ner long term liabilities	18, 219, 802	1	0 0	0	
	tal long term liabilities (sum of lines 46 thru 49)	18, 219, 802		0 0	0	
	tal liabilities (sum of lines 45 and 50)	24, 657, 033		0 0	0	5
	I TAL ACCOUNTS	44 767 7				
	neral fund balance	11, 730, 980				52
	ecific purpose fund			0		53
	nor created - endowment fund balance - restricted			0		54
1	nor created - endowment fund balance - unrestricted			0		55
	verning body created - endowment fund balance			0	_	56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	58
	placement, and expansion	11 720 000		0	_	F
	tal fund balances (sum of lines 52 thru 58)	11, 730, 980	1	0 0	0	
1101	tal liabilities and fund balances (sum of lines 51 and	36, 388, 013	4	0 0	0	60

	Financial Systems F/ ENT OF CHANGES IN FUND BALANCES	AYETTE REGIONAL	Provi der CO			ri od:	u of Form CMS- Worksheet G-1	
					To	om 10/01/2015 09/30/2016	Date/Time Pre 2/23/2017 9:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		17, 611, 887 -5, 880, 907 11, 730, 980 0 11, 730, 980 11, 730, 980 0 11, 730, 980		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	5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund	_			
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0			18.00 19.00

Heal th	Financial Systems FAYETTE REGIONAL HE	ALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Period: From 10/01/2015 To 09/30/2016	Worksheet G-2 Parts I & II Date/Time Pre 2/23/2017 9:30	pared:
	Cost Center Description		Inpatient	Outpatient	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		3, 936, 0	14	3, 936, 014	1.00
2.00	SUBPROVIDER - IPF		4, 021, 90	00	4, 021, 900	2.00
3.00	SUBPROVIDER - IRF		3, 6,		3, 644	3.00
4.00	SUBPROVIDER			0	0	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.00 8.00
8.00 9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 961, 5	58	7, 961, 558	
10.00	Intensive Care Type Inpatient Hospital Services		7,701,0		1, 701, 000	10.00
11.00	INTENSIVE CARE UNIT		1, 652, 6	12	1, 652, 612	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 652, 6	12	1, 652, 612	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16	、 、	9, 614, 1	70	9, 614, 170	17.00
18.00	Ancillary services	,	8, 480, 2		66, 891, 877	18.00
19.00	Outpati ent servi ces		284, 2		29, 937, 145	
20.00	RURAL HEALTH CLINIC		20172	0 0	0	20.00
21.00				0 0	0	21.00
22.00	HOME HEALTH AGENCY			727, 974	727, 974	22.00
23.00	AMBULANCE SERVICES			0 111, 946	111, 946	
24.00	СМНС			0	0	24.00
24.10	CORF			0 0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)			100.000	100,000	25.00
26.00	HOSPI CE NRCC		F 750 0	0 193, 992	193, 992	
27.00 28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	5, 752, 0 24, 130, 7		6, 724, 091 114, 201, 195	27.00 28.00
20.00	G-3, line 1)	LU WKSL.	24, 130, 70	90, 070, 409	114, 201, 193	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			52, 931, 002		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00 36.00	Total additions (sum of lines 30-35)			0		35.00 36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		52, 931, 002		43.00
	to Wkst. G-3, line 4)	l				I

Heal th	Financial Systems FAYETTE REGIONAL HI	EALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0064	Peri od:	Worksheet G-3	
			From 10/01/2015 To 09/30/2016	Date/Time Pre	narod
			10 077 307 2010	2/23/2017 9:30	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			114, 201, 195	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		71, 741, 607	2.00
3.00	Net patient revenues (line 1 minus line 2)			42, 459, 588	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		52, 931, 002	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-10, 471, 414	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	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 t	han 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 INCOME			4, 590, 507	
25.00	Total other income (sum of lines 6-24)			4, 590, 507	
26.00	Total (line 5 plus line 25)			-5, 880, 907	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		l	-5, 880, 907	29.00

	Financial Systems		YETTE REGIONAL				eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSIS		Provider C HHA CCN:		Period: From 10/01/2015 To 09/30/2016		pared:
						Home Health Agency I	2/23/2017 9: 3 PPS	<u>u am</u>
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS						1	
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			C		0	0	2.00
	Equipment			_			_	
3.00	Plant Operation & Maintenance	0	0			0 0	0	3.00
4.00 5.00	Transportation Administrative and General	0 197, 600				0 0 0 105, 468	0 303, 068	4.00 5.00
5.00	HHA REIMBURSABLE SERVICES	177,000				0 103,400	303,000	0.00
6.00	Skilled Nursing Care	228, 677				0 0		6.00
7.00	Physical Therapy	83, 561	0			0 0	83, 561	7.00
8.00 9.00	Occupational Therapy Speech Pathology	78, 513 596		-		0 0 0 0	78, 513 596	
10.00	Medical Social Services	37, 302		0		0 0	37, 302	
11.00	Home Health Aide	57, 048		0		0 0	57, 048	11.00
12.00	Supplies (see instructions)	0	-	0		0 0	0	
13.00 14.00	Drugs DME	0	-			0 0 0 0	0	
11.00	HHA NONREI MBURSABLE SERVI CES					0 0		11.00
15.00	Home Dialysis Aide Services	0	-			0 0	0	
16.00	Respiratory Therapy	0	-	0		0 0	0	16.00
17.00 18.00	Private Duty Nursing Clinic	0	0				0	17.00 18.00
19.00	Health Promotion Activities	0	0			0 0	0	19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service All Others (specify)	0				0 0		22.00 23.00
23. 00 23. 50	Telemedicine	23, 167					23, 167	23.00
	Total (sum of lines 1-23)	706, 464	0	0		0 105, 468	811, 932	
		Recl assi fi cati		Adjustments	Net Expenses			
		on	Trial Balance		for Allocatio			
		On	(col. 6 + col. 7)		(col . 8 + col 9)			
	I	7.00	(col. 6 +	9.00	(col. 8 + col			
1.00	GENERAL SERVICE COST CENTERS	7.00	(col. 6 + col.7) 8.00		(col. 8 + col 9) 10.00			1.00
1.00	Capital Related - Bldg. &		(col. 6 + col.7) 8.00		(col. 8 + col 9) 10.00			1.00
1.00		7.00	(col. 6 + col.7) 8.00		(col. 8 + col 9) 10.00			1.00
2.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	7.00 0	(col. 6 + col. 7) 8.00 0	C	(col . 8 + col 9) 10.00	 0 0		2.00
2.00 3.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	7.00 0 0	(col. 6 + col. 7) 8.00 0 0	c c c	(col . 8 + col 9) 10.00			2. 00 3. 00
2.00 3.00 4.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	7.00 0 0 0 0 0	(col. 6 + col.7) 8.00 0 0 0 0 0	C	(col . 8 + col 9) 10.00	0 0 0 0		2.00 3.00 4.00
2.00 3.00 4.00 5.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	7.00 0 0	(col. 6 + col. 7) 8.00 0 0 0 286, 459	C C C C C C	(col . 8 + col 9) 10.00 286,45	0 0 0 0 9		2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care	7.00 0 0 -16,609	(col. 6 + col. 7) 8. 00 0 0 286, 459 228, 677		(col . 8 + col 9) 10.00 286,45 228,67	0 0 0 9 9 7		2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	7.00 0 0 -16,609	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561		(col . 8 + col 9) 10.00 286,45 228,67 83,56	0 0 0 0 9 9 7 1		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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	7.00 0 0 -16,609	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513		(col . 8 + col 9) 10.00 286,45 228,67 83,56 78,51	0 0 0 0 9 7 1 3		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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	7.00 0 0 -16,609	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561		(col . 8 + col 9) 10.00 286,45 228,67 83,56	0 0 0 0 9 9 7 1 3 6		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 9.00 10.00 11.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	7.00 0 0 -16,609	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596		(col . 8 + col 9) 10.00 286,45 228,67 83,56 78,51 59	0 0 0 0 9 9 7 1 1 3 6 2		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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	7.00 0 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 6 + col . 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04	0 0 0 0 0 9 9 7 1 3 6 2 8 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0		(col . 8 + col 9) 10.00 286,45 228,67 83,56 78,51 59 37,30 57,04			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	7.00 0 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0		(col . 8 + col 9) 10.00 286,45 228,67 83,56 78,51 59 37,30 57,04	0 0 0 0 0 9 9 7 1 3 6 2 8 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			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
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			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
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ \hline \end{array}\\ \begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \hline 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			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 21.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ \hline \end{array}$	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04			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 21.00 22.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ \hline \end{array}\\\\ \begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES 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)	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286, 45 228, 67 83, 56 78, 51 59 37, 30 57, 04 23, 16			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 21.00 22.00 23.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ \end{array}\\ \begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}\\ \begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	7.00 0 0 -16,609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col. 6 + col. 7) 8.00 0 0 286, 459 228, 677 83, 561 78, 513 596 37, 302 57, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(col . 8 + col 9) 10.00 286,45 228,67 83,56 78,51 59 37,30 57,04 23,16			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 21.00 22.00

	Financial Systems		YETTE REGIONAL				Lieu of Form CMS-	
JUST A	ALLOCATION - HHA GENERAL SERVICE	CUST		Provider C		Peri od: From 10/01/2		
				HHA CCN:	15-7097	To 09/30/2	2/23/2017 9:3	epared: 30 am
						Home Healt Agency I	h PPS	
			Capital Rela	ated Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportat	ion Subtotal	1
		for Cost Allocation	Fixtures	Equi pment	Operation Maintenanc		(col s. 0-4)	
		(from Wkst. H,			Marintenanci	6		
		<u>col. 10)</u> 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.0
2.00	Capital Related - Movable	0		0			C	2.0
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.0
4.00	Transportation	0	0	0		0	0	4.0
5.00	Administrative and General HHA REIMBURSABLE SERVICES	286, 459	0	0		0	0 286, 459	5.0
5.00	Skilled Nursing Care	228, 677	0	0		0	0 228, 677	6.00
7.00	Physical Therapy	83, 561	0	0		0	0 83, 561	
3.00 9.00	Occupational Therapy Speech Pathology	78, 513 596	0 O	0		0	0 78, 513 0 596	
0.00	Medical Social Services	37, 302	Ō	0		0	0 37, 302	2 10.0
1.00 2.00	Home Health Aide Supplies (see instructions)	57, 048 0	0	0		0	0 57,048 0 0	
3.00	Drugs	0	0	0		0	C	
4.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	1	0	C	14.0
5.00	Home Dialysis Aide Services	0	0	0)	0	0 0	15.0
6.00	Respiratory Therapy	0	0	0		0	0 0	
7.00 8.00	Private Duty Nursing Clinic	0	0	0		0		
9.00	Health Promotion Activities	0	0	0		0	0 0	19.0
20.00	Day Care Program Home Delivered Meals Program	0	0	0		0		
22.00	Homemaker Service	0	0	0		0	0 0	
23.00 23.50	All Others (specify) Telemedicine	23, 167	0	0		0	0 23, 167	1
23.00	Total (sum of lines 1-23)	795, 323	0	0		0	0 795, 323	
		Administrative			•	·		
		& General 5.00	4A + 5) 6.00					1
00	GENERAL SERVICE COST CENTERS							1.0
. 00	Capital Related - Bldg. & Fixtures							1.0
. 00	Capital Related - Movable							2.0
. 00	Equipment Plant Operation & Maintenance							3.0
1.00	Transportation							4.0
5.00	Administrative and General HHA REIMBURSABLE SERVICES	286, 459						5.0
5.00	Skilled Nursing Care	128, 730	357, 407					6.0
7.00 3.00	Physical Therapy Occupational Therapy	47, 040 44, 198	130, 601 122, 711					7.0
. 00	Speech Pathology	336	932					9.0
0.00	Medical Social Services Home Health Aide	20, 999 32, 114	58, 301 89, 162					10.0
12.00	Supplies (see instructions)	32, 114	89, 162 0					12.0
3.00	Drugs	0	0					13.0
4.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.0
5.00	Home Dialysis Aide Services	0	0					15.0
6.00 7.00	Respiratory Therapy Private Duty Nursing	0	0					16.0 17.0
8.00	Clinic	0	0					18.0
	Health Promotion Activities	0	0					19. 0 20. 0
9.00	Day Care Program	0	U					20.0
19.00 20.00	Home Delivered Meals Program	0	0					21.0
19.00 20.00 21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0					22.0
9.00 0.00 1.00	Home Delivered Meals Program	0 0 13, 042 0	-					

COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider CO	CN: 15-0064 15-7097	Peri od: From 10/01/2015 To 09/30/2016	Date/Time Prep 2/23/2017 9:30	pared:
						Home Health	PPS	
		Capital Rel	ated Costs			Agency I		
		BIdgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		1.00		(SQUARE FEET)		54.00		
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures	0				0		1.00
2.00	Capital Related - Movable		0			0		2.00
	Equipment							-
3.00	Plant Operation & Maintenance	0	0	0		0		3.0
4.00	Transportation (see	0	0	0		0		4.0
	instructions)	_	_	_				
5.00	Administrative and General	0	0	0		0 -286, 459	508, 864	5.0
(00	HHA REIMBURSABLE SERVICES						000 (77	
6.00 7.00	Skilled Nursing Care Physical Therapy	0	0	0		0 0	228, 677 83, 561	6.00 7.00
7.00 8.00	Occupational Therapy	0	0	0			78, 513	
9.00	Speech Pathol ogy		0				596	
10.00	Medical Social Services	0	0	0		0 0	37, 302	
11.00	Home Health Aide	0	0	0		0 0	57,048	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00	Drugs	0	0	0		0	0	13.0
14.00	DME	0	0	0		0 0	0	14.0
	HHA NONREI MBURSABLE SERVI CES	1			-	1		
	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
18.00	Health Promotion Activities		0	0		0 0	0	
	Day Care Program		0				0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	23, 167	
23.50	Tel emedi ci ne	0	0	0		0 0	0	23.5
24.00	Total (sum of lines 1-23)	0	0	0		0 -286, 459	508, 864	
25.00	Cost To Be Allocated (per	0	0	0		0	286, 459	25.0
	Worksheet H-1, Part I)			0 005				
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 562938	26.0

	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provider CC		Period: From 10/01/2015	Worksheet H-2 Part I	
				HHA CCN:		To 09/30/2016		par 0 a
						Home Health Agency I	PPS	
			CAPI TAL					
	Cost Center Description	HHA Trial Balance (1)	RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	-
		0	1.00	DEPARTMENT 4.00	4A	5.00	7.00	
0	Administrative and General	0	21, 624	149, 753	171, 37			1
00	Skilled Nursing Care	357, 407	0	0	357, 40			
0	Physical Therapy	130, 601	0	0	130, 60			
0	Occupational Therapy	122, 711	0	0	122, 71		0	
0 0	Speech Pathology Medical Social Services	932 58, 301	0	0	93: 58, 30			
0	Home Heal th Aide	89, 162	0	0	89, 16			
0	Supplies (see instructions)	07,102	0	0		0 0	0	
0	Drugs	0	0	0	(0 0	0	
00	DME	0	0	0	(0 0	0	
00	Home Dialysis Aide Services	0	0	0	(0 0	0	11
00	Respiratory Therapy	0	0	0	(0 0	0	
00	Private Duty Nursing	0	0	0	(0 0	0	
00	Clinic	0	0	0	(0 0	0	1
00	Health Promotion Activities	0	0	0	(0 0	0	
00	Day Care Program	0	0	0	(0	0	
00	Home Delivered Meals Program Homemaker Service	0	0	0		0	0	
00	All Others (specify)	36, 209	0	0	36, 20	9 6, 312	0	
50	Tel emedi ci ne	0	0	0	30, 20	0, 512	0	
00	Total (sum of lines 1-19) (2)	795, 323	21, 624	149, 753	966, 70	168, 527	43, 635	
00	Unit Cost Multiplier: column		,	,	0.00000		,	21
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	<u>6 decimal places.</u> Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	cost center bescription	PLANT	LINEN SERVICE	HOUSEREELTING	DIEIARI		ADMI NI STRATI ON	
_		7.01	8.00	9.00	10.00	11.00	13.00	
0	Administrative and General	21,067	4, 796	12, 297	(28, 594	112, 038	
0 0	Skilled Nursing Care	0	0	0			0	
	Physical Therapy Occupational Therapy	0	0	0				
	Speech Pathol ogy		0	0			0	
			0			0		
0		0	0	0	(0 0	0	
0 0	Medical Social Services Home Health Aide	0	0	0 0	(0 0	0	
0 0 0	Medical Social Services	0	0 0 0	0 0 0	(0 0 0 0 0 0		-
0 0 0 0	Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0	0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0	
2 2 2 2 2 2 2 2 20	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME		0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	1(
0 0 0 0 0 00 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services		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	- 8 9 10 11
0 0 0 0 0 0 0 0 0 0 0 0 0 0	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy		0 0 0 0 0 0 0	0 0 0 0 0 0			0 0 0 0 0	8 0 10 11
)))))))))))))))))))	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing						0 0 0 0 0 0 0 0 0	10 11 12 13
C C C C C C C C C C C C C C C C C C C	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic						0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 10 11 12 13 14
)))))))))))))))))))	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities						0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
C C C C C C C C C C C C C C C C C C C	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						0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 9 10 11 12 13 14 15 16
C C C C C C C C C C C C C C C C C C C	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						0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 11 12 12 14 15 16 17
C C C C C C C C C C C C C C C C C C C	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						0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
5 5 5 5 5 5 5 5 5 6 5 7 5 7 5 7 5 7 5 7	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)					0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 11 11 11 11 11 11 11 11 11 11 1
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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)	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 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 28,594 594	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 9 10 11 12 13 14 15 16 17 18 19 19 19 19 19 19 19 19 19 19
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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) Telemedicine	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		D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 28, 594	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 9 10 11 12 13 14 15 16 17 18 19 19 20
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	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		D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 0 D 28, 594	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7 8 9 10 11 12 13 14 15 16 17 18 19 19
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 28, 594	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 8 10 11 12 12 14 14 15 16 17 18 19 19 20

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provider CC	CN: 15-0064	Period: From 10/01/2015		
			HHA CCN:	15-7097	To 09/30/2016		pared 0 am
					Home Health Agency I	PPS	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	14.00	15.00	16.00	24.00	25.00	26.00	
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 5.00 Medical Social Services 7.00 Home Health Aide 3.00 Supplies (see instructions) 7.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Home Delivered Meals Program 17.00 Home Service 18.00 Home Meal th Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 20 minus column 26, line 1, rounded to 			8, 685 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	432, 3 419, 7 153, 3 144, 1 1, C 68, 4 104, 7 42, 5 1, 366, 3	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	419, 716 153, 369 144, 103 1, 094 68, 465 104, 706	2. 0 3. 0 4. 0 5. 0 7. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 15. 0 18. 0 19. 0 19. 5
6 decimal places. Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
1.00 Administrative and General	27.00	28.00					1. (
 Administrative and General Skilled Nursing Care O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Speech Pathology O Home Heal th Ai de O Supplies (see instructions) D Drugs O BME O Respiratory Therapy O Respiratory Therapy O Respiratory Therapy O Home Dallysis Aide Services O Respiratory Therapy O Heal th Promotion Activities O Day Care Program O Home Delivered Meals Program O Home All Others (specify) Stelemedicine O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 	194, 299 70, 999 66, 710 506 31, 695 48, 472 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	614, 015 224, 368 210, 813 1, 600 100, 160 153, 178 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1. C 2. C 3. C 4. C 5. C 6. C 7. C 9. C 10. C 11. C 12. C 13. C 14. C 15. C 14. C 15. C 14. C 19. S 20. C 21. C

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	Financial Systems		YETTE REGIONAL				u of Form CMS-2	
BASI S	TION OF GENERAL SERVICE COSTS 1	TO HHA COST CEN	TERS STATISTICA	AL Provider C HHA CCN:		Period: From 10/01/2015 To 09/30/2016	Worksheet H-2 Part II Date/Time Pre 2/23/2017 9:3	pared:
						Home Health	PPS	
		CAPI TAL				Agency I		
	Cost Center Description	RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI V & GENERAL (ACCUM. COST)	PLANT	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	7.01	
1.00 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	3, 051 0 0 0 0 0	-		357, 40 130, 60 122, 71 93	7 0 1 0 1 0 2 0	3, 051 0 0 0 0 0 0 0	3.00 4.00
7.00 8.00 9.00 10.00 11.00	Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	0 0 0 0	0 0 0 0 0		89, 16	2 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 0 0 0 0	0			0 0 0 0 0 0 0	12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00 19. 50 20. 00 21. 00	Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	0 0 0 3, 051 21, 624	0 0 0 706, 464 149, 753	C	36, 20 966, 70 168, 52	0 0 0 3, 051	0 0 0 3, 051	18.00 19.00 19.50 20.00
22.00		7. 087512 LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	0. 211975 HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	0. 17433 CAFETERI A (MAN HOURS)	2 14. 301868 NURSI NG ADMI NI STRATI ON (FTE' S)	6. 904949 CENTRAL SERVI CES & SUPPLY (100%)	
4 00		8.00	9.00	10.00	11.00	13.00	14.00	1.00
1.00 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	1,924 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	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 19.50 20.00	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) Telemedicine Total (sum of lines 1-19)	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 0 0 5 1,552		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
21.00	Total cost to be allocated Unit cost multiplier	4, 796 2. 492723	12, 297	0	28, 59	4 112, 038	0	21.00

Heal th	Financial Systems	FA	YETTE REGIONAL H	EALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provider CCN:	15-0064	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7097	From 10/01/2015 To 09/30/2016	Part II Date/Time Pre 2/23/2017 9:30	
						Home Health	PPS	
		DUADNA OV				Agency I		
	Cost Center Description	PHARMACY (100%)	MEDI CAL RECORDS &					
		(100%)	LIBRARY					
			(GROSS					
			CHARGES)					
		15.00	16.00					
1.00	Administrative and General	0	727, 974					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00 7.00	Medical Social Services Home Health Aide	0	0					6.00 7.00
7.00 8.00	Supplies (see instructions)	0	0					7.00 8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	o					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00 19.00	Homemaker Service All Others (specify)	0	0					18. 00 19. 00
19.00	Tel emedi ci ne	0	0					19.00 19.50
20.00		0	727, 974					20.00
20.00	Total cost to be allocated	0	8, 685					21.00
22.00		0. 000000	0. 011930					22.00

PPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C		Peri od:	Worksheet H-3	
				HHA CCN:		From 10/01/2015 To 09/30/2016	Part I Date/Time Pre 2/23/2017 9:30	pared 0 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line	•	Costs (from	+ 2)	1	(col. 3 ÷ col.	
		0	1.00	<u>Part II)</u> 2.00	3.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, A	GGREGATE OF TH		ITATION COST, OF	R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
. 00	Skilled Nursing Care	2.00	614, 015		614, 01		164. 22	
. 00	Physical Therapy	3.00	224, 368	0			329.95	
. 00 . 00	Occupational Therapy Speech Pathology	4.00 5.00	210, 813 1, 600	0			446. 64 55. 17	
. 00	Medical Social Services	6.00	100, 160	0	100, 16		1, 472. 94	
. 00	Home Health Aide	7.00	153, 178		153, 17		37.69	
. 00	Total (sum of lines 1-6)		1, 304, 134	0	1			7.(
					Program Visit	s irt B		-
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
				i di ti ni	Deducti bl es Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
0.0	Limitation Cost Computation		474.40			-		
. 00 . 01	Skilled Nursing Care Skilled Nursing Care		17140 50031	0				8. 8.
. 02	Skilled Nursing Care		50035	0		2		8.0
. 03	Skilled Nursing Care		50042	0				8.0
. 04	Skilled Nursing Care		99915	C	1, 00	8		8.0
. 00	Physical Therapy		17140	C		3		9. (
. 01	Physical Therapy		50031	0		5		9.0
. 02 . 03	Physical Therapy Physical Therapy		50035 50042	0		8 7		9. (9. (
. 03 . 04	Physical Therapy		99915	0	19			9.0
0.00	Occupational Therapy		17140	C		4		10.
0.01	Occupational Therapy		50031	C		3		10.
0. 02	Occupational Therapy		50035	C		5		10.
0. 03	Occupational Therapy		50042	C		0		10. (
0. 04	Occupational Therapy		99915	C				10. (
1.00	Speech Pathology		17140	0	0	0		11.
1.01 1.02	Speech Pathology Speech Pathology		50031 50035	0		6 0		11. 11.
1.02	Speech Pathology		50042	0		0		11.
1.04	Speech Pathol ogy		99915	Ő	1	4		11.
2.00	Medical Social Services		17140	C		1		12.0
2. 01	Medical Social Services		50031	0		4		12.
2.02			50035	0		0		12.0
2.03	Medical Social Services		50042	0		0		12.
2.04	Medical Social Services		99915	0		1		12.
3. 00 3. 01	Home Health Aide Home Health Aide		17140 50031	0	11	0		13. 13.
3.01	Home Heal th Ai de		50035	0		0		13.
3.02	Home Heal th Aide		50042	0		2		13.
3.04	Home Health Aide		99915	C	28	7		13. (
4.00	Total (sum of lines 8-13)	F 100 F 100 F		0	2, 41			14. (
	Cost Center Description	From Wkst. H-2 Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Charges 1 (from HHA	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	÷ cor. 4)	
		0	1.00	<u>Part II)</u> 2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa	ations						
5.00	Cost of Medical Supplies	8.00	0	0	M	0 0	0. 000000	1 15

	IONMENT OF PATIENT SERVICE COSTS	5		Provider CC	N. 15 0004	Peri od:	Worksheet H-3	
				HHA CCN:	15-7097	From 10/01/2015 To 09/30/2016	Part I Date/Time Pre 2/23/2017 9:3	
				Title	XVIII	Home Health Agency I	PPS	
			Program Visits		Cost of Servi ces		1	
			Part	t B	Jei vi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Deductibles &	
	-	6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
_	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
00	Skilled Nursing Care	C	1, 429			0 234, 670		1.
00	Physical Therapy	C				0 105, 254		2.
00	Occupational Therapy	C				0 100, 941		3.
00	Speech Pathology	C				0 1, 103		4.
00	Medical Social Services	C				0 23, 567		5.
00	Home Health Aide	C				0 15, 076		6.
00	Total (sum of lines 1-6)	C	2, 410			0 480, 611		7.
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
00	Skilled Nursing Care							8.
00 01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care							8.
)4	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
04	Physical Therapy							9.
. 00	Occupational Therapy							10.
. 01	Occupational Therapy							10.
. 02	Occupational Therapy							10.
. 03	Occupational Therapy							10.
. 04	Occupational Therapy							10.
. 00	Speech Pathology							11.
. 01	Speech Pathology							11.
. 02	Speech Pathology							11.
. 03	Speech Pathol ogy							11.
04	Speech Pathol ogy							11.
00	Medical Social Services							12.
01 02	Medical Social Services Medical Social Services							12
02	Medical Social Services							12.
03								12.
04	Home Heal th Ai de							13.
01	Home Heal th Aide							13.
02	Home Heal th Aide							13.
03	Home Heal th Ai de							13.
04	Home Health Aide							13.
. 00	Total (sum of lines 8-13)							14.
		Prog	ram Covered Cha	rges	Cost of Services			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &	Coi nsurance		Deductibles &	Deductibles & Coinsurance	
	-	6.00	Coi nsurance 7.00	8.00	9.00	Coi nsurance 10.00	11.00	
		0.00	1.00	0.00	7.00	10.00	11.00	
	Supplies and Drugs Cost Computa	tions						

APPORT	FIONMENT OF PATIENT SERVICE COST	S		Provider CCN:	15-0064	Peri od:	Worksheet H-3	3
				HHA CCN:	15-7097	From 10/01/2015 To 09/30/2016	Part I Date/Time Pre	
				Title X	VI I I	Home Health Agency I	2/23/2017 9:3 PPS	<u>30 ani</u>
	Cost Center Description	Total Program				Agency I		
		Cost (sum of						
		col s. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, AGO	GREGATE OF THE F	PROGRAM LI	MITATION COST, OR	2	
	BENEFICIARY COST LIMITATION							_
1 00	Cost Per Visit Computation	224 (70						1 1
1.00	Skilled Nursing Care	234,670						1.
2.00	Physical Therapy	105, 254						2.
3.00 4.00	Occupational Therapy	100, 941 1, 103						3.
4.00 5.00	Speech Pathology Medical Social Services	23, 567						4. 5.
5.00	Home Heal th Aide	15,076						6.
7.00	Total (sum of lines 1-6)	480, 611						7.
. 00	Cost Center Description	400,011						/.
		12.00						1
	Limitation Cost Computation					I		
3.00	Skilled Nursing Care							8.
8. 01	Skilled Nursing Care							8.
3. 02	Skilled Nursing Care							8.
3. 03	Skilled Nursing Care							8.
3.04	Skilled Nursing Care							8.
9.00	Physical Therapy							9.
9.01	Physical Therapy							9.
9.02	Physical Therapy							9.
9.03	Physical Therapy							9.
9.04	Physical Therapy							9.
10.00 10.01	Occupational Therapy Occupational Therapy							10.
10.01	Occupational Therapy							10.
0.02	Occupational Therapy							10.
0.03	Occupational Therapy							10.
1.00	Speech Pathol ogy							11.
1.01	Speech Pathology							11.
1. 02	Speech Pathol ogy							111.
1.03	Speech Pathol ogy							11.
1.04	Speech Pathol ogy							11.
2.00	Medical Social Services							12.
2.01	Medical Social Services							12.
2. 02	Medical Social Services							12.
2.03	Medical Social Services							12.
2.04	Medical Social Services							12.
13.00	Home Health Aide							13.
3.01	Home Health Aide							13.
3.02	Home Health Aide							13.
13.03	Home Health Aide							13.
13.04	Home Health Aide							13.
4.UU	Total (sum of lines 8-13)							14.

Health Financial Systems		FAYETTE REGIONAL	L HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVI	CE COSTS		Provider C	CN: 15-0064	Period: From 10/01/2015	Worksheet H-3 Part II	
			HHA CCN:	15-7097	To 09/30/2016		
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Descri	ption From Wkst.	C, Cost to Charge	e Total HHA	HHA Shared	Transfer to		
	Part I, co	. Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT	OF COST OF HHA SEF	VICES FURNISHED I	BY SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 Physical Therapy	66	0. 558247	7 0)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	s 71	0. 433462	2 C		0 col. 2, line 1	5. 00	4.00
5.00 Cost of Drugs	73	0. 393982	2 C		0 col. 2, line 1	6. 00	5.00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	LTH SYSTEM Provider CC	N: 15-0064	Peri od:	Worksheet H-4	2552
H	IHA CCN:	15-7097	From 10/01/2015 To 09/30/2016		
	Title	XVIII	Home Health Agency I	PPS	
		Part A	Not Subject to Deductibles &	Deductibles &	
	-	1 00	Coi nsurance	Coi nsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGES	1.00	2.00	3.00	
Reasonable Cost of Part A & Part B Services		·			1
0 Reasonable cost of services (see instructions)			0 0	0	1
0 Total charges			0 0	0	2
Customary Charges				1	
0 Amount actually collected from patients liable for payment for	servi ces		0 0	0	3
on a charge basis (from your records)	aumant		0	0	
0 Amount that would have been realized from patients liable for p for services on a charge basis had such payment been made in ac			0 0	0	4
with 42 CFR §413.13(b)	cordance				
0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5
0 Total customary charges (see instructions)			0 0	0	6
0 Excess of total customary charges over total reasonable cost (c	omplete		0 0	0	7
only if line 6 exceeds line 1)			0		
0 Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ITIIne		0 0	0	8
0 Primary payer amounts			0 0	0	9
	I		Part A	Part B	
			Servi ces	Servi ces	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
00 Total reasonable cost (see instructions)			0	0	10
00 Total PPS Reimbursement - Full Episodes without Outliers			0	379, 031	11
00 Total PPS Reimbursement - Full Episodes with Outliers			0	5, 502	
00 Total PPS Reimbursement - LUPA Episodes			0	14, 276	
00 Total PPS Reimbursement - PEP Episodes			0	1,830	
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	7,037	
00 Total PPS Outlier Reimbursement – PEP Episodes 00 Total Other Payments			0	0	
00 DME Payments			0	0	
00 Oxygen Payments			0	0	
00 Prosthetic and Orthotic Payments			0	0	20
00 Part B deductibles billed to Medicare patients (exclude coinsur	ance)			0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)			0	407, 676	
00 Excess reasonable cost (from line 8)			0	0	
00 Subtotal (line 22 minus line 23) 00 Coinsurance billed to program patients (from your records)			0	407, 676	
00 Coinsurance billed to program patients (from your records) 00 Net cost (line 24 minus line 25)			0	0 407, 676	
00 Reimbursable bad debts (from your records)			0	407,070	20
00 Reimbursable bad debts for dual eligible beneficiaries (see ins	tructions)				28
00 Total costs - current cost reporting period (line 26 plus line			0	407, 676	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	30
50 Pioneer ACO demonstration payment adjustment (see instructions)			0	0	
00 Subtotal (see instructions)			0	407, 676	
01 Sequestration adjustment (see instructions)			0	8, 154	
00 Interim payments (see instructions) 00 Tentative settlement (for contractor use only)			0	399, 522 0	
00 Balance due provider/program (line 31 minus lines 31.01, 32, an	d 33)		0	0	
			0		
00 Protested amounts (nonallowable cost report items) in accordanc	e with CMS	Pub. 15-2.	0	0	35

	IS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-0064		eriod:	Worksheet H-5	
PRO	IGRAM BENEFI CI ARI ES	HHA CCN:	15-7097		rom 10/01/2015 p 09/30/2016	Date/Time Prep 2/23/2017 9:30	
					Home Health Agency I	PPS	<u>o un</u>
		I npati en	t Part A			t B	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
<u> </u>		1.00	2.00		3.00	4.00	1
)0)0	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			0		399, 522 0	1 2
0	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)						3
	Program to Provider		[
1 2				0		0	3
3				0		0	3
4				0		0	3
5				0		0	З
~	Provider to Program			0		0	
0 1				0		0	
2				0		0	3
3				0		0	З
4				0		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		399, 522	4
	TO BE COMPLETED BY CONTRACTOR						
0	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
	Program to Provider						_
)1)2				0 0		0	5
3				0		0	5
	Provider to Program						
0				0		0	5
1 2				0		0	Е Е
29	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on			-		-	6
	the cost report. (1)					_	
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0		0	6
)2)0	Total Medicare program liability (see instructions)			0		0 399, 522	7
			I		Contractor	NPR Date	,
					Number	(Mo/Day/Yr)	
	Name of Contractor	()		1.00	2.00	

	Financial Systems F SIS OF HOSPITAL-BASED HOSPICE COSTS	AYETTE REGIONAL		CN: 15-0064	Peri od:	Worksheet 0	2552
			Hospi ce CC	N: 15-1548	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
					Hospi ce I	2/23/2017 7.3	
		SALARI ES	OTHER	SUBTOTAL (co 1 plus col.	I. RECLASSI FI -	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	- T - T		1			÷
00	CAP REL COSTS-BLDG & FIXT*		C		0 0	0	
00	CAP REL COSTS-MVBLE EQUIP*		C)	0 0	0	
00 00	EMPLOYEE BENEFITS DEPARTMENT*	0	24 520	24 5	0 0	0	
00	ADMINISTRATIVE & GENERAL* PLANT OPERATION & MAINTENANCE*	0	34, 529	34, 5	0 0	34, 529 0	
00	LAUNDRY & LINEN SERVICE*	0	0	,	0 0	0	
00	HOUSEKEEPI NG*	0	C		0 0	0	
00	DI ETARY*	0	C		0 0	0	
00	NURSI NG ADMI NI STRATI ON*	0	C		0 0	0	
). 00	ROUTINE MEDICAL SUPPLIES*	0	C		0 0	0	10
. 00	MEDI CAL RECORDS*	0	C		0 0	0	
. 00	STAFF TRANSPORTATION*	0	C		0 0	0	12
. 00	VOLUNTEER SERVICE COORDINATION*	0	C		0 0	0	13
1.00	PHARMACY*	0	C		0 0	0	14
. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	C		0 0	0	15
. 00	OTHER GENERAL SERVICE*	0	C)	0 0	0	16
. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17
	DIRECT PATIENT CARE SERVICE COST CENTERS			1	-		
. 00	INPATIENT CARE-CONTRACTED**	0	C		0 0	0	
. 00	PHYSI CI AN SERVI CES**	0	C)	0 0	0	
. 00	NURSE PRACTITIONER**	0	C)	0 0	0	
3.00	REGI STERED NURSE**	0	C)	0 15, 988	15, 988	
9.00		0	Ĺ		0 0	0	
. 00	PHYSICAL THERAPY**	0			0 0	0	
. 00	OCCUPATIONAL THERAPY** SPEECH/LANGUAGE PATHOLOGY**	0	C C		0 0	0	
. 00 . 00	MEDICAL SOCIAL SERVICES**	0			0 2,822	2, 822	
. 00	SPIRITUAL COUNSELING**	0	0		0 2,022	2,022	
. 00	DI ETARY COUNSELING**	0	C		0 0	0	
b. 00	COUNSELING - OTHER**	0	C		0 0	0	
. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	C		0 4, 357	4, 357	
. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	C		0 0	0	
. 00	PATIENT TRANSPORTATION**	0	C		0 0	0	39
. 00	I MAGI NG SERVI CES**	0	C		0 0	0	40
. 00	LABS & DIAGNOSTICS**	0	C		0 0	0	41
. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	28, 959	28, 9	59 0	28, 959	42
. 00	OUTPATI ENT SERVI CES**	0	C		0 0	0	43
. 00	PALLIATIVE RADIATION THERAPY**	0	C		0 0	0	
. 00	PALLIATIVE CHEMOTHERAPY**	0	C		0 0	0	
. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	C)	0 0	0	46
~~~	NONREI MBURSABLE COST CENTERS			1			1
	BEREAVEMENT PROGRAM *	0	C		0 0		
. 00	VOLUNTEER PROGRAM * FUNDRAI SI NG*	0			0 0	0	
. 00	HUNDRALSING* HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0				0	
. 00	PALLIATIVE CARE PROGRAM*					0	
. 00	OTHER PHYSICIAN SERVICES*					0	
. 00	RESIDENTIAL CARE*		c r		0 0	0	
. 00	ADVERTI SI NG*	0	c r		0 0	0	
. 00	TELEHEALTH/TELEMONI TORI NG*	0	c r		0 0	0	
. 00	THRI FT STORE*	0	C C		0 0	0	
). 00	NURSING FACILITY ROOM & BOARD*	0	C.		0 0	0	
	OTHER NONREI MBURSABLE (SPECI FY)*	0	C.		0 0	0	
	TOTAL		63, 488	63, 4	88 23, 167	86, 655	

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

LYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0064	Peri od:	Worksheet 0	
			Hospice CCN:	15-1548	From 10/01/2015 To 09/30/2016	Date/Time Pro	epare
						2/23/2017 9:	
		ADJUSTMENTS	TOTAL (col. 5		Hospi ce I		
			± col. 6)				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	0	0				1
0	CAP REL COSTS-BEDG & FIXT CAP REL COSTS-MVBLE EQUIP*		0				1
0	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
0	ADMI NI STRATI VE & GENERAL*	0	34, 529				4
0	PLANT OPERATION & MAINTENANCE*	0	0				5
0	LAUNDRY & LINEN SERVICE*	0	0				6
0	HOUSEKEEPI NG*	0	0				7
0	DI ETARY*	0	0				8
0	NURSING ADMINISTRATION*	0	0				9
00	ROUTINE MEDICAL SUPPLIES*	0	0				10
00	MEDICAL RECORDS*	0	0				11
00	STAFF TRANSPORTATION*	0	0				12
00	VOLUNTEER SERVICE COORDINATION*	0	0				13
00	PHARMACY*	0	0				14
	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15
00	OTHER GENERAL SERVICE*	0	0				16
00	PATIENT/RESIDENTIAL CARE SERVICES DIRECT PATIENT CARE SERVICE COST CENTERS						17
00	INPATIENT CARE-CONTRACTED**	0	0				25
00	PHYSICIAN SERVICES**		0				26
00	NURSE PRACTITIONER**	0	0				27
00	REGI STERED NURSE**	0	15, 988				28
00	LPN/LVN**	0	0				29
-	PHYSI CAL THERAPY**	0	0				30
00	OCCUPATIONAL THERAPY**	0	0				31
00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
00	MEDICAL SOCIAL SERVICES**	0	2, 822				33
00	SPIRITUAL COUNSELING**	0	0				34
00	DI ETARY COUNSELI NG**	0	0				35
00	COUNSELING - OTHER**	0	0				36
00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	4, 357				3
00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38
00 00	PATIENT TRANSPORTATION** IMAGING SERVICES**	0	0				39
00	LABS & DI AGNOSTI CS**	0	0				40
00	MEDICAL SUPPLIES-NON-ROUTINE**		28, 959				42
00	OUTPATIENT SERVICES**		20, 939				43
00	PALLIATIVE RADIATION THERAPY**	0	0				44
00	PALLIATIVE CHEMOTHERAPY**	0	0				45
00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
	NONREIMBURSABLE COST CENTERS						
00	BEREAVEMENT PROGRAM *	0	0				60
00	VOLUNTEER PROGRAM *	0	0				61
-	FUNDRAI SI NG*	0	0				62
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSICIAN SERVICES*		0				65
-	RESI DENTI AL CARE* ADVERTI SI NG*		0				66
	TELEHEALTH/TELEMONI TORI NG*		0				67
	THRIFT STORE*		0				69
	NURSING FACILITY ROOM & BOARD*		0				70
	OTHER NONREIMBURSABLE (SPECIFY)*		0				71
	TOTAL		86, 655				100

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE ROUTINE HOME	Provider C	CN: 15-0064	Period: From 10/01/2015	Worksheet 0-2	
ARE		Hospi ce CCI		To 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared: 0 am
			-	Hospi ce I		_
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			1			
25. 00 INPATIENT CARE-CONTRACTED						25.0
26. 00 PHYSI CLAN SERVI CES	0	0		0 0	0	
27. 00 NURSE PRACTITIONER	0	0		0 0	0	1
28. 00 REGI STERED NURSE	0	0		0 15, 988	15, 988	
29.00 LPN/LVN	0	0		0 0	0	29. (
0. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.0
1. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	
3.00 MEDICAL SOCIAL SERVICES	0	0		0 2, 822	2, 822	33.
4. 00 SPIRITUAL COUNSELING	0	0		0 0	0	34.
5. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.
6. 00 COUNSELING - OTHER	0	0		0 0	0	36.
7.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 4, 357	4, 357	37.
8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.
9.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.
0. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.
1.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.
2. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	28, 959	28, 95	9 0	28, 959	42.
3. 00 OUTPATI ENT SERVI CES	0	0		0 0	0	43.
4.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.
5. 00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.
00.00 TOTAL *	0	28, 959	28, 95	9 23, 167	52, 126	100.

		ADJUSTMENTS	TOTAL (col. 5							
		6,00	<u>± col. 6)</u> 7.00	-						
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00							
25.00	INPATIENT CARE-CONTRACTED				25.00					
26.00	PHYSI CI AN SERVI CES	0	0		26.00					
27.00	NURSE PRACTITIONER	0	0		27.00					
28.00	REGI STERED NURSE	0	15, 988		28.00					
29.00	LPN/LVN	0	0		29.00					
30.00	PHYSI CAL THERAPY	0	0		30.00					
31.00	OCCUPATIONAL THERAPY	0	0		31.00					
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00					
33.00	MEDICAL SOCIAL SERVICES	0	2, 822		33.00					
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00					
35.00	DI ETARY COUNSELING	0	0		35.00					
36.00	COUNSELING - OTHER	0	0		36.00					
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4, 357		37.00					
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00					
39.00	PATI ENT TRANSPORTATI ON	0	0		39.00					
40.00	I MAGI NG SERVI CES	0	0		40.00					
41.00	LABS & DI AGNOSTI CS	0	0		41.00					
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	28, 959		42.00					
43.00	OUTPATI ENT SERVI CES	0	0		43.00					
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00					
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00					
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00					
100.00	TOTAL *	0	52, 126		100.00					
* Tran	' Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.									

Heal th	Financial Systems FAYETTE REGIONAL H	HEALTH SYSTEN	l	In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0064	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 10/01/2015		
		Hospi ce CC	N: 15-1548	To 09/30/2016	Date/Time Pre 2/23/2017 9:3	
				Hospi ce I	2/23/2017 9.3	
	Descriptions		HOSPICE DI REC		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
				) EXPENSES FROM		
				WKST B PART I	,	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0	-	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 0	-	3.00
4.00	ADMINISTRATIVE & GENERAL		34, 52	9 15, 107		4.00
5.00	PLANT OPERATION & MAINTENANCE			0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0		6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSING ADMINISTRATION			0 0		9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 0	0	10.00
11.00	MEDI CAL RECORDS			0 2, 315		11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0 0	-	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
F0 00	LEVEL OF CARE		1	0	0	
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		52, 12		52, 126	51.00
52.00 53.00	HOSPICE INPATIENT RESPITE CARE			0	0	52.00 53.00
55.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS			0	0	53.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99.00	NEGATI VE COST CENTER			0	0	99.00
100.00			86, 65	5 17, 422	-	
	,			•	•	•

llaal th	Financial Systems					of Form CMC	DEED 10
	Financial Systems ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	AYETTE REGIONAL H	Provider C		Period:	eu of Form CMS-2 Worksheet 0-6	
00017					From 10/01/2015	Part I	
			Hospi ce CCI	N: 15-1548	To 09/30/2016		pared:
					lleoni ee l	2/23/2017 9:3	0 am
	Descriptions	TOTAL EXPENSES CA			Hospice I E EMPLOYEE	SUBTOTAL	
	Descriptions	TOTAL LAFENSES	FIX	EQUI P	BENEFITS	JUDIOTAL	
			11A	Leon	DEPARTMENT		
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	1	3.00
4.00	ADMI NI STRATI VE & GENERAL	49, 636	0		0 0	49, 636	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	0 0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	0	10.00
11.00	MEDI CAL RECORDS	2, 315	0		0 0	2, 315	
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17.00
F0 00	LEVEL OF CARE			1			50.00
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	, i i i i i i i i i i i i i i i i i i i	50.00
51.00 52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	52, 126	0		0 0	52, 126	51.00
52.00 53.00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0	0				52.00 53.00
53.00	NONREIMBURSABLE COST CENTERS	0	0		0 0	<u> </u>	53.00
60,00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0				61.00
62.00	FUNDRAI SI NG	0	0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0				63.00
64.00	PALLIATIVE CARE PROGRAM	0	0				64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0 0		65.00
66,00	RESI DENTI AL CARE	0	0		0 0		66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	o o	68.00
69.00	THRI FT STORE	0	0		0 0	o o	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	-			0	70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0 0	)	99.00
100.00	TOTAL	104, 077	0		0 0	104, 077	100.00

COST #	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0064 N: 15-1548			Worksheet O- Part I Date/Time Pr 2/23/2017 9:	rep	oared: ) am
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVI		Hospi ce I HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS			_					
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMINISTRATIVE & GENERAL	49, 636							4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C						5.00
6.00	LAUNDRY & LINEN SERVICE	0	C	)	0				6.00
7.00	HOUSEKEEPING	0	C			0			7.00
8.00	DI ETARY	0	C	)		0		0	8.00
9.00	NURSING ADMINISTRATION	0	C			0			9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	C			0			10.00
11.00	MEDI CAL RECORDS	2, 111	C			0			11.00
12.00	STAFF TRANSPORTATION	0	C			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C			0			13.00
14.00	PHARMACY	0	C	)		0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C	)		0			15.00
16.00	OTHER GENERAL SERVICE	0	C			0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	C	)		0			17.00
	LEVEL OF CARE			1					
50.00	HOSPICE CONTINUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	47, 525			_				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	C		0	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	C	)	0	0		0	53.00
(0.00	NONREI MBURSABLE COST CENTERS								(0.00
60.00	BEREAVEMENT PROGRAM	0	C			0			60.00
61.00	VOLUNTEER PROGRAM	0				0			61.00
62.00 63.00		0				0			62.00 63.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0			
64.00 65.00	PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES	0				0			64.00 65.00
65.00 66.00	RESIDENTIAL CARE	0			0	0		0	65.00 66.00
67.00	ADVERTI SI NG	0			0	0		9	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0			68. 00
69.00	THRIFT STORE	0				0			69.00
70.00	NURSING FACILITY ROOM & BOARD	0	L L	<b>'</b>		0			70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	· ·		0	0		0	70.00
99.00	NEGATIVE COST CENTER	0			0	0		0	99.00
	INCOMPTE JUST CENTER	0		1	0	0			,,,

2.00CAP REL COSTS-MVBLE EQUIP3.00EMPLOYEE BENEFITS DEPARTMENT4.00ADMI NI STRATI VE & GENERAL5.00PLANT OPERATION & MAINTENANCE6.00LAUNDRY & LINEN SERVICE7.00HOUSEKEEPING8.00DI ETARY9.00NURSING ADMINISTRATION10.00ROUTI NE MEDI CAL SUPPLIES0011.00MEDI CAL RECORDS0013.00VOLUNTEER SERVICE COORDINATION0013.00PHARMACY0015.00PHYSI CI AN ADMINISTRATI VE SERVICES00000000000015.00PHYSI CI AN ADMINISTRATI VE SERVICES00000000000000000000000000000000000000000000000000000000000000000000<	
Hospice IDescriptionsHospice IDescriptionsHospice IDescriptionsNURSI NG ADMI NI STRATI ONMEDI CAL SUPPLIESSTAFFVOLUNTEER SERVICE COORDINATIONGENERAL SERVICE COST CENTERSImage: Complexity of the service COORDINATIONVOLUNTEER SERVICE COORDINATIONGENERAL SERVICE COST CENTERSImage: Complexity of the service COORDINATIONVOLUNTER SERVICE COORDINATIONOO10.0011.0012.0013.00CAP REL COSTS -MVBLE EQUIP 3.00Image: Complexity of the service CORDINATIONImage: Complexity of the service CORDINATION0.00CAP REL COSTS -MVBLE EQUIP 3.00Image: Complexity of the service CORDINATIONImage: Complexity of the service COMPARIANCE0.00CAP REL COSTS -MVBLE EQUIP 3.00Image: Complexity of the service CORDINATION3.00EMPLOYEE BENEFITS DEPARTMENT 4.00Image: Complexity of the service COMPARIANCEImage: Complexity of the service 4.00Image: Complexity of the service COMPARIANCEComplexity of the service 4.00Image: Complexity of the service 4.00Image: Complexity of the service 4.00Image: Complexity	
DescriptionsNURSING ADMINISTRATIONROUTINE MEDICAL SUPPLIESMEDICAL RECORDSSTAFF TRANSPORTATIONVOLUNTEER SERVICE COORDINATION1.00CAP REL COSTS-BLDG & FIXT 2.009.0010.0011.0012.0013.002.00CAP REL COSTS-BUDG & FIXT 2.0000010.0011.0012.003.00EMPLOYEE BENEFITS DEPARTMENT 4.00ADMINISTRATIVE & GENERAL 5.0000010.004.00ADMINISTRATIVE & GENERAL 5.00000015.00PLANT OPERATION & MAINTENANCE 6.00000016.00LAUNDRY & LINEN SERVICE 7.00000107.00HOUSEKEEPING 8.00000118.00DI ETARY 9.00000019.00NURSING ADMINISTRATION 1.00000111.00MEDICAL RECORDS000111.00MEDICAL RECORDS000112.00STAFF TRANSPORTATION 0001113.00VOLUNTEER SERVICE COORDINATION00114.00PHARMACY 00000115.00PHYSICIAN ADMINISTRATIVE SERVICES00000	
GENERAL SERVICE COST CENTERS1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MUBLE EQUIP3.00EMPLOYEE BENEFITS DEPARTMENT4.00ADMINISTRATIVE & GENERAL5.00PLANT OPERATION & MAINTENANCE6.00LAUNDRY & LINEN SERVICE7.00HOUSEKEEPING8.00DI ETARY9.00NURSING ADMINISTRATION10.00ROUTINE MEDICAL SUPPLIES0011.00MEDICAL RECORDS12.00STAFF TRANSPORTATION0013.00VOLUNTEER SERVICE COORDINATION0014.00PHARMACY000015.00PHYSICIAN ADMINISTRATIVE SERVICES000000000000000000000000000000000000000000000000000000000000000000000000 <td></td>	
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00EMPLOYEE BENEFITS DEPARTMENT4.00ADMINISTRATIVE & GENERAL5.00PLANT OPERATION & MAINTENANCE6.00LAUNDRY & LINEN SERVICE7.00HOUSEKEEPING8.00DI ETARY9.00NURSING ADMINISTRATION10.00ROUTINE MEDICAL SUPPLIES0011.00MEDICAL RECORDS0012.00STAFF TRANSPORTATION0013.00VOLUNTERE SERVICE COORDINATION0014.00PHARMACY0015.00PHYSICIAN ADMINISTRATIVE SERVICES0000000000000000000000000000000000000000000000000000000000000000000000000000 <td></td>	
2.00CAP REL COSTS-MVBLE EQUI P3.00EMPLOYEE BENEFITS DEPARTMENT4.00ADMI NI STRATI VE & GENERAL5.00PLANT OPERATION & MAI NTENANCE6.00LAUNDRY & LI NEN SERVI CE7.00HOUSEKEPI NG8.00DI ETARY9.00NURSI NG ADMI NI STRATI ON10.00ROUTI NE MEDI CAL SUPPLI ES0011.00MEDI CAL RECORDS0013.00VOLUNTEER SERVI CE COORDI NATI ON0013.00PHARMACY0015.00PHYSI CI AN ADMI NI STRATI VE SERVI CES000015.00PHYSI CI AN ADMI NI STRATI VE SERVI CES	
3.00EMPLOYEE BENEFITS DEPARTMENT4.00ADMINI STRATI VE & GENERAL5.00PLANT OPERATI ON & MAINTENANCE6.00LAUNDRY & LINEN SERVICE7.00HOUSEKEEPING8.00DI ETARY9.00NURSI NG ADMINI STRATI ON10.00ROUTI NE MEDI CAL SUPPLI ES0011.00MEDI CAL RECORDS0011.00VOLUNTEER SERVI CE COORDI NATI ON0013.00VOLUNTEER SERVI CE COORDI NATI ON14.00PHARMACY0015.00PHYSI CI AN ADMINI STRATI VE SERVI CES000015.00C00000015.00C0000000015.00C0000000015.00C0000000015.00C0000000000000000000000000000000000000 <td< td=""><td>1.00</td></td<>	1.00
4.00ADMI NI STRATI VE & GENERAL5.00PLANT OPERATI ON & MAI NTENANCE6.00LAUNDRY & LI NEN SERVI CE7.00HOUSEKEEPI NG8.00DI ETARY9.00NURSI NG ADMI NI STRATI ON0010.00ROUTI NE MEDI CAL SUPPLI ES0011.00STAFF TRANSPORTATI ON12.00STAFF TRANSPORTATI ON13.00VOLUNTEER SERVI CE COORDI NATI ON0014.00PHARMACY0015.00PHYSI CI AN ADMI NI STRATI VE SERVI CES	2.00
5.00PLANT OPERATION & MAINTENANCE6.00LAUNDRY & LINEN SERVICE7.00HOUSEKEEPING8.00DIETARY9.00NURSING ADMINISTRATION10.00ROUTINE MEDICAL SUPPLIES0011.00MEDICAL RECORDS0012.00STAFF TRANSPORTATION13.00VOLUNTEER SERVICE COORDINATION0014.00PHARMACY0015.00PHYSICIAN ADMINISTRATIVE SERVICES00000015.000000015.0000015.000000015.00000000000000000000000000000000000000000000000000000000000000000000000 <t< td=""><td>3.00</td></t<>	3.00
6.00LAUNDRY & LI NEN SERVI CE7.00HOUSEKEEPI NG8.00DI ETARY9.00NURSI NG ADMI NI STRATI ON10.00ROUTI NE MEDI CAL SUPPLI ES0011.00MEDI CAL RECORDS0012.00STAFF TRANSPORTATI ON13.00VOLUNTEER SERVI CE COORDI NATI ON14.00PHARMACY15.00PHYSI CI AN ADMI NI STRATI VE SERVI CES000015.00O000015.0000015.000000015.000000000000015.0000000000000000000000000000000000000000000	4.00
7. 00       HOUSEKEEPING         8. 00       DI ETARY         9. 00       NURSING ADMINISTRATION         00       ROUTINE MEDICAL SUPPLIES         010. 00       ROUTINE MEDICAL SUPPLIES         010. 00       ROUTINE MEDICAL SUPPLIES         011. 00       MEDICAL RECORDS         011. 00       STAFF TRANSPORTATION         012. 00       STAFF TRANSPORTATION         013. 00       VOLUNTEER SERVICE COORDINATION         014. 00       PHARMACY         015. 00       PHYSICIAN ADMINISTRATIVE SERVICES	5.00
8. 00       DI ETARY         9. 00       NURSI NG ADMI NI STRATI ON         10. 00       ROUTI NE MEDI CAL SUPPLI ES         11. 00       MEDI CAL RECORDS         0       4, 426         11. 00       STAFF TRANSPORTATI ON         13. 00       VOLUNTEER SERVI CE COORDI NATI ON         14. 00       PHARMACY         15. 00       PHYSI CI AN ADMI NI STRATI VE SERVI CES	6.00
9.00       NURSI NG ADMI NI STRATI ON       0       1         10.00       ROUTI NE MEDI CAL SUPPLI ES       0       0         11.00       MEDI CAL RECORDS       0       4,426         12.00       STAFF TRANSPORTATI ON       0       1         13.00       VOLUNTEER SERVI CE COORDI NATI ON       0       0       0         14.00       PHARMACY       0       0       0       0         15.00       PHYSI CI AN ADMI NI STRATI VE SERVICES       0       0       0       0       1	7.00
10.00       ROUTI NE MEDI CAL SUPPLIES       0       1         11.00       MEDI CAL RECORDS       0       4,426         12.00       STAFF TRANSPORTATI ON       0       1         13.00       VOLUNTEER SERVICE COORDINATI ON       0       0       0         14.00       PHARMACY       0       0       0       0         15.00       PHYSICI AN ADMINISTRATIVE SERVICES       0       0       0       0       0	8.00
11.00       MEDI CAL RECORDS       0       1         12.00       STAFF TRANSPORTATI ON       0       0         13.00       VOLUNTEER SERVICE COORDINATI ON       0       0       0         14.00       PHARMACY       0       0       0       0         15.00       PHYSICI AN ADMINISTRATIVE SERVICES       0       0       0       0       0	9.00
12.00       STAFF TRANSPORTATION       0       1         13.00       VOLUNTEER SERVICE COORDINATION       0       0       1         14.00       PHARMACY       0       0       0       1         15.00       PHYSICIAN ADMINISTRATIVE SERVICES       0       0       0       0       1	0.00
13.00       VOLUNTEER SERVICE COORDINATION       0       0       1         14.00       PHARMACY       0       0       0       1         15.00       PHYSICIAN ADMINISTRATIVE SERVICES       0       0       0       0       1	1.00
14.00         PHARMACY         0         0         1           15.00         PHYSICIAN ADMINISTRATIVE SERVICES         0         0         0         1	2.00
15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 0 0 1	3.00
	4.00
	5.00
	6.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 11. 1	7.00
LEVEL OF CARE	
	50.00
	51.00
	52.00
	53.00
NONREI MBURSABLE COST CENTERS	
	50.00
	51.00
	52.00
	53.00
	64.00
	5.00
	6. 00
	57.00
	68.00
	9.00
	70.00
	71.00
100. 00  TOTAL   0  0  4, 426  0  0 10	99.00

		YETTE REGIONAL				u of Form CMS-	
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSIS	Provider C	CN: 15-0064	Period: From 10/01/2015	Worksheet 0-6 Part I	
			Hospi ce CCI	N: 15-1548	To 09/30/2016	Date/Time Pre	epared:
					Hospi ce I	2/23/2017 9:3	
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENER		TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
		14.00	SERVI CES 15.00	16.00	CARE SERVICES	18.00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00							8.00
9.00 10.00	NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES						9.00 10.00
10.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE			-			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	
51.00	HOSPICE ROUTINE HOME CARE	0	0		0	104, 077	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	9	0 0	0	53.00
60, 00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM	0			0	0	60,00
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRAI SI NG	0			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64.00	PALLIATIVE CARE PROGRAM	0			0	0	
65.00	OTHER PHYSICIAN SERVICES	0			0	0	
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	
70.00	NURSING FACILITY ROOM & BOARD					0	
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	
99.00	NEGATIVE COST CENTER	0	0		0 0	0	
100.00	TOTAL	0	0	1	0 0	104, 077	1100.00

Heal th	Financial Systems	FAYETTE REGIONAL H	HEALTH SYSTEM		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC	CN: 15-0064	Peri od:	Worksheet 0-6	1
STATI S	TICAL BASIS				From 10/01/2015	Part II	
			Hospi ce CCN	N: 15-1548	To 09/30/2016	Date/Time Pre	
					Hospi ce I	2/23/2017 9:3	U alli
	Cost Center Descriptions	CAP REL BLDG & C		EMPLOYEE	RECONCILIATION	ADMI NI STRATI VE	
	cost center bescriptions	FIX	FOULP	BENEFITS	RECONCILIATION	& GENERAL	
		(SQUARE FEET) (I		DEPARTMENT		(ACCUMULATED	
			DOLLAR VALUE)	(GROSS		COSTS)	
				SALARI ES)		00010)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		2.00	0.00			
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0		0		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0		-49,636	54, 441	1
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	0 1, 111	
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	
7.00	HOUSEKEEPING	0	0		0 0	0	
8.00	DI ETARY	0	0		0 0	0	
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	0	
11.00	MEDI CAL RECORDS	0	0		0 0	2, 315	
12.00	STAFF TRANSPORTATION	0	0		0 0	0	1
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	1
14.00	PHARMACY	0	0		0 0	0	
15.00	PHYSI CI AN ADMINI STRATI VE SERVI CES	0	0		0 0	0	
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	
17.00	LEVEL OF CARE					0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE				0 0	52, 126	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	02, 120	1
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	
00.00	NONREI MBURSABLE COST CENTERS					0	00.00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	
66.00	RESIDENTIAL CARE	0	0		0 0	0	
67.00	ADVERTI SI NG	0	0		0 0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
69.00	THRI FT STORE	0	0		0 0	0	
70.00	NURSING FACILITY ROOM & BOARD		Ű		0	Ū	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
	NEGATIVE COST CENTER		-			-	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	I) 0	0		0	49, 636	100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	00	0. 911739	
		· ·					

Heal th	Financial Systems	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS	ERVICE COSTS	Provider CO Hospice CCI		Period: From 10/01/2015 To 09/30/2016		pared:
-					Hospi ce I	2/23/2017 7.3	
	Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPIN (SQUARE FEET	G DI ETARY	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	
						HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			1		1	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0 0		100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	0. 000000	0. 000000	101. 00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL		HEALTH SYSTEM Provider C		In Lie Period:	Worksheet 0-0	
	TI CAL BASI S	SERVICE COSTS	Hospi ce CC		From 10/01/2015 To 09/30/2016	Part II Date/Time Pre 2/23/2017 9:3	epared:
					Hospi ce I		_
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATI (MI LEAGE)	VOLUNTEER ON SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	CAP REL COSTS-BLDG & FLXT			1			1.00
2.00	CAP REL COSTS-DEDG & TTXT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	551					10.00
11.00	MEDI CAL RECORDS		551				11.00
12.00	STAFF TRANSPORTATI ON				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	(	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	(	15.00
16.00	OTHER GENERAL SERVICE				0 0	(	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	)	0 0	(	50.00
51.00	HOSPICE ROUTINE HOME CARE	551	551		0 0	(	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	C		0 0	(	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	C		0 0	C	
	NONREI MBURSABLE COST CENTERS		-				
60.00	BEREAVEMENT PROGRAM				0 0	(	60. 00
61.00	VOLUNTEER PROGRAM				0 0	C	61.00
62.00	FUNDRAI SI NG				0 0	C	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	C	
64.00	PALLIATIVE CARE PROGRAM				0 0	(	
65.00	OTHER PHYSI CI AN SERVI CES				0 0	(	
66.00	RESI DENTI AL CARE				0 0	(	
67.00	ADVERTI SI NG				0 0	(	
68.00	TELEHEALTH/TELEMONI TORI NG					(	
69.00	THRI FT STORE					(	
70.00	NURSING FACILITY ROOM & BOARD					(	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)				0	C	
	. ,					l (	
	NEGATIVE COST CENTER		1 101		0		99.00 100.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part UNIT COST MULTIPLIER	0, 000000	4, 426 8. 032668		0 0.00000	0. 000000	

COST A	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENE	RAL SERVICE (	COSTS	Provider C	CN: 15-0064	Peri od:	Worksheet 0	S-2552-10 -6
	TI CAL BASI S			Hospi ce CC		From 10/01/2019 To 09/30/2010	5 Part II	repared:
						Hospi ce I		
	Cost Center Descriptions	PHYS	SICIAN	OTHER GENERAL	PATI ENT/			
			STRATI VE	SERVI CE	RESI DENTI A			
			VICES	(SPECI FY	CARE SERVIC			
		(PATTE	NT DAYS)	BASI S)	(IN-FACILIT	Y		
		11		1/ 00	DAYS)			
	GENERAL SERVICE COST CENTERS	10	5.00	16.00	17.00			-
1.00	CAP REL COSTS-BLDG & FIXT				1			1.00
2.00	CAP REL COSTS-BEDG & TTAT							2.00
2.00 3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL							4.00
4.00 5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DI ETARY							8.00
9.00	NURSI NG ADMI NI STRATI ON							9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES							10.00
11.00	MEDICAL RECORDS							11.00
12.00	STAFF TRANSPORTATION							12.00
13.00	VOLUNTEER SERVICE COORDINATION							13.00
14.00	PHARMACY							14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES		551					15.00
16.00	OTHER GENERAL SERVICE			(				16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES					0		17.00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE		0	(				50.00
51.00	HOSPICE ROUTINE HOME CARE		551	(				51.00
52.00	HOSPICE INPATIENT RESPITE CARE		0	(		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE		0	(	)	0		53.00
	NONREI MBURSABLE COST CENTERS			-				
60.00	BEREAVEMENT PROGRAM			(				60.00
61.00	VOLUNTEER PROGRAM			(	1			61.00
62.00				0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			(				63.00
64.00 65.00	PALLIATIVE CARE PROGRAM							64.00
	OTHER PHYSI CI AN SERVI CES		0			0		65.00
66.00 67.00	RESI DENTI AL CARE ADVERTI SI NG		0		()			66.00 67.00
68.00	TELEHEALTH/TELEMONI TORI NG				<u>í</u>			68.00
69.00	THRIFT STORE			( )				69.00
70.00	NURSING FACILITY ROOM & BOARD				1			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		0	ſ		0		71.00
	NEGATI VE COST CENTER		0			Ĩ		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, P	art I)	0	0		0		100.00
100.00								

	Financial Systems	FAYETTE REGIONAL H				u of Form CMS-	
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SE OF CARE	RVICE COSIS BY	Provider C		Period: From 10/01/2015	Worksheet 0-7	
			Hospi ce CC	N: 15-1548	To 09/30/2016	Date/Time Pre 2/23/2017 9:3	pared: 0 am
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Cc	ost to Charge	НСНС	HRHC	HI RC	
		Part I, Col. 9 line	Ratio				
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS				!		
1.00	PHYSI CAL THERAPY	66.00	0. 558247		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 393982		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0. 169672		0 0	0	6.00
6.01	BLOOD LABORATORY	60. 01	0.00000		0 0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 433462		0 0	0	7.00
8.00	CLINIC	93.00	0. 616031		0 0	0	8.00
8.01	BIC	93. 01	0. 728440		0 0	0	8.01
8.02	UCIC	93. 02	0. 000000		0 0	0	8.02
8.03	CIC	93.03	0.000000		0 0	0	
8.04	RIC	93.04	0.000000		0 0	0	1
8.05	PODI ATRY	93.05	0.399883		0 0	0	8.05
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
		Records)					
	Cost Center Descriptions	HGI P HC	CHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGIP (col. 1 x	
	•		col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATI ONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0		0 0	0	6.00
6.01	BLOOD LABORATORY	0	0		0 0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	7.00
8.00	CLINIC	0	0		0 0	0	8.00
8.01	BIC	0	0		0 0	0	8.01
8.02	UCIC	o	0		0 0	0	8. 02
8.03	CIC	0	0		0 0	0	8.03
8.04	RIC	0	0		0 0	0	
8.05	PODI ATRY	o	0		0 0	0	1
9.00	RADI OLOGY-THERAPEUTI C						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0		0 0	0	
		· · ·		•		-	

	Financial Systems FAYETTE REGIONAL HI ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C		Peri od:	u of Form CMS-2 Worksheet 0-8	
ALCUL	ATTON OF HUSPITAL-BASED HUSPICE PER DIEM CUST	Provider Co	JN: 15-0064	From 10/01/2015	worksneet 0-8	
		Hospi ce CCN	N: 15-1548	To 09/30/2016	Date/Time Pre	pared
					2/23/2017 9:3	
				Hospi ce I		
			TITLE XVIII		TOTAL	
			MEDI CARE	MEDI CAI D		
	Γ		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					4
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.0
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	1
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0 0		4.0
. 00	Program cost (line 3 times line 4)			0 0		5.0
	HOSPICE ROUTINE HOME CARE			- 1	-	4
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			104, 077	6.
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				551	7.
. 00	Total average cost per diem (line 6 divided by line 7)				188.89	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	-	51 0		9.
0.00	Program cost (line 8 times line 9)		104, 0	78 0		10.
	HOSPICE INPATIENT RESPITE CARE					4
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			0	11.0
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.
	Total average cost per diem (line 11 divided by line 12)				0.00	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		0 0		14.0
	Program cost (line 13 times line 14)			0 0		15.
	HOSPICE GENERAL INPATIENT CARE					4
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,			0	16.0
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 13)				0	1
3.00	Total average cost per diem (line 16 divided by line 17)				0.00	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		0 0		19.
0. 00	Program cost (line 18 times line 19)			0 0		20.
	TOTAL HOSPICE CARE		1			
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				104, 077	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				551	
3 00	Average cost per diem (line 21 divided by line 22)				188.89	23.

ALCULA	TION OF CAPITAL PAYMENT	Provider CCN: 15-0064	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Pre 2/23/2017 9:30		
		Title XVIII	Hospi tal	272372017 9.30 PPS	U alli	
				1.00		
	PART I - FULLY PROSPECTIVE METHOD				-	
	CAPITAL FEDERAL AMOUNT			100 570	1 1.	
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			180, 578 0		
	Capital DRG outlier payments			0		
	Model 4 BPCI Capital DRG outlier payments			0		
	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	6.40		
	Number of interns & residents (see instructions)		,	0.00	4.	
00	Indirect medical education percentage (see instructions)			0.00	5.	
	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines 1 and 1.01	, columns 1 and	0	6.	
	1.01)(see instructions)			0.00	7.	
	30) (see instructions)					
					8	
					10	
	Disproportionate share adjustment (see instructions)	,		0.00		
	Total prospective capital payments (see instructions)			180, 578	12	
				1.00		
-	PART II - PAYMENT UNDER REASONABLE COST					
	Program inpatient routine capital cost (see instructions)			0		
	5 1 5 1					
					3	
	Total inpatient program capital cost (line 3 x line 4)			0		
00 [				0		
				1.00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
00 [	Program inpatient capital costs (see instructions)			0	1	
	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	-	
-	Net program inpatient capital costs (line 1 minus line 2)			0		
	Applicable exception percentage (see instructions)			0.00		
	Capital cost for comparison to payments (line 3 x line 4)	notructions)		0 0. 00		
	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar	-	lino 6)	0.00		
	Capital minimum payment level (line 5 plus line 7)	y circuitstances (irrie 2 x	. The O	0		
	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0		
	Current year comparison of capital minimum payment level to		less line 9)	0		
. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	11.	
	Net comparison of capital minimum payment level to capital p	payments (line 10 plus lin	ie 11)	0	12.	
	Current year exception payment (if line 12 is positive, ente			0	13.	
. 00	Carryover of accumulated capital minimum payment level over	capital payment for the f	ollowing period	0	14	
	(if line 12 is negative, enter the amount on this line)					
	· · · · · · · · · · · · · · · · · · ·					
	Current year allowable operating and capital payment (see ir Current year operating and capital costs (see instructions)	nstructions)		0		